Practical Approaches for Identifying and Managing Abused and Neglected Children

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Abused and neglected children may pose exceptional challenges for early intervention providers, particularly speech-language pathologists, who are faced with large, diverse caseloads. This article focuses on practical strategies regarding reporting abuse, assessing the children effectively, and managing the bizarre behaviors they may exhibit. Many anecdotal descriptions are included. Although the article is written from the point of view of speech-language-pathologists, it may be useful for a number of professionals, including physicians, psychologists, psychotherapists, social workers, and educators.

The National Committee to Prevent Child Abuse (NCPCA) (1996) defines child abuse as a nonaccidental injury or pattern of injuries to a child. "Child abuse is damage to a child for which there is no ‘reasonable’ explanation. Child abuse includes nonaccidental physical injury, neglect, sexual molestation, and emotional abuse” (p. 1).

Moreover, child abuse is a type of domestic violence and may be associated with other patterns of assaultive, coercive behaviors that adults or adolescents use against intimate partners. In 1995, a survey of 34 states, constituting 67.3% of the U.S. population, indicated that 1,215 child maltreatment deaths were confirmed by child protective services (NCPCA, 1996). Professionals generally agree this is a low estimation of actual deaths. During the past 10 years, abuse fatalities have increased by 39%. For children who experience chronic maltreatment, development in all areas is compromised. Dependent upon the regularity, severity, and length of abuse, children who are not killed or who escape per-
permanent physical injuries may still develop into adults with serious problems. Those problems manifest most notably in social relations and communication.

Fifty percent of all children who experience child abuse-neglect are estimated to exhibit significant delays in communication abilities (Arkansas Department of Human Services, 1993; Hudson & Giardino, 1996; Katz, 1992). On the average, incidence data indicates 3 million new annual reports of child maltreatment nationally, with more than 70% of these reports substantiated as abuse-neglect cases (Fantuzzo, Stevenson, Weiss, Hampton, & Noone, 1997; U.S. Department of Health and Human Services, 1992). With approximately 4.3 million substantiated maltreatment cases and an anticipated 2 million abused-neglected children who may exhibit speech-language disorders, one can easily conclude that abuse-neglect may be an extremely prominent causal factor in the case-loads of many early intervention providers.

It seems that a history of child maltreatment may be overlooked once an identifiable disorder, such as developmental delay or psychiatric disturbance, is diagnosed (Baker & Cantwell, 1987; Baltaxe & Simmons, 1981). For example, in some retrospective studies, 50% of adults with a diagnosis of psychiatric disturbance were found to have experienced maltreatment themselves as children. The close association of psychiatric disturbance to language and speech disorder is well-established in the literature (Baker & Cantwell, 1987). Baltaxe and Simmons (1981) speculate that at least 50% of children with communication disorders will have at least one identifiable psychiatric disorder.

Considering the figures reported earlier in this article, one could easily postulate that as many as 25% of children with both communication and psychiatric disturbance may also have a history of child abuse-neglect. So, again, a logical, albeit questionable, conclusion is whether maltreatment is the “elephant” in our midst. It may be the elephant which we have apparently overlooked as an important factor to address in our delivery of speech-language and hearing services to children.

Beyond recognizing that maltreatment has an impact, what is the average early intervention provider, such as a speech-language-pathologist (SLP), to do? A typical response is to document the co-occurrence of the abuse-neglect with communication delays, address the pattern in a diagnostic report, and then quietly proceed with therapy as usual. All the while, the clinician may be plagued with an ill-feeling regarding just how to deal with the identified history of maltreatment or active case of maltreatment when a child is experiencing a period of maltreatment during the course of therapy. The question, “What is the average speech-language pathologist to do?” requires an obvious and simple answer. That answer is to provide the highest level of care possible for these children and their families, while recognizing that the speech-language service cannot be offered in a vacuum. Speech-language pathologists (SLPs) must become more aware of their responsibilities as legally mandated reporters of maltreatment and learn to operate more efficiently when intervening with abused and neglected children. The solution is far more easily stated than practiced.

Consider these scenarios:

- Melanie is a 25-year-old SLP providing language stimulation training to a teenage mother of an underweight toddler. The teenager and dia! mother are consistently difficulty=

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1Referring to the Scope of Practice statement regarding speech-language pathologists (ASHA, 1990), SLPs are professionals who identify, assess, and provide treatment for individuals of all ages with communication disorders. It is the duty of these professionals to counsel individuals with disorders of communication, their families, caregivers, and other service providers relative to the disability present and its management.
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Toddler who was born 2 months prematurely. The mother is anorexic and diagnosed with adjustment disorder. The teenage mother has recently moved home with her natural parents who are concerned that the teenager neglects the toddler. The parents are obviously devoted to their teenage daughter and grandchild. During the language stimulation sessions, the mother is extremely inconsistent with her toddler, showing affection one minute and angry outbursts in the next few minutes. The young mother confesses that she feels depressed and sometimes wishes that her baby would just disappear.

- Jim, an SLP for an urban public school, has reasonable cause to suspect that his 10-year-old speech impaired client, Billy, is experiencing physical abuse perpetrated by his parents. The parents were upset that Billy was having difficulty keeping his pants up. The father used a torn piece of fabric and tied Billy's pants on so tightly that the skin around his waist was rubbed raw to the point of bleeding. Billy confesses to Jim that he has had to wear these pants all day and night for the past 2 days and 2 nights. Jim provides the information to his immediate supervisor who empathizes with the plight of the child but suggests firmly that Jim should stay clear of filing a report and ignore the child's clothing.

- June is an SLP for the Department of Human Services. She is required to read a statement to all new clients as part of the orientation procedure, which states that client confidentiality may not be maintained if parents report information that may be consistent with reasonable cause to suspect child abuse or neglect. June has noticed that about 50% of the parents referred to her never seek a follow-up visit for speech-language services for their children following the orientation. Several families have complained that the agency is attempting to take their children away without cause.

- Six-year-old Mary masturbates frequently and publicly even during language group if she has to sit still for an extended period. Her cousin who is also in language group blurts out in the group that Mary has "done it" with her big brother John who is 14 years old.

- Mrs. Smith is the mother of a 3-year-old son who is diagnosed with autism. During the day, she keeps him confined inside a "cage" constructed of a baby bed with small slats turned upside down. She has gone to court regarding this abuse and was found innocent. Her attorney argued that the child would hurt himself if taken out of his cage because of the serious developmental disorder and history of self-abusive behaviors. An SLP has found no measurable improvement in the child's communication or social behaviors for the last 6 months during which the mother has implemented this strategy.

Each of these scenarios is based on real-life situations that the writer has experienced directly or has been consulted about. Each of these scenarios should stimulate thinking regarding the need for early intervention providers to know more about managing issues related to abuse and neglect. There are no easy solutions. However, this article offers information that should spark the professional thinking of SLPs and others, stimulating at least two or three solutions regarding these situations that would not have occurred to them previously.
Currently, only limited educational opportunities exist to prepare pre-service SLPs and better equip inservice SLPs for work with this particular population of children. This article provides a broad overview of child maltreatment, the issues faced by SLPs in dealing with these children, and information sources and general guidelines for approaching assessment and intervention individually or as members of multidisciplinary teams. Therefore, this article:

1. Provides an overview of the history of maltreatment, with emphasis on the U.S. population.
2. Describes federal and state laws regarding child abuse-neglect.
3. Describes behavioral disturbances experienced by children associated with abuse-neglect and how an SLP might intervene.
4. Reviews basic information regarding children's sexual and emotional development and the impact of abuse on social functioning.

**Overview of Federal Laws/State Statutes**

To establish the best and most efficient practices for dealing with abused and neglected children, it is vital that early intervention providers understand the law, the governing bodies enacted by the law, and the manner in which services are delivered. Information like this is essential for any professional who plans to influence maltreated children at microlevels, which is the case when treatment is provided directly to children, or, when SLPs intervene on a larger scale—which is the case when professionals seek to influence the laws and the functioning of agencies that are responsible for the policies and resulting services for abused/neglected children and their families. The federal law that served as the initiative for state statutes is The Child Abuse Prevention and Treatment Act. This law was originally enacted in 1974 as P.L. 93-247 (National Center on Child Abuse and Neglect, 1992). It has been amended numerous times and was rewritten completely in 1988 as the Child Abuse Prevention, Adoption and Family Services Act of 1988, P.L. 100-294. Additional amendments were added to address community-based programs and preventative services for homeless families. In 1992, the Act was reauthorized and amended as the Child Abuse, Domestic Violence, Adoption, and Family Services Act of 1992 (see P. L. 102-295). Additional amendments and revisions have occurred as recently as 1996, with the law currently titled as Child Abuse Prevention and Treatment Act, As Amended (1996). P.L. 93-247 consists of three titles that are described briefly below.

**Title I: The General Program**

The National Center on Child Abuse and Neglect is described in Title 1. This portion of the law established an advisory board, known as the Advisory Board on Child Abuse and Neglect, with a Secretary serving as the primary authority figure. The Board consists of 15 members, known for their expertise in child abuse and neglect, who are appointed by the Secretary of the National Center. To my knowledge, no SLP has served on the Advisory Board. Qualifications for potential members of the Advisory Board are well-described, with 11 considerations specified regarding the professionals to be appointed to the Board (law, social services, medicine, teachers, parents, voluntary groups, and others). Terms of office are for 4 years, with meetings held semiannually.

**Title II: Prevention**

Title II establishes community-based programs and preventative services for homeless families. In 1992, with the law currently titled as Child Abuse Prevention and Treatment Act, As Amended (1996). P.L. 93-247 consists of three titles that are described briefly below.

**Title III: Services Homeless**

This section addresses the needs of homeless children and their families, families and their homelessness. Public L

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*In addition to the advice of an attorney, responsible for the policies and resulting services for abused/neglected children and their families, the federal law that served as the initiative for state statutes is The Child Abuse Prevention and Treatment Act.*
Identifying and Managing Abused and Neglected Children

Described also within Title I is an Inter-Agency Task Force on Child Abuse and Neglect, responsible for coordinating federal efforts for prevention and treatment of child abuse. As the descriptor “inter-agency” implies, membership is from all federal agencies with some programs or activities related to child abuse and neglect. The task force is responsible for standards, coordinating the use of grants, and preparing a comprehensive plan for coordinating the goals and objectives of all federal agencies and organizations with programs and activities related to child abuse and neglect.

Communication with the public at large and with professionals, in particular, occurs through the publication of numerous documents that are disseminated through the National Clearinghouse on Child Abuse Neglect. A responsibility of the Secretary is to conduct research through the center regarding child abuse and neglect.

Title II: Community-Based Prevention Grants

Title II establishes support for the states for community-based assistance with the annual appropriated funds established at $45,000,000 in 1992, with funding ranging broadly since this time.

Title III: Preventative Services for Children of Homeless Families

This section of the law is about the requirements for researchers who submit grants that address the needs of maltreated children and their families, with some attention to homeless families and those families at risk for homelessness. Public Law 93-247 is the cornerstone for all state laws and statutes.

State Laws and Statutes Regarding Abuse and Neglect

For information regarding laws pertaining to child abuse-neglect in a specific state, participants might contact the state department of interest. In some states, that might be, for example, DCFS (Division of Children and Family Services), DHS (Department of Human Services) or DFS (Division of Family Services). Regardless of the state, laws are similar relating to:

- defining acts of abuse-neglect
- describing reporting procedures
- the obligations of mandated reporters
- the obligations of investigators

To determine whether procedures to deal with abuse-neglect are adequate within a particular setting, clinicians might guide their evaluation according to the 20 questions in Table 1. The sample questions are reflective of appropriate answers for the state of Arkansas. However, there are greater similarities among state statutes than there are differences. Another resource is Statutes at a Glance Fact Sheet: Reporting Penalties (National Clearinghouse on Child Abuse and Neglect, 1997).

To summarize, clinicians are potential reporters of abuse. Given this potential, clinicians should:

1. Have a working knowledge of federal laws and the laws of their specific state.
2. Develop guidelines for the workplace regarding suspicious case histories, routine visual scans of children, and reporting procedures.
3. Review and revise procedures within various settings to eliminate discrepancies between practice and necessities. In doing this review, SLPs should consult with attorneys well-versed in the legal issues.

In addition to the wealth of published information available regarding reporting, clinicians should always seek the advice of an attorney who specializes in child abuse-neglect. The state Prosecuting Attorney General’s office will generally be one of the best resources for legal advice.
verbal information with another professional within the same facility with whom you would be free to collaborate.

Beyond the case history and parental interview, the next critical area for potential identification of maltreatment is direct examination of the child. Routinely, SLPs conduct oral-facial and otoscopic examinations, observe gross motor skills, general appearance, and child behavior. Within the context of each of these routine functions, the clinician should make a conscious effort to be aware of signs of abuse and neglect. Different categories of abuse-neglect are briefly described along with the physical or behavioral symptoms associated with maltreatment.

**Signs of Physical and Emotional/Psychological Abuse**

Physical abuse is not the most common form of maltreatment; however, it is the easiest form to identify (Kessler & Hyden 1991). Emotional abuse may occur separate from physical abuse, but it is unlikely for physical abuse to occur without some type of psychological component. The injuries that most often would be correlated with physical abuse would not be readily obvious to an SLP. For example, see Figure 1. The most suspicious injuries often occur to the head (covered by hair), back, buttocks, and rear thighs, which are not easily visualized in a routine diagnostic or therapy session. It is not recommended that the SLP develop any routines to undress the child or require disrobing unless this is a common procedure established within their particular work environment. Given these constraints, there are still many observations the SLP can make to identify physical abuse.

Thinning hair or obvious patches of missing hair could be associated with alopecia or hair loss resulting from the hair being pulled out forcibly. Caution should be taken not to confuse alopecia with ringworm or tinea cor-

![Figure 1](image_url). Examples of areas of injuries to the back that may be indications of abuse.

pus, a fungus which results in a round, patchy-like raised area on the skin or scalp. If the fungus is active on the scalp, there may be several areas of circular, patchy bald areas.

The early intervention provider should be observant of seasonally inappropriate clothes (for example, long sleeves or dresses in the summer to cover injuries). Routine childhood injuries usually consist of bumps and bruises to bony prominences, such as the chin, forehead, elbows, knees, and shins. Unusual injuries to these areas would be multiple bruises, lacerations, and burns. The critical term is *multiple*. Children experiencing chronic abuse may present with many varieties of injuries to the skin at different stages of healing. In fair-skinned individuals, bruising at different stages of healing may vary in color from red, purple, brown, light-brown, or yellow. In darker-skinned individuals, bruising may vary in tone from reddish, green, brown, or black. Bruises may be the result of:

- bites (look for tooth patterns),
- slaps (look for hand patterns),
- binding (look for slash-like marks), or
- severe hits with cords (look for looped-shaped bruises to the skin).

Facial injuries, particularly bruising around the eyes, should be considered suspicious injuries.

**If eye injuries:**
- look up, around to initiate an immediate referral for evidence of an area (Kessler & Hyden 1991). See Figure 1.
- Some of the physical/emotional behavior of the parent should be highly suspicious:
  - Parent (. . . . . .)
  - Child ( . . . . . .)

Below is a typical conver:...
Injuries to abusers.

If eye injuries with resultant edema and blood in the eye are observed, instruct the child to look up, around, and down. Failure to be able to initiate an upward gaze might warrant immediate referral to a physician. This might be evidence of a blow-out fracture of the orbital area (Kessler & Hyden, 1991).

See Figure 2, which illustrates some physical signs of abuse that might be discovered during the orofacial examination. The early intervention provider should be concerned with any bruising near the corners of the mouth that might be consistent with the bruising that would occur from gagging a child. Examine the gums to see if there are any injuries that might indicate that a pacifier or bottle was forcibly shoved into the child’s mouth. An otoscopic examination might reveal blood in the ear or behind the tympanic membrane. Blood behind the tympanic membrane might be associated with a blow to the head. The child might be lethargic or experiencing vomiting. A physician or nurse should be consulted if these symptoms are observed.

Some of the common signs of psychological/emotional abuse are observable in both the behavior of the child as well as the behavior of the parent. For example:

- Parent describes the child critically and seems genuinely surprised or highly skeptical if the clinician points out positive traits
- Behavioral extremes are observed in the child; the child may be prone to angry outbursts or lengthy periods of sullen moods
- Child bullies or picks on other children
- Child behaves significantly different in the presence of the parents as opposed to when the parents are absent
- Adolescents may have a history of running away

Below is a sample transcript that reflects a typical conversation that might occur between a parent who is emotionally abusive. This scenario is drawn from an actual case of a divorced mother whose 10-year-old son was diagnosed with attention-deficit hyperactivity disorder. Along with her own depression, the mother was having to adjust to parenting alone in the face of some trying family issues.

**Clinician:** Joe did a great job today in group. I see some very positive changes in his expressive language. He’s not afraid to try to read or talk in group anymore.

**Parent:** You can’t be talking about my Joe (laughs). I get so frustrated with that boy that I get sick of looking at him. He won’t do a thing for me. His dad is worthless, too.

**Clinician:** It must be hard to have a child with the problems that Joe has. You need a break sometimes, too.

**Parent:** He won’t read for me, even slammed his book down. I screamed at him before I knew it.

**Signs of Sexual Abuse**

Although all forms of child maltreatment evoke strong emotional response, particularly from health professionals who service children, child sexual abuse may be among one of the most disturbing forms of abuse to consider as it may represent in adult minds such a basic violation of innocence or the presumed relationship between children and adults. Actually, children’s recovery from sexual abuse is significantly influenced by the way in which adults respond to the child who has been abused. This issue will be explored further in the discussion.

Sexual abuse is any form of sexual behavior that a child is persuaded, induced, or forced to participate in, assist with, or observe when the perpetrator or offending party is significantly more sophisticated or older than the victim. Generally, sexual abuse is considered when there is
Injuries to Ears, Nose, and Mouth

- Bruised swollen lip
- Blood clot in nostril
- Deviated nasal septum
- Lacerated frenulum of tongue
- Lacerated frenulum of lower lip

Forced feeding may injure lips and teeth and tear frenula of lips and tongue.

Direct blow to nose may result in deviation of nasal septum caused by cartilaginous injury or septal hematoma formation.

- Direct blow to external ear may cause hemorrhage and hematoma formation; blows repeated over time may result in "cauliflower ear".

Otoscopic views

- Dark blood trapped behind left tympanic membrane
- Air-fluid level
- Tear in pars tensa of right tympanic membrane

Blood trapped behind tympanic membrane may be sign of basal skull fracture.

Tear in tympanic membrane may result from direct blow to ear or basal skull fracture.

Figure 2. Examples of injuries that might be observed during the orofacial examination. (From “Physical, Sexual and Emotional Abuse of Children,” by M. C. McNeese & J. R. Hebeler, 1977, Clinical Symposia, 29, p. 7. Copyright 1977 by Ciba Geigy (now Novartis). Adapted with permission of the publisher.)

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an age difference of 5 years between the perpetrator and child. Sexual abuse includes rape, molestation, prostitution, noncontact sexual acts (sexual comments to the child, obscene media), oral sex, and penile penetration (Faller, 1993). In the electronic age, perpetrators of sex crimes against children are even finding ways to "stalk" potential victims via the Internet (Faller, 1993).

Individuals in health-related professions like speech-language pathology would not be involved in physical examinations that would indicate sexual abuse. However, there are some psychosocial behaviors of which the clinician should be aware. Faller (1993) suggests that the following are high probability indicators of sexual abuse:

- spontaneous statements that indicate precocious sexual knowledge
- sexually explicit drawings and play with toys
- sexual invitations to older persons and younger, naive children
- excessive masturbation

Children who are malnourished may have pleasant facial expressions, good coloring, and may appear alert. These children may be active and playful until the late stages of malnourishment when they become much weaker or frequently ill due to low resistance from nutritional deprivation, heart failure, or failure of other body systems.

Other common signs of neglect are:

- chronic truancy or unnecessary absences from school; frequently missed appointments
- generally dirty appearance of the child; frequent bouts of head lice and shingles
- pervasive deficits in overall functioning and poor problem solving
- extremely quiet child who is eager for the attention of adults
- poor dental hygiene; rotten, missing, or many broken teeth
- history of child abandonment

Puting Our Role as Reporters in Perspective

Any individual might be the perpetrator of a neglectful or abusive act toward a child without the singular act or lone period of crises representing child abuse or neglect leading to irreversible harm to the child. Clinicians must be observant and careful. Furthermore, clinicians must be aware that inefficient management or poor judgments about how to deal with children are not always beyond the parents’ ability to self-correct if they demonstrate a willingness to change, learn from their mistakes, and have a support system that promotes healthy functioning.

On the other hand, when abuse necessitates reporting and the formal involvement of other professionals, clinicians should and must
report—even anonymously—if it will save a child. Useful strategies that will prepare clinicians to deal with reporting before it has to occur include the following:

- Network with other healthcare professionals who commonly deal with issues of maltreatment—including physicians, nurses, social workers, psychiatrists, psychologists, psychotherapists, and educators.
- Be familiar with the juvenile and chancery courts and network with judges, lawyers, and law enforcement professionals.
- Be aware of organizations in your area that provide services to parents and children to prevent abuse.
- Be prepared to work harder than usual with families that are abusive, meaning you may need to (a) make arrangements for an advocate to get them to required appointments, and (b) implement interventions that involve intense parent training.

The Impact of Abuse/Neglect on Emotional and Sexual Development

Two of the least discussed areas of development in the field of speech-language pathology are the sexual and emotional development of children. One of the most thoughtful discussions of emotional development is offered by Daniel Goleman (1997), Emotional Intelligence: Why It Can Matter More Than IQ. Goleman defines emotion as “a feeling and its distinctive thoughts, psychological and biological states, and range of propensities to act” (p. 289). In contrast to emotion, a mood is a more subdued long-term expression of some internalized state. Temperament is the pattern of emotions that are most commonly expressed that typify an individual. Therefore, some people are described as cheerful, grumpy, or sad, for example. The basic family of emotions from which all other emotions are thought to emerge include anger, sadness, fear, enjoyment, love, surprise, disgust, and shame. Lois Bloom (1993) offers one of the most thorough discussions of the relationship of emotional expression to language development in young children.

In general, Bloom found that for children under the age of 2 years, the children were more active in language production when emotional expression was at a neutral valence—in other words, the children were experiencing neither strong negative or positive emotions. Based on Bloom’s findings, one can conclude that strong emotion negatively affects language use.

Children who experience significant abuse are children who likely experience emotional extremes resulting in reduced cognitive capacity for perceiving accurately their own emotional response as well as the responses of others. Thus, abused and neglected children experience delays in learning about their own emotional response as well as being able to interpret the emotional expressions of others. Maltreatment may create emotional turmoil that severely limits the child’s capacity for exploration, thinking, learning, or communication.

Goleman (1997) describes more current thinking to explain the function of the emotional brain. The amygdala (there are actually two) is found above the brainstem near the bottom of the limbic ring. The amygdala serves as a “first-alert” emotion activation system, with the capacity to override the function of the slower activation pathway from the senses to the thalamus to the neocortex. If the amygdala is triggered, the result is that hormones are secreted, the body is mobilized for movement, the heart beats faster, the senses are more alert, and the face may be fixed in a fearful expression, like establishing an individual is these emotional result of the emotion.

Such emotion without war frequently in abuse. For example, a 3 year-old male was sent to prison for dramatically from rage, with his jaw, when in therapy session subject to confusion.

Equally concerning to the development of children. Urquizu and milestones in development:

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For more information, children were more do not exploit; I female-male Masturbation; sh
IDENTIFYING AND MANAGING ABUSED AND NEGLECTED CHILDREN

fearful expression (Goleman, 1997). Traumatic events, like physical abuse or neglect, may establish emotional memories of which the individual is not consciously aware; however, these memories may be expressed as irrational, emotional outbursts later in life as a result of the abuse.

Such emotional outbursts that can occur without warning have been observed most frequently in children who have experienced abuse. For example, one physically abused 5-year-old male child whose father was in prison for drug-related crimes changed dramatically from smiling and playing to a fit of rage, with fists balled tightly and a tensely set jaw, when asked to repeat his name during a therapy session. Maltreated children may be subject to constant "amygdala hijacking."

Equally complex and significant in the development of children is their sexual development. Urquiz and Winn (1997) described the milestones in sexual development as follows:

- Infants in discovering themselves may engage in repeated self-stimulation of the genitals, with periodic erections for boys and vaginal lubrication with girls. Infants seek closeness (hugging, touching).
- From ages 2 to 5 years, children's self-stimulatory behaviors are more planful, and children left to their own devices may frequently engage in masturbatory behavior. At this time, children may be more curious about their bodies and enjoy the physical sensation of nakedness.
- School-age children have an increased interest and verbal capacity to exchange information about sexual ideas and feelings. Around the age of 7 years, strong inclination to presumed male-female roles may dominate play. Children have more knowledge of appropriate versus inappropriate behavior. Self-stimulation or masturbation may occur in more private situations or not at all.

Clinical Note: During this stage, parents should be encouraged to teach children the appropriate names for their body parts. Further, one of the most successful strategies at this stage to prevent sexual exploitation is to help children learn to identify risky situations rather than focusing on teaching that describes "good touches" and "bad touches." If a perpetrator has gotten close enough to begin the sexualization of the child through touching or discovering the child during masturbatory periods, the individual already has far too much access to the child. Given the thinking abilities of young children, they are better able to grasp the "big picture," rather than the discreet features.
Clinical Note: Sexual abuse in males is probably significantly under-reported. There seems to be an issue of reverse gender bias, with sexual abuse of male children generally tolerated to a greater extent. Early sexual activity among boys as opposed to girls also appears to be accepted more readily. Clinicians should be concerned with the impact of gender bias on clinical services to children. More research is needed.

Communication Assessment and Treatment

Because abused and neglected children often experience poor health and limited access to medical treatment, these children may often experience frequent bouts of middle ear dysfunction and exhibit varying degrees of hearing loss and reduced vision. SLPs and other early intervention providers should monitor carefully the results of hearing and vision screenings and share these results with other professionals, particularly psychologists and others who conduct psychological assessments. Routinely, abused-neglected children with undiagnosed vision and hearing problems may receive psychological examinations without preliminary vision and hearing screening (Burl, 1992). During the completion of my doctoral thesis, more than half of the abused and neglected children who were rejected for the study had histories of middle ear dysfunction, unilateral hearing loss, or reduced vision. One subject was rejected because of sickle cell anemia and the strong association between sickle cell crises and the increasing compromise of language function with each subsequent event.

Clinicians should be aware that in cases where the abuse or maltreatment was perpetrated by an adult, the child may be difficult for the adult examiner to assess directly in the early stages of intervention (Burl, 1992). Therefore, group assessments, individual observations, and caretaker interviews may be the diagnostic procedures of choice when children have experienced recent trauma.

In general, physically abused children will perform similarly to their nonabused counterparts in vocabulary and grammar (Burl, 1992; Fox, Long, & Langlois, 1988; Radford & Taylor, 1997). The most notable differences observed in physically abused children may be in pragmatic abilities. Physically abused children, by the nature of their experiences, are socialized to reject conversational partners and to respond impulsively and negatively.

Children who primarily experience neglect will demonstrate the most significant delays in communication development, with significant delays in all aspects of language (Fox et al., 1988). Children with primary experiences of neglect are generally more social with adult examiners and are eager for the adult's attention. As mentioned previously, children who have experienced neglect are typically significantly more delayed in all areas of language skills. These children have weaknesses in their strategies for learning. Therefore, clinicians might use a strong experiential approach to training, providing intense language stimulation through home-based interventions tied to common routines (eating, dressing, bathing, cooking, cleaning, and other activities) as well as play, drill-play, and drill to improve language and communication performance for academic skills.

Regardless of the pattern of abuse experienced, children who have experienced maltreatment share the need to heal emotionally. Interestingly, there is a reciprocal relationship between communication and emotional development. Therefore, as children grow in knowledge of language and its use for communication, they grow in their abilities to express problematic issues through talk and play. Play is a common technique used by a variety of healthcare professionals for different reasons. Although the psychologist, psychotherapist, or counselor resolve psychological intervention, promote language growth, and focus on which aspect of therapy the child learns, there is a focus on the child's emotional development.

As children during play, caregivers may re-enact play. This strategy might alter the context of play experiences and be used to reassert control over the child's own behavior. Although these situations are emotionally painful and traumatic, they also serve to retrain the child in the use of language and give the child an opportunity to re-enact situations in a manner that allows for constructive play.

This revisitor to the account of a recently abandoned episode that I was playing a role in led me to understand how play was so important for the child.

Child: I don't understand. (Cries)

Micha: But you have pushed me.

Child: That's okay, but I don't understand.
or counselor uses play therapeutically to resolve psychologically troubling issues, early intervention providers like SLPs use play to promote language growth. Regardless of which aspect is targeted in play therapy, all aspects are positively influenced. So, play therapy that directly focuses on psychological issues and emotion will indirectly promote language growth. Conversely, play therapy that focuses on language will indirectly promote improved psychological function as the child learns through language to perceive objects, relationships, emotions, and experiences and talk about them. Therefore, play therapy changes brain functioning and can serve to retrain the presumed overactive function of the amygdala, which short-circuits reasoning ability.

As children revisit their experiences of trauma during play, clinicians will find that the children may re-enact episodes of abuse during their play. This strategy allows children to safely deal with the experience. During their play, children might alter power relationships so that in the context of play, the child might change the outcome of traumatic events. Children with experiences of abuse-neglect need such developmentally appropriate experiences of control over their bodies and environment. Additionally, neglected children need opportunities to solve problems and to overcome learned helplessness (Urquizza & Winn 1997).

This revisiting of the traumatic event is illustrated in the following diary language sample of a 3-year-old boy whose father had recently abandoned the family after an angry episode that the child witnessed. The little boy was playing with plastic toy figures that he used to represent his family members. The play was spontaneous and unsolicited.

Child: I don’t want to be your daddy any more. [Child imitates adult male voice] Poor Michael, no more daddy. I guess I’ll just have to get me a new daddy. [Child pushes adult figure off table]

Speech-language pathologists can help children who are abused and neglected with accompanying delays in speech and language by structuring therapy to teach the children the words they need most to express themselves and to label their own emotions. The SLP can also work in conjunction with other professionals, like the psychotherapist, to learn how to assist the child to label feelings and put experiences in perspective to promote emotional healing and improved social competence.

Such an example occurred recently when this writer evaluated the speech and language of a 9-year-old boy who had experienced significant physical abuse, resulting in a broken nose and other trauma to the head and face. During the session, this 9-year-old boy exhibited dysarthric speech characteristics, with limited facial expression. A noticeable tremor of his hands was observed, and I commented that I noticed his hands were shaking. He commented, “Yeah, my hands shake a lot when I meet new people.” I asked how he felt when meeting new people and he said, “nervous.” I responded that his nervousness with new people was something I would expect. Adults who were supposed to care of him did some really cruel things and made it hard for him to know which adults he could trust. I inquired further regarding his counselor who brought him to our therapy session. He indicated that he felt pretty comfortable with the counselor and that he was not as nervous with him. I told the boy that the counselor would not take him anywhere that might be a dangerous place. I told him that the counselor thought that our clinic was a safe place for him.

**Some Therapeutic Strategies**

In summary, there is a vast amount of information available regarding speech-language intervention and the issue of child maltreatment. The art lies in blending the information
from these far-flung fields in order to serve children more effectively. To be effective, intervention programs must take into account ways of dealing with the environmental and emotional issues that serve to disrupt the performance of abused-neglected children. The following eight strategies are important to consider and implement:

- Avoid isolated, closed door therapy sessions with any children and particularly with children who have been sexually abused.
- Maltreated children may have poor awareness of normal ways for adults and children to express affection to one another, like hugging, pats on the back, “high-fives,” or hand slapping to indicate praise. Allow them to reject touching if they so choose.
- Avoid complicated rules where touching is concerned.
- Listen and watch if children spontaneously begin to act out or talk about traumatic events; acknowledge what you see and hear and redirect the child in ways that are adaptive. Maintain a neutral tone of voice and a pleasant facial expression.
- Listen, watch, and label children's expression of positive and negative emotion and use it as a teaching moment to assist children in learning to change their expressions and regain emotional control in healthy ways.4
- Establish a predictable routine; this is comforting to the child.
- Use speech and language activities that are reasonable for the child’s current living situation.
- It is just as important to train children when not to talk as it is to train them when to talk. Abused children will have difficulty negotiating and sharing talk space just as they have difficulty sharing or negotiating any other activity.
- Finally, set high standards for the children that are promoted by the unified team of the child, family, teacher, and other health care professionals.

Conclusions

Child abuse and neglect are ancient and universal problems. This article specifically addresses ways early intervention providers in the United States, with emphasis on SLPs, can identify abuse and neglect and manage children who are at risk for, are experiencing, or who have experienced abuse and neglect. To conclude, Table 2 is a summary of suggestions when abuse or neglect is suspected.

Table 2. Action

<table>
<thead>
<tr>
<th>Document</th>
<th>Observations/behavior</th>
<th>Spontaneous</th>
<th>Strong behaviors</th>
<th>Compulsions</th>
<th>Related stimuli</th>
<th>Observer tone and expression</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get a second opinion, preferably from an outside or trained to observe.</td>
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<td>Do not bias your conclusions.</td>
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<td>Call the police if abuse is likely.</td>
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<td>Do not talk to the child when he or she has another child.</td>
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<td>Keep track of changes or changes in the child.</td>
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<td>Know your limits.</td>
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</table>

References


4An activity often used in therapeutic day treatment nurseries is to have the children label how they are feeling. If they are feeling bad, they can go to the “telephone” and order some new feelings that would go along with a happy face.
Learning to and regain your ways. This train child is to train children to train. They have a happy face. If they is for the ancient and specifically, providers in the name of SLPs, and manage experiencing, and neglect. It is for the unisonals.

### Table 2. What To Do If Abuse-Neglect Is Suspected

<table>
<thead>
<tr>
<th>Action</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Document</strong> without speculation about cause. <strong>Observations of appearance:</strong> (weight, height for age)</td>
<td>The child’s foot was wrapped with duct tape.</td>
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<tr>
<td><strong>Behavior:</strong></td>
<td>J. screamed when an adult male entered.</td>
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<tr>
<td><strong>Spontaneous comments:</strong></td>
<td>J. said, “He hurts me when mommy leaves.”</td>
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<tr>
<td><strong>Strong body odors:</strong></td>
<td>• urine or bowel odors • odorous discharges from ears, eyes, genitalia.</td>
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<tr>
<td><strong>Related statements from parents, peers, caretakers.</strong></td>
<td>Parent: “He’s clumsy as hell—always falling.”</td>
</tr>
<tr>
<td><strong>Get a second opinion</strong> immediately, preferably from a nurse or social worker trained to observe for signs of abuse. Do not bias your source by reporting your concern too quickly.</td>
<td>Clinician: “Would you look at J’s foot?” Clinician: “What should we do?”</td>
</tr>
<tr>
<td><strong>Call the police if the abuse is life-threatening.</strong></td>
<td>Clinician: “Mr. Smith is lunging with a knife.”</td>
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<td><strong>Do not talk about the child in his or her presence or near other children.</strong></td>
<td>This includes spelling, whispering, gestures.</td>
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<td><strong>Keep track of children who are frequently absent, tardy, or changing addresses.</strong></td>
<td>Homeless families are at greater risk.</td>
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<tr>
<td><strong>Know your agency’s policy.</strong></td>
<td>See Table 1. Reporting is mandatory in a number of states.</td>
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<tr>
<td>• Consistent with state laws?</td>
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<td>• Consistent with federal laws?</td>
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**References**


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Cocaine use during pregnancy, particularly cocaine use during the fetal period, is a significant public health concern. Cocaine use by mothers during pregnancy can lead to a variety of adverse outcomes for the fetus. These outcomes may include fetal growth restriction, placental abnormalities, preterm birth, and neonatal abstinence syndrome. The maternal use of cocaine during pregnancy can also result in infant behavioral and cognitive problems, including poor language development, social and emotional difficulties, and academic underachievement. It is crucial for healthcare providers to be knowledgeable about the risks associated with cocaine use during pregnancy and to provide appropriate counseling and interventions to support pregnant women in making healthy choices for themselves and their developing fetuses.

Cocaine use during pregnancy can also have long-term effects on the child's development. Recent studies have shown that prenatal exposure to cocaine can lead to cognitive and behavioral problems in childhood, including difficulties with attention, memory, and executive function. Furthermore, children exposed to cocaine in utero may have increased risk of mental health problems, such as anxiety and depression, in adolescence and adulthood.

The risks associated with cocaine use during pregnancy highlight the importance of public health interventions aimed at reducing cocaine use among pregnant women. These interventions may include prenatal counseling and education programs, medication-assisted treatment, and support for individuals with substance use disorders. It is essential to provide comprehensive care and support to pregnant women to ensure the best possible outcomes for both mother and child.