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Rationale and development of a screening instrument for social nurses to identify risks on child abuse and neglect

Summary

A preliminary version of a screening instrument to identify early signs of parenting problems related to physical child abuse and neglect is presented. Target group are families with newborn children. The screening will be integrated in the professional activities of social nurses employed by Child & Family, a government agency that is commissioned by law with the promotion of health care and well-being of families with young children in the Flemish Community in Belgium. Underlying the instrument's rationale is Belsky's (1980) ecological model of child maltreatment and the pedagogical view on the etiology of child physical abuse and neglect, developed by Baartman (1996). The present version is based on thorough literature reviews and on the analyses of actual narratives by social nurses and social workers. The content of the clusters is described and illustrated by means of concrete items. Finally, the project's future stages are explained. Attention is devoted to research on the instrument's applicability, reliability and validity, as well as to the large-scale implementation and training of social nurses.

Introduction

In order to identify precursors to intrafamilial child abuse and neglect and to prepare strategies for early treatment and prevention, it is necessary to screen for risk factors related to family and parenting problems (McCurdy, 1995). During the last three decades many efforts have been undertaken to develop screening procedures for risk or abusive/neglectful potential in parents and families (Browne et al., 1988; Farnell, 1980; Starr, 1982). Some screening procedures proved to be successful, making correct predictions of future harm in the child or abusive/neglectful acts by the parent(s) in substantial numbers of cases (see e.g. Browne & Herbert, 1997). Most procedures, however, produced large numbers of so-called 'false positives' by classifying non-abusive caregivers as at risk for abuse. Rodwell and Chambers (1992) reported in their review an average of approximately 50% false positives. They concluded that

the prediction of primary caregivers' potential for different forms of child maltreatment (physical, emotional, sexual abuse, neglect) by means of standardized assessment procedures is a very controversial issue, raising many questions and uncertainties. Prediction of child maltreatment is complex for many reasons.

At first, a purely statistical fact, in particular the low base rate of child maltreatment in the general population, makes prediction an extremely difficult task, regardless of the refinement and the psychometric properties of the screening procedure. Wang and Daro (1998) found that about 47 out of every 1,000 children were reported as victims of maltreatment. Prevalence studies report average rates ranging from 1% to 5% of abuse in the general population (Kaufman & Zigler, 1989), with young children under age 3 being most vulnerable to physical abuse and neglect and older children and adolescents to emotional and sexual abuse (Starr et al., 1990). The low prevalence and incidence rates may leave scepticism in some scholars about the possibilities to make accurate predictions of child maltreatment in the general population (Kaufman & Zigler, 1989). Nevertheless, the suffering caused by child maltreatment cannot be ignored, nor its long-term psychological sequelae and its transgenerational dynamics. Both provide good reasons to continue and optimize screening efforts.

Secondly, prediction is strongly complicated by the lack of reliable and valid screening instruments and risk assessment procedures (Wald & Woolverton, 1990). This is partly due to the fact that child abuse and neglect was first a social and a practitioners' problem and only later entered into the field of scientific research (Lutzker et al., 1998). Many screening procedures were developed within a practical context, for instance to optimize decision-making processes in child protection services, without taking the growing but sometimes contradictory knowledge on etiology into account. Screening procedures served only practical purposes, with little or no time left for maximizing reliability and validity of the instruments.

Thirdly, prediction of child abuse and neglect by means of large-scale screening procedures is complicated by several ethical questions, for instance, respect for parents' privacy, labeling of high-risk families, and interventions accompanying risk assessment (Barker, 1990).

Fourthly, many features of the initial parent-child relationship on which prediction efforts are usually based, are inconsistant and even unknown yet.

Notwithstanding the aforementioned methodological and ethical difficulties, prevention and prediction of child abuse and neglect remain primary issues for policymakers and clinical workers, as primary and secondary preventative strategies following early identification of parenting problems may decrease suffering, reduce costs for society and produce more favorable long-term outcomes than treatment (Browne & Herbert, 1997).

Large-scale screening on risks for maltreatment in 0-to-3-year-old children in Flanders is possible with the help of Child & Family, a government agency that is commissioned by law with the promotion of health care and well-being of families with young children in the Flemish Community of Belgium. The agency's principal target group are future parents and families with children up to age 3. Employing about 600 social nurses, who assist and follow-up families with young children by means of hospital visits (after delivery), home visits and consulta-

tions, the agency reaches about 85% of all families with a newborn child in the Flemish Community (Kind & Gezin, 1997). Furthermore, follow-up visits may be planned in high-risk families or in families and children with special medical, developmental or pedagogical needs, including families with a handicapped child, underprivileged families and abusive or neglectful families. The present research project is part of the agency's recently increased efforts with respect to the prevention of child maltreatment in Flanders.

The project serves the following goals.

1) Developing a screening instrument for risks on child maltreatment in families with children between 0 and 3 years old. According to the agency's definition, child maltreatment is 'every threatening or violent physical, psychological or sexual interaction, by which the child is victimized, either in an active or a passive way' (Kind & Gezin, 1997, p. 3, our translation). Our screening instrument will particularly focus on physical and emotional abuse and on neglect. Less attention will be devoted to sexual abuse, due to the low base rate in the target age group (0-to-1-year-olds, later extensions will cover children until age 3), and to the differences in etiology between child physical and sexual abuse (Starr et al., 1990).
2) Enhancing the nurses' sensitivity towards issues of child abuse and neglect by offering them an instrument which may guide their observations and interactions in families with a newborn child.
3) Providing support to nurses when intervening in high-risk families. By implementing the screening instrument we hope to make significant contributions to their decision-making processes (for instance, to answer questions as 'Is this a high-risk family which needs further help by professionals?'). The actual content of their decision, that is the kind of help that will be offered, will not be guided by this project. In terms of Janis and Mann's model on the psychology of decision-making (1977), an attempt will be made to enhance the accuracy of the nurses' decisions.

General rationale

The identification of risk factors for child maltreatment is a long-standing issue. The predictive power of several isolated risk factors has been examined since more than thirty years by retrospective and prospective research designs (see for a review, Ammerman & Hersen, 1990). Reviewing these studies, it is very difficult to infer causal relationships, due to the methodological restrictions of the studies and to a lack of integrative theories or models.

Retrospective designs provided only correlational associations between variables, reducing possibilities for prediction. Further, small samples and confined criteria to assess child maltreatment strongly diminished the use of research results for screening purposes. This does not mean, however, that results are completely inconclusive. A number of risk factors have shown significant predictive power, especially after thorough examination in prospective designs, in particular, one or both parents having a history of child abuse, social isolation, and personality dysfunctioning (see Ammerman & Hersen, 1990; also Baartman, 1996).

Organizing the salient factors into a comprehensive theoretical framework or model is another issue which has impeded the progress of accurate prediction in this area. Azar et al. (1998) pointed to the one-sided nature of the earliest etiological models, in which child maltreatment was considered a phenomenon caused by a single determinant (e.g. psychiatric disorder in the parent). Gradually, theorists recognized the multi-determined nature of child maltreatment as well as its different forms (physical abuse, emotional abuse, sexual abuse, neglect).

Nowadays, many scholars rely on ecological models, encompassing child, parent and context characteristics related to child maltreatment. One model which has shown both pertinent heuristic value and empirical support was developed by Belsky (1980; Belsky & Vondra, 1989). In this model child maltreatment is considered as an extreme case of parenting problems. Various risk factors were synthesized into a framework, including following determinants of parenting: parental personality, marital relations, social network, developmental history, and child characteristics (see Belsky & Vondra, 1989, pp. 156-187 for a detailed description). A core determinant is the parent's personality, which may play the role of a 'buffer' against outer stressors (e.g. unemployment) and predisposing child factors (e.g. prematurity), protecting the child against potential maltreatment. The rationale of our screening instrument is based on Belsky's model, giving a central place to personality characteristics of primary caregivers. Since no fixed set of characteristics was outlined in the model, however, additional elements will be included in our rationale, stemming from empirical literature on the etiology of child maltreatment. In particular, findings from studies on early parenting processes and parent-child relationships will be integrated. Indeed, in recent years researchers have increasingly focused on early manifestations of inadequate parenting, problematic and disturbed parent-child relationships as precursors to child maltreatment (Ammerman, 1990; Becker-Lausen & Mallon-Kraft, 1997; Rogosch et al., 1995). Social interactional views, stressing parental cognitions, emotions, attitudes, attributions and information processing mechanisms (Milner, 1993) gain more and more importance, as do pedagogical views, that stress parent-child interactions and parenting processes (Baartman, 1996; Cerezo, 1997; Rogosch et al., 1995).

Recently, Baartman (1996) has developed a theoretical framework on the etiology of physical child abuse and neglect, based on a pedagogical view. The core concept of the theory is 'parental awareness', a notion which was first introduced by Newberger (1980; Newberger & White, 1989) within the cognitive-structural paradigm in developmental psychology. Parental awareness was initially defined as 'an organized knowledge system with which the parent makes sense out of the child's responses and behavior and formulates policies to guide parental action' (Newberger, o.c., p. 47). It is a construct which may help to understand parental reasoning about children and child rearing. As in Selman's theory of social understanding and Kohlberg's theory of moral development, different levels of parental reasoning complexity could be identified in empirical research, going from an 'egoistic orientation', in which the child is considered merely as a projection of the parent's own experience and the parental role is organized around parental needs, to a 'systems orientation', which is characterized by the

parent's understanding of the child's changing psychological complexity and a balance between the child's needs and the parent's own needs (Dekovic, 1996; Newberger & White, 1989). Baartman extended the notion of parental awareness by adding emotional aspects of parenting to the cognitive aspects described by Newberger. Two dimensions or dynamics underlying parental awareness were distinguished: 1) a cognitive/emotional dimension defined as the parental capacity to take the child's perspective, and 2) a moral dimension, reflecting a balance or an imbalance between the child's and the parent's claims. Abusive parents may be characterized by a lack of perspective-taking abilities. In general, they have inadequate expectations about their child -not with regard to knowledge of child development and developmental milestones but with regard to the interpretation of their parental role and of the benefits of having a child on their own personal well-being-, negative emotions, and a lack of sensitivity and responsiveness towards their child's needs (Baartman, 1996; Rogosch et al., 1995). Further, there is a permanent imbalance between their claims and the child's claims. The parent's claims dominate due to distorted perceptions and misinterpretations of the child's behavior and to their childhood during which their own claims were not met by their parents (Baartman, 1996). Finally, parent's beliefs about the appropriateness and the use of (physical) discipline as a rearing strategy are integrated in the theoretical framework as a possible mediator between a lack of perspective-taking, conflicting claims and abusive behavior. Baartman's theoretical framework is based on the integration of a large number of empirical studies on parenting and parent-child relationships in abusive and neglectful families. A central place is given to personality characteristics of parents engaging in abusive behavior, since parental awareness may be considered as a personality determinant in Belsky's ecological model. However, a pedagogical view is adopted by stressing manifestations of lacking parental awareness in the parent-child interaction and by defining child abuse and neglect as extreme cases of parenting problems, expressing a mismatch between parent and child, which is not so much due to external stressors (e.g. unemployment), but rather to internal factors (in particular, conflicting claims affected by parental emotional deprivation during infancy and by self-serving needs to protect self-esteem) threatening the bonding process from the early beginning of the infant's life.

Both dimensions of parental awareness (perspective-taking, conflicting claims) will be integrated in the screening instrument and operationalized by means of four clusters (expectations, emotions, sensitivity, beliefs about discipline). Additionally, three other 'proximal' or strongly predictive risk factors of physical child abuse and neglect (Baartman, 1996) will be included: 1) the parent's history, 2) social support provided to the parent, and 3) parental personality characteristics, not directly related to the interaction with the child. Throughout the literature these factors were reported frequently not only as mere correlates in retrospective studies, but also as significant precursors to child abuse and neglect in prospective studies (Baartman, 1996; Coohey & Braun, 1997; Kolko, 1996; Rogosch et al., 1995). Finally, a cluster will be added, containing items on the child's role as an actor in the interaction with parents and caregivers.

Many studies stressed the intergenerational dynamics of child abuse and neglect. Kaufman

and Zigler (1989) reviewed the literature and concluded that about 30% of the parents with a history of maltreatment in childhood maltreated their own children, a rate being six times more than the prevalence rate in the general population, estimated at about 5% (Wang & Daro, 1998). Far more important for the intergenerational transmission than a history of childhood abuse are the psychological sequelae of maltreatment and the way parents actually cope with the negative experiences of their childhood (Rogosch et al., 1995). Prospective studies showed that attachment to maltreating parents is a significant mediating factor (Crittenden, 1988; Zuravin et al., 1996). Maltreated children who, despite the maltreatment, developed positive attachment patterns (e.g. safety), were found to be less vulnerable to transmission than children who developed attachment patterns dominated by anxiety or avoidance. Other factors which may favor intergenerational transmission are witnessing (physical) violence between spouses, domestic violence and stabilized coercive family interaction patterns (Cerezo, 1997; Coohey & Braun, 1997; Patterson, DeBaryshe & Ramsey, 1989; Rutter, 1989).

The lack of social support is repeatedly reported as a significant precursor to child maltreatment (Cerezo, 1997; Erickson & Egeland, 1996; Milner, 1993). Socially isolated mothers with a young infant who are deprived from support by their spouse, their own mother or their family, are a particularly vulnerable group. In Belsky's model, social support may operate as a buffer against maltreatment. Availability and absence of social support are also affected by the parent's personality. In the model, the social support variable takes a less prominent place than the parent's personality.

Numerous parental (personality) characteristics not directly related to child-rearing were found to have more or less predictive power with regard to child maltreatment. Most prominent and most thoroughly studied are depression (e.g. Scott, 1992), alcohol and drug abuse (Kolko, 1996; Milner & Dopke, 1997), generalized hyperreactivity and oversensitivity (Casanova et al., 1992), attributional styles (Bugental et al., 1989; Kolko, 1996; Milner & Dopke, 1997) and a lack of coping or problem-solving abilities (Cantos et al., 1997).

The inclusion of a cluster on the child's active contribution to the interaction with parents and caregivers is based on paradigms in social sciences stressing the proactive role of children in their own development (Lerner et al., 1981) and on empirical findings about the influence of child characteristics (e.g. temperament) on parenting and maternal behavior (Harrington et al., 1998; Houldin, 1987; Milliones, 1978). Remember that child-related characteristics are also part of Belsky's (1980) basic model on the ecology of child maltreatment.

Construction of the preliminary screening instrument

The target group of our project are the social nurses employed by Child & Family. They have to use the screening instrument in their daily work with families having a newborn child and to integrate it in their hospital visits, home visits, and consultations. Therefore, the instrument should as much as possible be tailored to their working conditions and to their professional needs. To realize this goal, it was decided to involve the nurses in all steps of construction. Hence, the selection of topics and items was not only based on a thorough literature review, but also on information from the practitioners' field gathered by means of focus groups.

The literature review was not confined to the integration of different etiological models into a comprehensive theoretical framework or to the search for the most predictive risk factors. In addition, advantages and limitations of various risk assessment procedures were studied as well as existing screening instruments. Although there is a great lack of reliable and valid assessment procedures and tools in this field, five instruments appeared to be highly relevant for our research objectives: 1) the Michigan Screening Profile of Parenting (Schneider, 1982), 2) the Maternal Characteristics Scale (Polansky et al., 1992), 3) the Child Abuse Potential Inventory (Milner, 1986), 4) the Potential Screening Scale (Avison et al., 1986), and 5) the Conflict Tactics Scale, Parent-Child version (Straus, 1997). Stressing the parent's personality and the parent-child interaction, the content of these instruments was closely related to the theoretical framework described in the previous paragraph. None of them, however, fully covered our pedagogical view of the etiology of child abuse and neglect. Besides, all instruments have to be administered from parents or caregivers, except the Maternal Characteristics Scale (clinicians), whereas social nurses are the main target group in our project. Further, by simply translating and applying existing instruments we could not realize all research objectives. Enhancing the nurses' sensitivity to issues of child abuse and neglect, guiding their observations in the work setting and helping them to make sensible and vigilant decisions about intervention in high-risk families, required a new instrument. Finally, it has to be stressed that child maltreatment and parenting are both strongly determined by cultural variables (Korbin, 1997). Indeed, definitions of child maltreatment and adequate parenting vary from culture to culture, as do parents' beliefs and values underlying childrearing and parenting practices. This implies that it may not be sufficient to translate and implement existing instruments developed outside the Flemish context.

Three focus groups of practitioners employed by Child & Family were composed, two consisting of social nurses (n = 18) and one of social workers (n = 9) stemming from underprivileged families. Social nurses participated voluntarily, therefore, selection was only based on personal motivation and interest in the research topic. Different provinces and regions (urban, non-urban) were represented in the groups. The social workers were involved because of their background and their current counseling work in multiproblem families (including abusive and neglectful families) in Antwerp, which is the largest city in the Flemish Community.

The technique of focus groups is a method of data collection which proved to be very successful in the development of survey instruments (Morgan, 1993). All participants share information relevant to the research topic. This may facilitate group discussion and allows to collect many data in a rather short period of time. Three sessions were organized to interview the social nurses about their perceptions of risk factors related to parenting problems in hospital visits, home visits and consultations and about their professional experience (in particular risk identification, decision-making and intervention) with this issue. Two interview sessions were organized in the same way for the social workers. All sessions were recorded on audiotape.

Starting point for all group discussions was the nurse's or social worker's individual concern about parenting problems in families with a newborn child. The basic question was to tell about situations in which one was worried about the ongoing parenting process. To concretize this question and to enhance the vividness of the accounts, use was made of the 'critical inci-

dent' technique (Flanagan, 1954). The nurse or social worker was invited to explain in detail which aspects of the situation might raise concern and how these were related to parent, child or context characteristics. Further questions dealt with checking information and making decisions about intervention. We are aware that the accounts by nurses and social workers may be strongly influenced by implicit theories on childrearing, child maltreatment and risk assessment. Our aim was not to examine the content of these theories nor to explain them in terms of professional experience, personality factors or other variables. The narratives offered us a wealth of concrete information on the appearance of risk factors for parenting problems and child maltreatment in the daily work of the nurses and social workers. A comparison with the literature review revealed remarkable similarities between the practitioners' accounts and the prevailing tendencies on risk factors and etiological models. Content analysis showed that nurses and social workers mostly began their accounts by discussing an unusual child or context characteristic (e.g. a developmental delay, a single mother). Gradually, they turned to more subtle aspects of parenting and parent-child interaction (e.g. parental expectations, responsiveness), to the history of parents and families, to the parents' personality, and to social support. Much attention was devoted to these risk factors throughout all group discussions (e.g. by means of probes, by asking other participants whether they shared similar experiences), since they were considered to have high predictive power and took a prominent place in our conceptualization of child abuse and neglect. Another recurrent theme throughout the narratives was the interaction between the nurse and the parent. Next to their concerns about childrearing, the nurses often experienced a certain amount of tension in their relationship with parents, due to parental interaction styles (e.g. lack of communication, concealing information about the child's problems or progress) or the atmosphere in the family. Although the relationship between parents and professional caregivers is not a specific risk factor of child abuse and neglect, we decided to include it in the screening instrument in order to enhance the nurses' sensitivity and alertness for signs of parenting dysfunctioning.

Next to the question of worries about the parenting process, a question was asked on decision-making processes. What actions did nurses undertake when they observed that there was a risk of early parenting problems? It was particularly interesting to find out whether they differentiated between risk factors. Did certain risk factors raise their alertness more than others, accelerating provision of help or referral to specialized professionals? Our analysis of narratives from a small group of social nurses revealed that decision-making with regard to parenting issues is not a well-planned activity, but rather depends on situational circumstances (e.g. time, caseload), personal experience (e.g. acquaintance with the issue, sensitivity), individual training, and team characteristics (e.g. possibilities for intervision, support). Further, the nurses could not determine which risk factors actually enhanced their alertness and accelerated decision-making. For these reasons, continuous attention will be given to the control of decision-making processes in the use of the screening instrument.

Combining the findings of the literature review and the practitioners' narratives, a preliminary screening instrument was developed.

Structure and content of the instrument

The screening instrument consists of three parts. The first part deals with the interaction between parent and nurse, the second part with 'proximal' risk factors of child abuse and neglect, and the third part with 'distal' (or less predictive, see Baartman [1996]) risk factors. Due to the fact that in most cases the mother is the caregiver with whom the nurses have contacts during home visits and consultations, the instrument is oriented towards mothers. This does not mean that the father's role in the etiology of child abuse and neglect will be ignored. Information on the father will be taken into account as well. For instance, some items will directly focus on domestic violence, spouse abuse and support provided by the father.

Part one focuses on the interaction between nurse and mother and contains seven items (see Table 1 for item formulations). In particular, the nurse is asked to report problematic aspects of the interaction. The items cover different aspects of the interaction. For instance, let us consider Item 1 'The parent does not keep appointments about home visits and consultations'. Problems may be observed in that parents constantly ignore the appointments with the nurse (either for a home visit or for a consultation), that they want to change the time schedule of visits and consultations, that they agree on a home visit but send the nurse away empty-handed because they have arranged another appointment instead, that they have to go shopping, and so forth. Problems in Item 7 'You have but limited access to this family' can be observed when mother repeatedly refuses the nurse to enter the living room or the child's room, when the home visits are restricted to one small front room, or, in extreme cases, when the mother does not allow the nurse to do her regular work and has already undertaken some actions which are usually performed by the nurse (e.g. weighing the child).

Table 1. *Items of part one: Interaction between parent and nurse*

Item n°	Formulation
1	'The parent does not keep appointments about home visits and consultations.'
2	'It is very difficult to build up a relationship with this parent.'
3	'The parent tells you she/he will follow your advice, but actually doesn't.'
4	'The parent gives you incorrect/false information about the care and the development of the child.'
5	'In this family there is an atmosphere of secrecy.'
6	'You feel not at ease in this family.'
7	'You have but limited access to this family.'

The items have to be scored on a rating scale. Initially, when testing the preliminary version in groups of nurses, a four-point scale is used, going from 0 = this problem never occurred to 3 = this problem occurred very often. (1) The rationale for a multiple-choice format is that the instrument has to help the nurses in guiding their observations, to help them qualify their interpretations, and to decrease black-or-white or all-or-none categorizations about parents' behavior. Additionally, however, different rating formats (i.e. two-point forced choice scales) will be tested throughout the construction phase. Rather than confining ourselves to a simple checklist which is rated once, we would like to stress the dynamics of the relationship between nurse and mother throughout the multiple contacts in various settings and at different moments. Further, as many as possible potential biasing factors related to the nurse's style of interaction or personality must be eliminated. Indeed, the nurse's evaluation of her relationship with the mother may be affected by a certain partiality or a one-sided perspective, stemming from personal experience, history, working conditions, situational aspects, etc. A complete exclusion of such biasing factors seems impossible, they are, inevitably, part of every decision-making process (Dalgleish, 1997). Serious efforts will be undertaken to minimize their influence, however. One way to realize this, is to help the nurses guide and structure their observations in their contacts with the mother, and to make them check their hypotheses on problematic aspects throughout the visits, this means from the first visit in the hospital to the last home visit, and throughout the consultations. This implies that, after having noticed (by observation or self-report from the mother) a problem, the nurse should question herself and her actions ('Isn't this problem in the first place due to my own behavior or attitude towards this parent?', 'What is my account in the interaction?'). Next, she should try to modify her intervention in order to find out what may be her contribution to the problem ('How can I modify my behavior or attitude towards this parent?'). Finally, she has to test how persistent the problems are throughout the interactions. These steps (questioning, modifying interventions, testing hypotheses) have to be repeated until the last regular home visit. After that visit, the items have to be rated.

Part two focuses on proximal risk factors of child abuse and neglect. It consists of eight clusters (Inappropriate expectations, Negative emotions, Lack of sensitivity and responsiveness, Beliefs about the usefulness of discipline in childrearing, History, Lack of social support, Non-child related parental personality characteristics, and The child as actor in the interaction with parents and caregivers) and contains 60 items. In Table 2 a few examples are given for each cluster. The information necessary for scoring the items can be obtained by observation, self-report, or report by others. For the same reasons that were given in part one, a four-point rating scale, going from 0 = never observed or reported to 3 = very often observed or reported, will be used when testing the preliminary version. However, in addition to this format, other rating formats (i.e. a two-point forced choice format) will be tested as well.

Again, we would like to stress that it is our purpose to help the nurses guide and systematize their records throughout visits and consultations. Potential risk factors should be scored after the regularly-scheduled last home visit. From the beginning, however, the nurse should be

alert and notice whether risk factors are present. In case of a positive score, she should try to obtain as much information as possible that is relevant to the topic covered by the item. Next, she should test whether the problem is persistent in some way, in particular, whether it can still be observed in next home visits or consultations. These steps (obtaining more information, hypotheses testing) should be repeated up to the last regularly-scheduled home visit. The final score should reflect the frequency and intensity of the problem.

Table 2. *Clusters and exemplifications of part two: Proximal risk factors of child abuse and neglect*

Cluster	Description	Examples
I	Inappropriate expectations	'The parent expects the baby to behave according to her/his wishes.'
		'The parent is disappointed with the baby.'
II	Negative emotions	'The parent tends to ascribe negative intentions towards the baby's behavior.'
		'Little love is expressed by the way the parent talks about the baby.'
III	Lack of sensitivity and responsiveness	'The parent never asks about the reason of the baby's behavior.'
		'The parent's reaction towards the child's behavior is rather unpredictable.'
IV	Beliefs about discipline in child-rearing	'The parent says that it helps to give the baby a good shaking when he/she is crying.'
		'The parent acknowledges that children from time to time need a slap.'
V	Parental history	'The parent is preoccupied by her/his own history.'
		'The parent says there was little affection by parents and family during her/his own childhood.'
VI	Lack of social support	'The parent is dissatisfied with her/his contacts with family and friends.'
		'There are suspicions of (physical) violence between the partners.'
VII	Parental personality characteristics (non-child related)	'The parent seems unable to cope with stressful situations.'
		'The parent has a gloomy view about her/his own future.'
VIII	Child as actor in interactions	'The baby does not stop crying, despite repeated efforts by caregivers to comfort him/her.'
		'I myself find that this actually is a 'difficult' child.'

In part three, distal factors related to child abuse and neglect are assessed on the basis of an existing (computerized) registration format. Child, parent and context characteristics (see Table 3 for the list of characteristics) will be included.

Table 3. *Items of part three: Distal factors of child abuse and neglect (child, parent and context characteristics)*

Child characteristics	1. Prematurity 2. Low birthweight 3. Crying infant 4. Mental or physical handicap 5. Chronic illness
Parent characteristics	1. Parent (mother) younger than 20 years 2. Alcohol abuse by one or both parents 3. Drug abuse by one or both parents
Context characteristics	1. Underprivileged family 2. Long-term unemployment 3. Frequent moves 4. Out-of-home placement of other children 5. Single parent

Distal factors are part of many risk assessment and screening procedures (see, for instance, Browne & Herbert, 1997). However, it becomes more and more clear that these factors alone are not sufficient to accurately predict child abuse and neglect.

In particular, reviews of empirical literature (Ammerman, 1990) raise serious doubts on child characteristics. Up to now, no specific child factor appeared that unconditionally related to child abuse or neglect. Completely ignoring child characteristics, on the other hand, would diminish the sensitivity of an instrument, since some child factors (e.g. prematurity) may contain risk potential in some specific contexts (Ammerman, 1990). It may seem plausible to suppose that these contexts are closely related to some of the core concepts of our etiological model and that, for instance, a lack of parental awareness or a deplorable childhood of one or both parents, in combination with specific child characteristics as prematurity or physical handicap, may increase the risk for child abuse or neglect. Including these distal factors in the instrument will allow us to test this hypothesis. Following child characteristics will be taken into account: prematurity, low birthweight, crying infant, mental or physical handicap, and chronic illness.

Social context characteristics were found to be relatively good predictors of physical child abuse and neglect (Garbarino, 1997). At least in the United States little bias of parents' socioeconomic status or social class was found in referrals to child protecive services for child mal-

treatment (Drake & Zuravin, 1998). Although the question remains whether this finding can be generalized and applied to the Flemish context, it points to the advantage of taking into account some aspects of the family's social context, when screening for risks on child abuse and neglect. Since 1992, the social living and health conditions of all families in the Flemish Community with a newborn child have been registered systematically by Child & Family in order to identify and to help seriously underprivileged families. The following screening criteria are used: 1) monthly income, 2) parental education, 3) development of the child in the family, 4) parental working conditions, 5) material facilities and living conditions, and 6) health. For each criterion 'critical' scores for social deprivation have been determined. If a family has a critical score on three or more criteria, it is identified as seriously underprivileged and taken into account for further help by the nurse or other specialized professionals. The final score on the family's status of social deprivation will be included in our instrument. Information will be registered on the following parent and context characteristics: long-term unemployment of one or both parents, frequency of moves (more than once in the baby's first three months), placement of children in residential or foster care because of maltreatment, single parent, age of the parent (if mother is under age 20), and alcohol or drug abuse by one or both parents.

In this part, a scoring format with a 'yes'- and a 'no'-category will be used.

A response category 'no or insufficient information available' will be added to all items of the instrument.

Application of the preliminary version and future planning

The list of items will be accompanied by a detailed user's manual. This will contain the objectives of large-scale screening for risks on child abuse and neglect, the underlying rationale, and descriptions of clusters and items. Further, the hypothesis testing model and the scoring procedures will be explained. It will be concretized how relevant information can be obtained on the interaction with the parent, parental awareness, beliefs about discipline, the family's supportive social network, the parent's personality, history, and the child as an active contributor to the interaction with parents and caregivers. Suggestions for probes and interventions will be made in order to generate and test concrete hypotheses on the variables assessed by the clusters and the items.

The manual will also contain instructions on how the instrument can be integrated in the nurses' professional activities and how it may become part of a stepwise screening and decision-making process regarding risk assessment of child abuse and neglect in families with young children. As mentioned before, our final objective is to enhance the nurses' alertness for early signs of disturbed parent-child relationships and to offer a blueprint to risk assessment that may help them making more accurate or vigilant (Janis & Mann, 1977) decisions about referral or future help to high-risk families.

We are aware that a training manual will not be sufficient to successfully implement the screening instrument in Child & Family, taking into account that about 600 social nurses are employed by the agency. For this reason, group training sessions for nurses will be organized in the near future in close co-operation with trainers of the agency.

Until now, however, the instrument has but a preliminary character. Although its content is based on etiological models of child abuse and neglect, on thorough literature reviews and direct information provided by nurses and social workers, only face validity is attained. Most important at this moment is to try out the preliminary version in groups of social nurses to test whether the instrument can be used and integrated in their professional context. In the first place, it is particularly important to find out whether the present version fully covers the spectrum of risks perceived by the nurses, whether visits and consultations yield sufficient and relevant information on clusters and items, and whether the hypothesis testing model and the scoring formats actually work. Next, data has to be collected on the instrument's reliability (interrater agreement, internal consistency, test-retest reliability, factorial structure). Research on the applicability and the reliability of the preliminary version will be carried out in the near future, previous to large-scale implementation in the agency. Future research will focus on the integration of the instrument in a stepwise screening procedure for nurses and teams, as well as on the validation. Both issues of construct and predictive validity will be addressed. Construct validity may be tested, among others, by correlating scores with scores on existing instruments assessing child abuse potential in parents (e.g. by means of Milner's [1986] Child Abuse Potential Inventory), parental stress (e.g. by means of the Parenting Stress Index [Abidin, 1983; De Brock, Vermulst & Gerris, 1990], parental reasoning complexity (e.g. by means of Dekovíc's [1996] semi-structured interview on parental awareness). Testing issues of predictive validity, either concurrent or future predictive validity (Milner, 1986), implies that external criteria reflecting risks for child abuse and neglect have to be selected (e.g. referral to the Confidential Doctor Centers in Flanders). Especially with regard to future predictive validity, selection of relevant criteria is a very complex matter, since the number of possible indicators with high long-term value is very limited (Milner, 1998).

Note

1. Regularly, after the hospital visit, four home visits are planned within three months after birth in case of a first child, three home visits within this period are planned in case of a next child. Further, there are three ambulatory consultations within the first three months.

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