

# Bringing Back the Social History



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## KEYWORDS

- Adverse childhood experiences • Child maltreatment • Negative attributions
- Psychosocial risk factors • Toxic stress

## KEY POINTS

- The social history plays a key role in determining a child's current and future health.
- A useful social history involves asking about key elements of a child's environment, including the circumstances in which the child is being raised, adults involved in the child's life, presence of key factors associated with increased risk, and, most importantly, caregiver-child relationship and attachment.
- The social history should be obtained starting at the first well-child visit and at each visit thereafter. Children at highest risk often live in dynamic, often chaotic, environments, with frequent changes in their living situations and household compositions, increasing the importance of obtaining a social history at each visit.
- Child maltreatment (abuse or neglect) can have devastating health consequences that last for life and diminish emotional health and intellectual ability.
- Understanding each child's familial psychosocial risk and protective factors through the social history is an important link to preventing harmful parenting tactics, other threats to healthy development, and even potentially preventing child maltreatment.

## WHY THE SOCIAL HISTORY MATTERS

A child's family environment is one of the most important and critical determinants of the child's health (current and future) and it is integral to the child's well-being and development.<sup>1-4</sup> A robust body of research has shown the role that this environment plays in brain and emotional development.<sup>2,3,5</sup> These environmental influences also

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have an impact on a child's physical health and play a significant role in determining future health and disease.<sup>4-11</sup> Thus, a social history not only is useful in identifying risk for child injury and maltreatment but also in identifying factors that might contribute to children's health problems. Strengthening families and supporting parents also promote children's health, development, and safety and help prevent child maltreatment.

A large body of research highlights the importance of environmental influences in the prenatal to early childhood period (ie, before age 2).<sup>2,3,5</sup> Therefore, obtaining a social history focused on the important aspects of the child's family environment is a critical component of early well-child care. The social history should be obtained at every visit because the family environment is frequently changing, and it influences child development in a dynamic way. The information obtained from social histories has the potential to contribute to a lifetime of health and well-being.

### **THE ILL EFFECTS OF MALTREATMENT CAN LAST A LIFETIME**

Adverse childhood experiences, especially child maltreatment, are linked to risk factors for ill health as adults and early death.<sup>6,7</sup> Child maltreatment occurs in many forms (physical, sexual, or emotional abuse or neglect). It is not uncommon for a child to suffer from multiple forms of maltreatment at the same time.<sup>12,13</sup> Maltreatment is known to confer myriad deleterious health effects, both physical and mental.<sup>6,7</sup> In some instances, the effects of maltreatment are so severe that life ends in infancy or early childhood. In fact, 70% of deaths from maltreatment occur in children under 3 years of age.<sup>14-16</sup>

### **CHILD MALTREATMENT PREVENTION BEGINS WITH PRIMARY CARE**

Problems in the family environment are often contributors to child maltreatment and indicate risk for a variety of negative outcomes (discussed previously). A social history that identifies families at risk for maltreatment has the potential to identify problems before they escalate to these most serious outcomes, in addition to helping families and children function better.

This type of prevention strategy is in line with the biopsychosocial model proposed by Engel,<sup>17</sup> which provides a broad view of child health and includes the psychosocial aspect when assessing children. This concept is well stated by Flaherty and colleagues<sup>11</sup>: "A comprehensive assessment of children's health should include a careful history of their past exposure to adverse conditions and maltreatment. Interventions aimed at reducing these exposures may result in better child health."

### **GOALS OF THE SOCIAL HISTORY**

The goal of the social history is to assess the strengths and weaknesses in a child's environment to identify aspects of family life that can be reinforced and encouraged as well as identify potential sources of harm to the child that must be addressed. A comprehensive social history may also identify opportunities for parental education regarding parental expectations and age- and health-appropriate developmental milestones. The social history provides insight into a child's environment, which includes the circumstances in which the child is being raised, a comprehensive listing of the adults involved in the child's life, disciplinary practices, presence of key factors associated with increased risk for maltreatment, and, most importantly, caregiver-child relationship and attachment.<sup>4,18,19</sup> Assessing the nature of the caregiver-child relationship is important. A healthy, secure attachment between parents and children

strongly predicts healthy child outcomes. The children at highest risk experience frequent changes in both their housing situations and household compositions, increasing the importance of obtaining a social history at each visit. Strengths, such as family supportiveness and concern for each other, are often ignored when focusing risk, but such strengths can buffer against even significant family risk.<sup>20–22</sup> Making a comprehensive social history an integral part of every visit also allows the primary care provider to follow-up on prior issues and identify any new stressors that may have arisen since the last visit.<sup>23</sup>

The social history also helps develop rapport; the authors have often found that thoughtfully asked questions assessing attachment have resulted in otherwise distant or suspicious parents opening up. This aspect of history taking conveys interest in the parent and family and gives the parent an opportunity to feel listened to. Thus, it strengthens the relationships between the primary care provider, parent/caregiver, and child.

Insight into family dynamics—functions and malfunctions—can be gained through a set of social history questions and should include a listing of each adult in contact with the child (including paramours, babysitters, nannies, and daycare workers as well as other adults in the home). This listing should include the ages of each adult, their relationship (to the child), and their role in the home. There is often a temptation in a social history to assume a given family structure and to focus on only the adults who are related, but unrelated adults living in the home are often associated with a higher risk for children.<sup>24</sup> The social history also provides a great opportunity to understand the parents' developmental expectations for their children and to educate parents about the child's needs and capabilities so that parental expectations are appropriately aligned with their child's developmental stage.

Both current and past social histories are relevant. The past history has the potential to reveal a risk for a recurrence of past problems as well as unresolved issues for the parent. The current history informs the health care provider of immediate issues. Specific questions regarding these risk factors can help identify problems to address and create opportunities to provide resources and education. Because child maltreatment entails a problem in the caregiver-child relationship, early identification of parenting problems or attachment issues is paramount. Occasionally, serious or severe problems are unearthed. By addressing the problems directly, a host of negative outcomes, including child maltreatment, can be prevented or curtailed. For example, there is a burgeoning body of research demonstrating that helping parents with mental illness get appropriate treatment can have long-term benefits for their children's health.<sup>25</sup> Also, the Safe Environment for Every Kid (SEEK) model, which includes training for providers on how to assess the family environment and brief screening for common psychosocial problems together with parent education resources, has been demonstrated to reduce risk of child maltreatment.<sup>26,27</sup> Structured social history assessments in the primary care setting are an important component in the prevention of child maltreatment.

As part of a research study of children and their families presenting to an emergency department, the authors' research team of physicians, social workers, and a psychologist developed a set of questions to assess social history. These questions, some of which are presented in **Table 1**, are typically part of social work assessments when a family is identified as at risk, but the authors have found them useful to identify risk in all families. Such social histories are useful in building rapport quickly with parents and understanding the issues that parents see as key to their child's well-being (see **Table 1**). The authors' approach to the social history is somewhat expanded in that not only are the past and current social circumstances included but also key aspects

<b>Table 1</b>	
<b>Topics for surveillance and sample questions to initiate discussion</b>	
<b>Topics</b>	<b>Sample Questions</b>
Child's contacts and household	<ol style="list-style-type: none"> <li>1. Who lives with or is often in your child's primary home?</li> <li>2. Is there another home that your child lives in?               <ol style="list-style-type: none"> <li>a. If yes, who lives with or is often in the child's secondary home?</li> </ol> </li> <li>3. Has your child changed homes in the past 6 mo?               <ol style="list-style-type: none"> <li>a. If yes, how many times?</li> <li>b. What was the reason for each change?</li> </ol> </li> </ol>
Parental thoughts about child's personality and disposition	<ol style="list-style-type: none"> <li>4. Describe your child's personality.</li> <li>5. Provide 3 words to describe your child.</li> </ol>
Parental expectations	<ol style="list-style-type: none"> <li>6. How does your child communicate his/her wants/needs to you?</li> <li>7. How do you think your child is doing compared with other children his/her age?</li> </ol>
Understanding child's actions and parent-child interactions	<ol style="list-style-type: none"> <li>8. What is your favorite thing your child does?               <ol style="list-style-type: none"> <li>a. What do you do in response to this behavior?</li> <li>b. Why do you think your child does this?</li> </ol> </li> <li>9. What is your child's most frustrating behavior?               <ol style="list-style-type: none"> <li>a. What do you do in response to this behavior?</li> <li>b. Why do you think your child behaves this way?</li> </ol> </li> <li>10. Have you ever been really frustrated with your child?               <ol style="list-style-type: none"> <li>a. What were the circumstances?</li> <li>b. What did you do?</li> </ol> </li> <li>11. How does your child misbehave?               <ol style="list-style-type: none"> <li>a. Why does your child misbehave?</li> <li>b. What do you do when your child misbehaves?</li> </ol> </li> <li>12. What's it like to take care of (insert child's name)? Easy/average/difficult—why?</li> </ol>
Disciplinary practices	<ol style="list-style-type: none"> <li>13. Do you want to raise your child the same way you were raised or differently? Why?</li> <li>14. How do you discipline your child?               <ol style="list-style-type: none"> <li>a. Do you or have you ever spanked your child? What were the circumstances?</li> <li>b. Do you or have you ever used an object to discipline your child? What were the circumstances?</li> </ol> </li> </ol>
Child care	<ol style="list-style-type: none"> <li>15. What is your regular childcare arrangement?</li> <li>16. Who watches your child(ren) while you run errands or shop, for example?</li> </ol>
Child and parental literacy and education	<ol style="list-style-type: none"> <li>17. Is your child in Head Start, preschool, or other early childhood enrichment?</li> <li>18. How is your child doing in school?</li> <li>19. Is he/she getting the help to learn what he/she needs?</li> <li>20. How happy are you with how you read?</li> <li>21. Do you read to your child every night?</li> </ol>

(continued on next page)

Table 1 (continued)	
Topics	Sample Questions
Household environment	<p>22. Are there any significant life stressors in your family?</p> <ul style="list-style-type: none"> <li>• Death of family member or close friend</li> <li>• Major accident or illness in family</li> <li>• Separation/divorce</li> <li>• Custody battle</li> <li>• Move/relocation</li> <li>• Job change               <ul style="list-style-type: none"> <li>◦ Job loss—who?</li> <li>◦ New job—who?</li> <li>◦ Mom back to work after maternity leave</li> </ul> </li> <li>• Social isolation (local support system of family and/or friends)</li> <li>• Incarceration</li> <li>• Deployment</li> <li>• Return home from military service</li> <li>• New baby in the family</li> <li>• Excessive crying</li> <li>• Potty training</li> <li>• Other _____</li> </ul> <p>23. Do you ever have trouble making ends meet?</p> <p>24. Do you ever have a time when you don't have enough food?</p> <ol style="list-style-type: none"> <li>a. Do you have WIC?</li> <li>b. Do you have food stamps?</li> </ol> <p>25. Is your housing ever a problem for you?</p> <p>26. Do you ever have trouble paying your electric/heat/telephone bill?</p> <p>27. Do you need help accessing benefits or services for your family?</p> <p>28. Do you have questions about your immigration status?</p>
Risk factors	<p>29. Have you pushed, shoved, kicked, hit, and/or slapped another adult?</p> <p>30. Have you been pushed, shoved, kicked, hit, and/or slapped by another adult?</p> <p>31. Of the people in contact with your child:</p> <ol style="list-style-type: none"> <li>a. Who is or has been involved with social services? Explain.</li> <li>b. Who has or had domestic violence/interpersonal violence in his/her home? Explain.</li> <li>c. Who has current or past police involvement, criminal activity, and/or incarceration? Explain.</li> <li>d. Who is using or has used drugs? Explain.</li> <li>e. Who has or had an alcohol problem/abuse? Explain.</li> <li>f. Who has or had mental health issues, including anger or temper management issues, depression, bipolar disorder, posttraumatic stress disorder, or schizophrenia? Explain.</li> <li>g. Who has gang involvement? Explain.</li> </ol>

#6–13: May help identify negative attributions and parental unrealistic expectations.

#11: Suggested and used by Howard Dubowitz, MD; Professor of Pediatrics, University of Maryland.

#12: Suggested and used by Diane Baird, MSW; Instructor of Pediatrics, Kempe Center, Department of Pediatrics, University of Colorado.

#16–20, 22–27: *Data from* Social history questions incorporated from the "IHELLP" mnemonic; and *Adapted from* Kenyon C, Sandel M, Siverstein M, et al. Revisiting the social history for child health. *Pediatrics* 2007;120(3):e734–8.

WIC, special supplemental nutrition program for women, infants, and children.

of the parent-child relationship and the approach to parenting. This is but one sample of questions that could facilitate a discussion of family risk factors. The SEEK model is another (Appendix 1).<sup>26,27</sup> Also, the American Academy of Pediatrics (AAP) has a brief set of recommended questions for beginning a discussion about children's exposure to violence (Box 1).<sup>28</sup>

## KEY PSYCHOSOCIAL RISK FACTORS THAT INCREASE THE RISK OF TOXIC STRESS AND CHILD MALTREATMENT

Key psychosocial factors known to increase the risk for child maltreatment include negative attributions (interpreting child behavior as malevolent, hostile, or needy), unrealistic expectations of the child, harsh disciplinary practices, and prior or current caregiver mental health problems, including anger management problems, substance abuse, prior social service involvement for abuse or neglect, and domestic violence/intimate partner violence (IPV).<sup>29-38</sup>

Huebner and colleagues<sup>16</sup> investigated fatalities and near-fatalities from child maltreatment and found that 48% of victims had been previously involved with Child Protective Services (CPS). Frequently identified risk factors in the children's family environments included caregiver substance abuse (65%), IPV (51%), and caregiver mental health problems (34%).

In addition to indicating risk for child maltreatment, each of these factors can add substantial risk of physical and psychological harm to a child apart from child maltreatment and can create a continuum of toxic stress (ie, prolonged activation of the stress response system due to frequent or prolonged exposure to stressors that results in disruption of neurobiological development and impedes future health).<sup>2,3</sup> Certain psychosocial risk factors are known to increase the probability of a poor outcome due to toxic stress.<sup>2,3,6-8</sup> The presence of multiple risk factors can be especially harmful for a child's development and, as the number increases, so does the likelihood of maltreatment.<sup>12,38</sup> Early identification of particular key risk factors allows more thoughtful child- and family-specific interventions and referrals for mitigating the risk and its toxic effects.<sup>3</sup>

## PSYCHOSOCIAL RISK FACTORS

### *Negative Attributions and Unrealistic Expectations*

When expectations are unrealistic or unreasonable, problems can ensue. Expectations affect the way the information is interpreted and can result in wrong conclusions and sometimes even harmful actions. Some parents may not have an accurate understanding of what is normal child development and thus they have unrealistic expectations regarding a child's capabilities.

Such unmet expectations may lead parents to search for explanations for why their child is not meeting expectations. These explanations are revealed in the parental attribution ascribed to a child's personality or temperament and are often negative. For example, parents may expect toilet training to be feasible before it is and assume young children have more control over the process of toilet training than they do.<sup>39</sup> These unrealistic expectations place the child at risk of harm when the child fails to "comply" and make the child's "failure" inevitable: "He knows how to use the potty, he's just not doing it because he knows it stresses me out." The parent may also misinterpret an action (or lack of action) as defiant or spiteful. This in turn may evoke anger in a parent.

A growing literature shows that hostile attributions toward even very young infants are common, and the authors have frequently encountered examples of such attributions.<sup>40,41</sup> For example, some parents attribute an infant's crying as anger or a sign of weakness (eg, "Why are you so mad?" or "Don't be a crybaby.") Some parents

**Box 1****Sample questions from the American Academy of Pediatrics to help start the discussion with patients and families about exposure to violence**

## Violence overview

- Are there any behavior problems with the child at home and/or school?
- Has anyone come or gone from the household lately?
- Are there any problems with sleep and enuresis?
- Has your child ever witnessed anyone being harmed at home or in the community?

## Bullying and cyberbullying

- Sometimes kids get picked on at school. Does this happen to you/your child? Has the child heard of or seen incidences of this?
- Have there been any problems at school with behavior?

## Community violence

- Has the child had stomach pains, headaches, and other somatic complaints that seem to have no source?
- Has the child's behavior changed dramatically, seemingly without cause (eg, difficulty sleeping, avoiding people, or performance in school)?
- Has anything violence-related or frightening happened in the child's school or neighborhood since the last time you saw the child?

## Child abuse and neglect

- Are there other signs or symptoms that are concerning for abuse or neglect?

## Domestic and intimate partner violence

- Are you safe at home?
- Does anyone hit you or call you names?

## Sexual abuse

- Has child disclosed being sexually abused?
- Has child had stomach pains, headaches, and other somatic complaints that seem to have no source?
- Has child's behavior changed dramatically, seemingly without cause (eg, difficulty sleeping, avoiding people, or performance in school)?
- Are there other signs or symptoms that are concerning for sexual abuse?

## Teen dating violence

- Have there been any new boyfriends/girlfriends? How has that changed life for you? Do you feel safe with that person?

The following AAP Web site has a list of diagnostic, decision-support, and screening tools to identify children exposed to violence: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Diagnostic-Tools.aspx>.

*Adapted from* American Academy of Pediatrics. Medical Home for Children and Adolescents Exposed to Violence. Available at: <http://www.aap.org/en-us/advocacy-and-policy/aap-healthinitatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Addressing-Exposure-to-Violence-with-Families-and-Patients.aspx>. Accessed on August 4, 2014.

interpret the need for frequent feedings as greed or impatience. Refusal to eat can also frustrate parents. When an infant's behavior is interpreted as stubborn, controlling, or ungrateful, the risk of harm is further increased. Another common misinterpretation that may increase the risk of maltreatment is when an infant is described as "spoiled" because the infant calms down when soothed or held by the caregiver. This positive response by the infant helps foster attachment, but when it is interpreted negatively as spoiled, it can harm caregiver-child bonding.

Different forms of maltreatment can occur as a result of caregiver misattributions and adult maladaptive responses. Sometimes a caregiver becomes frustrated to the point of yelling at and cursing an infant or child or using derogatory terms. Other maltreating actions include withholding food "until I say we can eat" to show the infant who is in charge or to teach him/her not to be demanding or impatient or isolating the infant for extended periods of time to "teach him/her to "toughen up and stop being a crybaby." A key point of risk is that when caregivers regard behavior as "bad" and/or purposeful, they are likely to believe that this behavior can and should be corrected. Sometime parents use physical means to "correct" or "teach a lesson," including spanking and slapping an infant or child, resulting in physical injury. Anger rather than empathy becomes the driving force, and there may be a perceived need to assert authority and use emotional intimidation, physical force, or punishment. Parents sometimes describe infants or children as "getting what they deserve," or "getting what they had coming to them." When a physical injury results, sometimes the caregiver even blames the child: "If she had not been doing \_\_\_\_, or if he would have just listened, then she/he wouldn't have gotten injured." The misattribution of soiling (with stool or urine) or crying may be an especially dangerous tipping point for some adults. The combination of unrealistic expectations, negative attributions, limited empathy, and use of corporal punishment to correct unwanted behaviors places a child at significant risk of harm.<sup>42</sup>

Guidelines on anticipatory guidance for parents regarding expected child developmental behaviors and emotions, such as temper tantrums or anger, may be too late for some. The problem is that the guidelines are based on age-appropriate stages of physical and emotional development, with the intent to guide parents in advance of development. Current recommendations of when to provide guidance may not be far enough in advance if a parent or caregiver is way off, with unrealistic expectations and beliefs about when and what a child can do and understand. Extremely unrealistic expectations increase risk to the child and limit the usefulness of anticipatory guidance that tracks normative development. Waiting to address issues until it is developmentally appropriate likely misses those at highest risk for maltreatment and, consequently, misses an important prevention window as well. Thus, getting a clear sense of parents' developmental expectations and attributions is important in identifying when to provide needed anticipatory guidance. The social history can help primary care physicians identify inappropriate expectations and attributions and enable opportunities to address them. Negative attributions from case examples are illustrated in [Table 2](#).

### ***Physical Discipline***

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More than 90% of American families report using physical discipline at some time during a child's life, and such discipline frequently occurs with very young children.<sup>43</sup> In a nationally representative study, 6% of parents reported spanking their infants 4 to 9 months of age, 29% of parents reported spanking children 10 to 18 months, and 64% of parents reported spanking children 19 to 35 months of age.<sup>44</sup> Much research has focused on physical discipline in this early developmental period and its

<b>Child's Actions/Disposition</b>	<b>Parental Misinterpretation</b>
Normal development behaviors	Bad, evil, "the devil", bitch, whore, self-centered, pouting, stubborn (especially infant), demanding, impatient
Crying	Mad, angry, weak, cry baby, titty baby, drama queen, demanding, impatient, trying to get attention
Crying, but soothes from crying when picked up/cradled	Child is spoiled
Frequent feeds	Greedy, ungrateful, selfish, self-centered, demanding, impatient
Not wanting to feed	Ungrateful, stubborn, controlling, rejection or dislike of parent
Spitting up	Ungrateful, retaliatory
Soiling (urine or stool)	Deliberate act by infant/child to control, make parent mad, or retaliate

impact.<sup>44,45</sup> Spanking has been significantly associated with aggression, school-age behavioral problems, and increased risk of physical abuse.<sup>46,47</sup> Escalation of spanking is evident in many reports of physical abuse substantiated by CPS.<sup>45,47-49</sup> Gershoff<sup>50</sup> points out that despite ample evidence that spanking is linked to undesirable outcomes, societal change around this issue has been slow in the United States. A growing list of national professional organizations have established official policy statements disavowing the use of spanking and endorsing nonpunitive discipline.

Learning a family's disciplinary approach at the first well-child visit may be important because some families report spanking as early as 2 months of age.<sup>45</sup> The AAP Early Brain and Child Development Leadership Workgroup recommends discussing disciplinary practices when a child is 15 months of age.<sup>51</sup> Although this may be appropriate for many families, it is too late for some. Waiting for the developmentally appropriate time to provide anticipatory guidance regarding disciplinary practices is especially too late for the patient population at the greatest risk for harm and maltreatment, who may not be readily identified as at risk.

### **Parental Mental Health**

Mentally ill parents are more likely to maltreat their child, and the child is at risk for a host of other negative outcomes both in the short term and in the long term.<sup>52-55</sup> Parents with mental illness are also more likely to need assistance in effective parenting.<sup>56</sup> Research shows that mothers with mental health diagnoses, such as depression, or who ascribe negative attributions to their children were more likely to use physical discipline and to be reported for abuse.<sup>30,34</sup> The links between mental health and child maltreatment indicate that priority should be given to identifying mental health problems in caregivers to prevent both immediate and future harm to children. Given the chronic and recurrent nature of many forms of mental illness, asking about past problems may also provide useful information.<sup>57</sup>

### **Substance and Alcohol Abuse**

Among the psychiatric disorders, substance abuse was the most common and the most powerfully associated with child maltreatment.<sup>58</sup> Some studies have found

that the risk of violence is not increased for individuals with mental health disorders unless substance abuse is also present.<sup>59</sup> In a study investigating the prevalence of drug and alcohol disorders among physically abusive and neglectful parents and caregivers, 40% of adults who reported an abusive behavior and 56% who reported a neglectful behavior had a substance abuse disorder.<sup>60</sup> In addition, Chaffin and colleagues<sup>59</sup> noted, “substance abuse disorders are highly prevalent in the population at large.” A Canadian study of approximately 8500 participants found that children in homes with parental substance abuse problems were at a more than 2-fold increased risk for child physical and sexual abuse.<sup>61</sup> Additionally, parental substance abuse increased the likelihood of re-reports to CPS.<sup>62</sup>

### ***Prior Child Protective Services Involvement***

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Two key topics when considering CPS involvement are prior CPS involvement and intergenerational maltreatment. Unfortunately, a referral to CPS does not necessarily prevent repeat maltreatment. Thompson and Wiley<sup>63</sup> studied a cohort of children who were referred to CPS as infants and found that 42.3% were re-referred within 10 years of the initial report. Huebner and colleagues<sup>16</sup> analyzed fatalities and near-fatalities from child maltreatment, and 48% of families had prior CPS involvement. Connell and colleagues<sup>64</sup> found that children were at the greatest risk for re-referral to CPS in the 6-month period after case closure but that the risk continued for the next few years. Overall, research has found an alarming 40% to 70% of cases are re-referred to CPS within 5 years.<sup>64–67</sup> Levy and colleagues<sup>66</sup> found that “the greatest risk of re-abuse occurred during the first 2 years following an initial discharge diagnosis of maltreatment.” The rates and time periods vary among the studies, but they all indicate a significant rate of recurrence. Thus, maltreatment seems to be a chronic problem in some families, and recurrent involvement of CPS is an ongoing risk. Asking parents about current or recent CPS involvement identifies what is likely to be a profound stressor for parents as well as markers of risk to children.

In addition to recidivism, the cycle of intergenerational abuse is of concern and places the children at increased risk for maltreatment. Estimates of intergenerational abuse rates are approximately 30%.<sup>68,69</sup> Despite a frequent emphasis on intergenerational abuse, the evidence indicates that most abused children do not grow up to be abusive parents. Kaufman and Ziegler<sup>69</sup> point out that focus should not be on the question, “Do abused children become abusive parents?” The more important question is, “Under what conditions is the transmission of abuse most likely to occur?” This new question changes the focus from inevitable to preventable.

These issues make it imperative that the primary care provider be keenly aware of a family’s involvement with CPS and understand the circumstances regarding that involvement to take proactive measures against future problems and harm. This may be accomplished by anticipatory guidance and parental education or facilitating access to community-based resources and services.

### ***Intimate Partner Violence***

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IPV is known to increase the risk of child maltreatment and to cause behavioral and mental health problems for children exposed to it. IPV itself is often considered a form of child maltreatment.<sup>70–73</sup> IPV often co-occurs with child maltreatment, and a significant proportion of children from violent families report being abused at some point in their lives.<sup>31,37</sup> Nationally, in 2012, 28.5% of children who had at least one substantiated or indicated maltreatment report (per state CPS agencies) were also exposed to IPV. Furthermore, 31 states were able to report whether a risk factor contributed to a child fatality; 20% did involve IPV.<sup>14</sup> A study of child fatalities in Florida

found that men who had been violent with their partners had the highest probability of committing a fatal assault.<sup>15</sup> These statistics indicate that adults who have the capacity and propensity to use violence with their partners are also likely to use violence with children. A child may be physically abused directly by an aggressive adult or inadvertently harmed during an altercation between adults.<sup>74</sup> Additionally, lasting psychological damage to the child may occur from witnessing household violence. The well-known deleterious physical and mental effects of exposure to violence at a young age led the AAP to recommend screening for IPV at pediatric visits.<sup>6,70</sup> Such screening has a great deal of empirical support.<sup>75</sup>

## SUMMARY

Understanding the environment a child is growing up in is essential to optimizing a child's developmental potential and physical health as well as the parent-child attachment and relationship. Questions that focus in a strategic way on social history and parents' attitudes and approaches to parenting can help identify positive aspects of the parent-child relationship and the family unit. The social history also can identify areas where parental anticipatory guidance is needed, including sources of frustration, challenges, physical punishment, and erroneous negative interpretations of a child's actions that heighten the risk for maltreatment.<sup>76</sup> The social history can help establish rapport by showing concern for the parent and family and lay the foundation necessary to screen for topics more difficult to broach, such as IPV, substance abuse/alcohol problems, or caregiver depression.

Because the social environment of a child matters greatly for the child's current and future health, it is timely to obtain a detailed social history at the start of the patient-family-medical provider relationship. Because aspects of the family environment, both protective and harmful, have such a significant impact on health and brain development for pediatric patients, screening is paramount to foster healthy parenting, help identify unhealthy factors, and, in some instances, even prevent child maltreatment.<sup>77</sup>

Social workers are experienced at delving into sometimes difficult areas and addressing needs with families, but, unfortunately, it is not practical for most primary care offices to have social workers on staff. The social history can be obtained in the practice setting by anyone who is medically trained. When issues in need of action are identified, referral to a specialist for further evaluation, treatment, or resources may be necessary to meet the needs of the children and families. In some instances, a report to CPS is required if maltreatment is suspected. Successful outcomes for the child and family are dependent, in part, on strategies for identifying and mitigating risk for maltreatment and collaborative efforts between the family, medical home, and social service agencies, when indicated. The social history may well be the best all-around tool available for promoting a child's future health and well-being.

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## APPENDIX 1: SAFE ENVIRONMENT FOR EVERY KID PARENT QUESTIONNAIRE



### Parent Questionnaire (PQ)

**Dear Parent or Caregiver:** Being a parent is not always easy. We want to help families have a safe environment for kids. So, we're asking everyone these questions. They are about problems that affect many families. If there's a problem, we'll try to help.

Please answer the questions about your child being seen today for a checkup. If there's more than one child, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you prefer not to.

Today's Date: \_\_\_/\_\_\_/\_\_\_ Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_/\_\_\_/\_\_\_

#### PLEASE CHECK

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you need the phone number for Poison Control?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you need a smoke detector for your home?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does anyone smoke tobacco at home?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the last year, did you worry that your food would run out before you got money or Food Stamps to buy more? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the last year, did the food you bought just not last and you didn't have money to get more?                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you often feel your child is difficult to take care of?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you sometimes find you need to hit/spank your child?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you wish you had more help with your child?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you often feel under extreme stress?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the past month, have you often felt down, depressed, or hopeless?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the past month, have you felt very little interest or pleasure in things you used to enjoy?                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the past year, have you been afraid of your partner?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the past year, have you had a problem with drugs or alcohol?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In the past year, have you felt the need to cut back on drinking or drug use?                                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are there any other problems you'd like help with today?  |

**Please give this form to the doctor or nurse you're seeing today. Thank you!**

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