DEFINING PARENT ABUSE AND NEGLECT

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BACKGROUND

During the last thirty years public concern, professional attention and scientific investigation have been drawn to the area of family violence. The first major finding was in child abuse (Pfohl 1977), followed by focus on abuse of wives by their husbands. More recently we have become aware of mistreatment of the elderly (Steinmetz 1978). One sociological task is to explore the definitional and normative standards which social control agents use to judge a new form of deviance. In the United States there is a tendency to medicalize family violence, because physicians often treat its results as they shift family problems to the professional realm, which includes medicine (Conrad, Schneider 1980). Therefore, we sought to determine the standards which physicians use in judging parent abuse or neglect. This is important because definitions and standards will determine future data on incidence, developing etiological theories, and policy on prevention and treatment.

Besides measuring physicians' standards on parental abuse, we explored how their background and experience would affect their judgment. It could be expected that medical specialty would be related to definitions, due to differences in professional socialization, and possible experiences with parent abuse and neglect. We also wanted to determine if professional experience with older patients and actual experiences with their own parents affects their definition. And we felt that physicians' informal socialization experience with older persons in their homes, either as children or as adults, would affect their standards of parent abuse and neglect.

METHODS

The research design and methods are based on a previous study defining child abuse by Giovannoni and Becerra (1979). They constructed a set of 78 vignettes in 13 categories to measure professional and public reactions to child abuse and neglect.These categories included: uncleanliness, emotional neglect, inadequate housing, medical neglect, nutritional neglect, physical abuse, lack of supervision, and sexual abuse. We selected three vignettes from each category: 1) one which had been ranked *very serious* , one ranked near the middle of the seriousness scale, and one ranked *not so serious.*

We adapted the vignettes to the parent abuse study by exchanging the object of abuse or neglect. Thus, a vignette which read: "Parent banged the child against the wall while shaking him by the shoulders." was altered to:

The son/daughter banged the parent against the wall while shaking him by the shoulders."

The resulting questionnaire included 3 vignettes for 8 types of abuse, for a total of 24 vignettes. Physicians were asked to rank each vignette on a scale of increasing seriousness from 1 to 9. A common parent referent was provided for the judgments through the instruction to the respondents: "Assume that the statements refer to a *dependent* 70 year old parent and the son or daughter." To guard against response set, the 24 vignettes were randomly distributed to respondents.

Following their responses to the vignettes the physicians were asked for background information, including: medical specialization, years in practice, proportion of patients over 65, professional experience with parent abuse and neglect, and the respondent's experience, either as a child or an adult, in a home where an aged parent was cared for.

Sample. Questionnaires were mailed to all of 766 physicians holding clinical appointments at a medical school, with a return rate of approximately 30% (229). We recognize that this response rate is low, but it is comparable with similar studies (Block & Sinnott 1979, 31%; O'Malley 1979, 34%). Since sampling is a problem with this research, we consider the results exploratory. We are exploring the response pattern of a nonrepresentative, but rather large group of physicians

showing enough interest in this research to answer the questionnaire.

RESULTS

Table 1 shows the physicians' mean ranking of seriousness and the relative rank order of the 24 vignettes describing parent abuse

TABLE 1: PHYSICIAN'S JUDGMENT OF PARENT ABUSE & NEGLECT ITEMS (Seriousness scale, 1 - 9, increasing; N#229)

Maltreatment Category	Vignette Description	Scaled Rating	Rank Order
Physical Abuse		**8.3**	**1**
	1. Hit parent in face with fist.	8.5	1
	2. Hit parent with stick.	8.4	2
	3. Banged parent against wall.	8.1	5
Sexual Abuse		**7.7**	**2**
	4. Had intercourse with parent, one occasion.	8.0	6
	5. Repeatedly suggested sex to the parent.	7.6	10
	6. Fondled parent's genital area on one occasion.	7.5	11
Neglect Cleanliness		**7.6**	**3**
	7. Leave parent on filthy mattress; infected sores.	8.3	3
	8. Does not wash parent; arms & legs have sores.	7.9	8
	9. Do not see that parent has clean clothes.	6.5	16
Medical Neglect		**7.5**	**4**
	10. Ignored parent's illness; parent was dehydrated when admitted to hospital.	8.2	4
	11. Have not given parent medication.	7.7	9
	12. Repeatedly failed to keep medical appointments for parent.	6.7	13
Nutritional Neglect		**6.9**	**5**
	13. Regularly fail to feed parent for periods of 24 hours.	8.0	7
	14.Brought parent to hospital 3 times, underweight; parent gained weight in hospital.	6.6	15
	15. Failed to prepare regular meals; parent has to fix own meals.	6.2	18
Emotional Abuse		**6.7**	**6**
	16. Constantly scream at parent; call foul names.	7.4	12
	17. Ignore parent, seldom speak to him.	6.5	17
	18. Keep parent locked in.	6.1	19
Supervision		**6.0**	**7**
	19. Regularly left parent alone all night.	6.0	20
	20. Regularly left parent with neighbor.	6.0	21
	21. Regularly left parent alone in home.	5.9	22
Housing		**5.0**	**8**
	22. Live in old house, two windows are broken, with jagged glass left in them.	6.6	14
	23. Live in apartment with few furnishings, children & parents sleep on one mattress.	4.7	23
	24. Live in small two-room apartment.	3.7	24

and neglect. Only one vignette, "Live in a small two-room apartment," falls below the midpoint of the seriousness scale. The mean rank for all vignettes is 7.0 on a 9-point scale, and four of the categories rank above 7 in seriousness: physical abuse; sexual abuse; neglect of cleanliness; and medical neglect. Nutritional neglect is ranked 6.9.

Giovannoni and Becerra analyzed their data according to incidents involving assaults, parental role failure in physical care, and caretaker responsibilities other than physical. In keeping with our research requirement to reverse the roles of adult child and dependent parent, other distinctions were used to analyze parent abuse and neglect data. Categories of physical and sexual assaults are rank ordered first and second in seriousness. Three types of violations of the physical care role then follow in seriousness: neglect of cleanliness, medical neglect, and nutritional neglect. Emotional mistreatment, a violation of the non-physical role of the caretaker is next, followed by housing and supervision, which are obligations of the physical care role.

When physicians' responses to the individual vignettes are analyzed, other patterns appear. They consistently ranked as serious those violations of the caretaking role which could result in medical harm to the parent, and several were ranked as more serious than vignettes portraying sexual abuse.

There was *no* relation between the physicians' reactions to parent abuse and neglect vignettes and the backgound and experience variables: medical specialty, proportion of patients over 65, and previous professional experience with parent abuse and neglect. We used number of years of practice to measure age and general experience as a physician, and found that these variables were not related to the judgments. Similarly, neither experience with an aged parent in the respondent's childhood home, or such exposure as an adult seemed to affect their response patterns.

DISCUSSION

The results show that physicians do rank parent abuse and neglect as serious. They consistently used the *most serious* end of the continuum in ranking. Clearly, acts in which the adult child assaults the dependent and aged parent, as in physical and sexual abuse were ranked above the other categories of abuse and neglect. With child abuse, physical assaults are sometimes difficult to define because group norms often legitimate physical punishment of the child by the parent. This is not true for the relation of the adult child to the aged parent. Sexual abuse violates the norms for both role relations. The physicians also indicated that acts or neglect which would result in medical harm were very serious. Some acts which could result in serious medical problems were ranked more serious than some types of sexual abuse. Emotional mistreatment was ranked relatively low compared to physical harm to the parent. This may reflect the socialization of physicians, their role concepts, and their greater concern for physical as compared to psychological illness.

These results suggest intriguing questions for future research. If parent abuse and neglect are seen as very serious by these physicians, then why are these problems of the elderly only now being recognized as a social problem? Perhaps it is due to the rather low incidence of the problem. We disagree with this answer, and submit that the reported incidence of parent abuse will remain low until it is institutionally established as a social problem. It is not clear now, whether the problem will be medicalized, or recognized by some other professional group. If it is institutionalized as a social problem, then it will be recognized and reported, and thus, will justify official and general concern. We must also ask: How will the problem of parent abuse and neglect rank with other serious social problems requiring treatment by service, research and judicial agencies?

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