Toward a nursing definition of child maltreatment using seriousness vignettes

To determine whether nurses operationally define child maltreatment in a like manner regardless of their practice specialty, eight practice groups (N = 596) participated in a mail survey. The survey allowed nurses to judge the potential seriousness of child maltreatment incidents. Multivariate statistical analyses revealed significant group differences. Follow-up analyses of variance (ANOVAs) revealed a difference between anesthetists and community health nurses on one factor (parental sexual mores). However, an investigator-developed scale demonstrated the differences would lack substantive value in clinical practice. It was concluded that nursing specialty groups define similarly the seriousness of child abuse and neglect despite varied backgrounds.

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THE OVERALL purpose of the study on which this article is based was to examine differences among nurses by practice specialty (eg, public health, psychiatry, and anesthesia) in their assessment of the seriousness of given examples of possible child maltreatment. The study attempted to determine whether nurses, as they become more independent and accountable for their professional practice, speak with a common vocabulary in assessing potential negative parenting practices.

Child maltreatment is not only a serious social and public health problem, it presents potential ethical, legal, and practical dilemmas for every health care provider. All 50 states mandate professionals who must report actual as well as suspected cases of child abuse and child neglect.

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However, child abuse and neglect legislation does not include standardized definitions to explicate which parental acts are deemed serious enough for professionals to report. What differentiates the seriousness of discipline, punishment, and child maltreatment? The answers are not easy. Yet, all health care providers face this issue every day. Adding to the dilemma is the professional's responsibility to recognize and report incidents encountered outside the clinic or hospital. Health care providers are licensed 24 hours per day. Child abuse and neglect then takes on added importance because of the professional's potential criminal and civil liability for not reporting an incident. Even if not legally bound, it might be argued, health professionals are ethically required to report instances of child abuse and neglect encountered either in their practice or in the public domain.

The National Center for Child Abuse and Neglect estimates that between 1 million and 6 million children are abused or neglected in the United States each year.[1] This is undoubtedly a conservative figure because of the "iceberg phenomenon." Moreover, usually only the most severe cases are recognized or reported. Fontana conservatively estimates that more than 5,000 children die each year in this country as a result of child abuse or neglect.[2] Hall further illustrates the severity of the problem by reporting that more deaths in children are attributed to child abuse than to automobile accidents, leukemia, cystic fibrosis, and muscular dystrophy combined.[3]

Child maltreatment is not a recent phenomenon. There is written historical evidence that child abuse and neglect are longstanding problems.[4] In tracing the history of child maltreatment, Radbill cites examples of ritualistic infanticide in the tribal customs of early humans.[5] Continued documentation of child abuse and neglect in history texts, the Bible, and works of authors like Charles Dickens provides evidence that societal definitions of child maltreatment have changed in type but not in fact.[6] Only during the past 100 years has society developed laws to protect the rights and well-being of children at serious risk, even to the point of usurping parental rights and beliefs.[7] Child maltreatment was discussed rarely in the medical literature until Henry Kempe's 1962 article, in which he used the now classic term, "battered child syndrome."[8]

Kempe and his colleagues were highly successful in mobilizing not only professional but public and legislative concern. In 1973, Congressional hearings on the problem of child maltreatment resulted in the passage of the Child Abuse Prevention and Treatment Act of 1974.[9] One provision of the act requires states to enact mandatory reporting legislation before becoming eligible for grant funds and research and demonstration projects. Within a year, all 50 states enacted mandatory reporting laws detailing who must report suspected as well as actual cases of child abuse and neglect.[10] However, because lawmakers recognize the gravity of interfering with

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individual parental rights, the necessary definitions of abusive or neglectful practices are lacking in spite of the widespread and perpetual occurrence of the problem. In most cases, definitions are left to health care providers and local public officials.

DEFINITIONAL PROBLEMS

Jason argues that, because definitions of child maltreatment vary widely, a serious impediment exists to any research in the area.[11] Besharov supports this contention and further states that definitional problems affect research comparability, reliability, and taxonomies.[12] Outlining directions for work in the coming decade, Krugman contends that defining child maltreatment is an unfinished task and should remain that way.[13] His rationale is based on the local and societal differences that exist in differentiating abuse, neglect, and ignorance. Krugman's cautiousness about definitions supports that of lawmakers cited earlier. One of the problems in attempting to define child abuse and neglect comes from a failure to realize that definitions vary contextually. Probably the most useful view of the definitional problem is presented by Valentine and her colleagues in examining a multidisciplinary approach to child maltreatment. They contend that three types of definitions exist:

1. those to guide legal intervention;
2. those to be used in case management; and
3. those to study causal relationships and characteristics in research.[14]

Thus a major definitional problem arises for all professionals. It is not clear what does and what does not constitute child maltreatment. Actually, each individual conceptually defines a negative parenting practice based on his or her personal values, life experiences, and professional orientation. The number of unstandardized definitions causes confusion and uncertainty among the very professionals who are expected to identify, treat, and prevent the problem.

The definitional controversy is highly relevant for nurses. Heretofore, nurses have been viewed conceptually as employees, directly and indirectly, of physicians. Because physicians are mandated to report suspected cases of child maltreatment, it was apparently assumed that all incidents of maltreatment known to nurses would likewise be known to physicians and would be reported. However, physicians have not been reliable and consistent reporters of abusive and neglectful incidents.[15] This information, coupled with the intimate nature of the nurse-patient relationship and the increasing tendency for nurses to have more professional autonomy, leads one to assume that nurses will continue to become aware of ever increasing numbers of child maltreatment cases unknown to other health care providers. Legally, nurses can no longer deny their role as gatekeepers in child abuse and neglect. They can no longer assign responsibility for reporting such cases to other professionals but must accept this role themselves.

Of all nurses, those in public health have the most experience with cases along the continuum of child abuse and neglect, whereas those in inpatient care are more likely to see only the most severe cases that necessitate hospitalization. Many nurses have questioned their judgment of the seriousness of child abuse and neglect and

have compared it to that of other nurses. If all nurses have a legal and professional responsibility to act as gatekeepers, it is important to know whether they define the seriousness of potential incidents of child abuse and neglect in a like manner.

Prior research has confirmed that other professional groups (ie, pediatricians, police officers, social workers, lawyers, judges, and teachers) and lay groups do define differently the level of seriousness attached to incidents of potentially negative parenting practices.[16-18] Furthermore, through factor analysis techniques, Giovannoni and Becerra have demonstrated that different professional groups and lay groups subsume potential incidents of maltreatment under different rubrics. However, few empirical data exist to document nurses' attitudes, beliefs, and assessments of child abuse and neglect. This study proposed to begin describing the "cognitive lens" of nursing, referred to by Gelles.[18]

Chater has demonstrated that professional nurses do vary on psychological tests according to their specialty of nursing practice.[19] Likewise, in simulation games, nurses have been shown to make clinical decisions that differ according to their specialty of orientation.[20] Therefore, it was hypothesized that nurses of various specialties would demonstrate statistically significant differences in the seriousness ratings assigned to hypothetical situations of child maltreatment.

CONCEPTUAL FRAMEWORK

The study's conceptual framework is based on that used by McKirnan to describe the process whereby professionals assign labels of deviant behavior.[21] Behaviors are labeled deviant when they exceed certain acceptable boundaries—boundaries that are determined differently by each profession or professional. McKirnan's model is readily transferrable to the problem of defining child maltreatment. The model conceptually divides the decision-making process of professionals into three parts (which are analogous to the steps in the nursing process of assessment and planning):

1. recognition of the problem;
2. denotative and connotative definition of the client's behavior; and
3. development of a problem resolution strategy.

Although case management strategies were part of the overall study, they are not reported here.

A supplemental feature of the study's conceptual framework is based on the epidemiological model of the dynamics of child maltreatment proposed by Justice and Justice.[22] Justice and Justice's model addresses the family and the larger environment. Their model presents in epidemiological terms the dynamic interaction among the model components: host or hosts (parents), agent (child), and environment (physical and social). These components are not easily isolated because of their interactive nature. The vector in the model represents the "cultural script" parents bring with them to their own parenting careers. These are the same scripts brought by nurses to their professional endeavors.

METHODOLOGY

Sample

Subjects were selected using a disproportionate stratified random sampling

technique from 3,800 US Army nurses assigned throughout the world. To compare by practice specialty nurses' seriousness ratings of potentially abusive or neglectful acts, it was essential that a population be selected for which the key variable (ie, practice specialty) could be accurately controlled. The consistent and homogeneous criteria used by the Army to award specialty status made this population ideal in this regard.

Because the data analysis plan included a factor analysis of items, the sampling goal was to select 100 nurses from each of eight specialty groups: administration, community health, psychiatry, pediatrics, operating room, anesthesia, obstetrics-gynecology, and medical-surgical. Two groups—administration and community health—contained fewer than 100 nurses per group who met the study criteria. Therefore, a census of these two groups was used ($n = 50$ and $n = 83$, respectively). The final sample contained a total of 733 potential respondents.

Survey instrument

The key component of the survey instrument was developed from 78 "seriousness vignettes" by Giovannoni and Becerra and modified by Furukawa.[17,23] Vignettes were constructed using examples of potentially negative child-rearing practices from statutes, actual clinical cases, and advice from experts in the field. Each of the 78 vignettes provided background or descriptive data and the results of a parental act (for example, "The parent immersed the chid in a tub of hot water. The child suffered second-degree burns."). The Giovannoni and Becerra instrument was developed to be administered personally to respondents. Furukawa modified the basic tool for self-administration by mail.

The instrument required respondents to assign a seriousness value to each of the 78 vignettes using a nine-point Likert scale, with "nine" being the most serious. Vignettes were to be judged independently of one another. To limit the effects they might have on one another, the vignettes were presented randomly. Respondents were asked to rate the seriousness of an incident and its attendant consequences as it related to the overall welfare of the child. Instructions were included to control for the age and sex of the child as well as for the nurses' potential concerns about basing decisions on a minimal amount of information.

Although the types of child abuse and neglect are numerous, incidents were believed to fall into major categories or constructs.[17] To complement the 78 seriousness vignettes, 11 overarching categories or constructs (Table 1) of types of possible child abuse and neglect also were presented to the respondents in a separate portion of the survey. With explicit definitions of the categories and detailed instructions, respondents were asked to rank the a priori constructs from most ("1") to least ("11") serious. The study proposed to contrast this ranking with the ratings that emerged from the seriousness vignettes.

Acceptable reliability and validity data on the Giovannoni and Becerra vignettes were available and published elsewhere.[17] However, it could not be assumed that the vignettes would be reliable when used with a different population (ie, nurses). Therefore, the instrument's reliability was tested. The face validity for items included in the questionnaire was based on the expert opinions of nurses and a social worker,

Table 1. Categories of child abuse and neglect generated by nonnurse professionals, community members, and nurses

Professionals[17]	Community members[17]	Nurses*
Physical abuse	Physical abuse	Physical abuse
Sexual abuse	Sexual abuse	Sexual abuse
Failure to provide Emotional mistreatment Educational neglect	Failure to provide	Failure to provide
Supervision	Supervision	
Parental sexual mores Drugs-alcohol	Drugs-sex	Parental sexual mores Drugs-Alcohol
Fostering delinquency		
		Medical and nutritional neglect

*Data from current study.

each with several years of extensive work in child protection. Factor analysis was used as the measure of construct validity.

Procedure

A pilot test was conducted on 116 subjects from the population who were then not included in the subsequent sampling. Data were collected over a three-month period using a total of four mailings to nonrespondents. Returns were received from 82% (596 of 733) of the target sample.

RESULTS

To test the null hypothesis that there would be no difference in the levels of seriousness attached by nurses to vignettes of child maltreatment, a stepwise data analysis was carried out. Seriousness vignettes were collapsed using principal components factor analysis with varimax rotation. The resultant factors were tested for reliability. Multivariate analysis of variance (MANOVA) was performed to test for significant differences among nursing specialty groups in their ratings of the seriousness vignettes. Post hoc analysis was carried out on the ratings to identify significant between-group differences. Finally, the 11 a priori constructs were analyzed for significance vis-à-vis the between-group differences identified on the seriousness vignettes.

Table 2 provides a summary of demographic variables by specialty group. Further analysis indicated no relationship between religious preference and race and membership in specialty groups; the symmetric uncertainty coefficients were 0.02 and 0.03, respectively.

To establish an experiential base line, two questions were asked to assess the respondents' self-perceived knowledge

Table 2. Summary of demographic variables by group

Variables	Chief nurses (n = 45)	Community health (n = 75)	Psychiatry (n = 74)	Pediatrics (n = 82)	Operating room (n = 64)	Anesthesia (n = 68)	Obstetrics/ gynecology (n = 73)	Medical-surgical (n = 82)	Mean for all groups (n = 563)
Sex, %									
Female (n = 373)	55.6	81.3	40.5	82.9	70.3	11.8	98.6	78.0	66.3
Male (n = 190)	44.4	18.7	59.5	17.1	29.7	88.2	1.4	22.0	33.7
Highest degree, %									
Diploma	2.3	0.0	4.2	1.2	7.8	8.7	5.6	2.5	4.0
Baccalaureate	30.2	56.0	38.9	80.2	75.0	59.4	69.4	69.6	61.6
Master's	65.1	44.0	54.2	18.5	17.2	29.0	25.0	27.8	33.5
Doctorate	2.3	0.0	2.8	0.0	0.0	2.9	0.0	0.0	0.9
Years in nursing									
Mean	22.5	13.7	12.5	9.1	14.0	16.5	11.5	9.6	12.9
Standard deviation	9.2	8.1	7.0	4.5	8.6	5.1	10.5	5.3	8.1
Age (in years)									
Mean	46.0	37.4	37.1	32.1	37.8	40.1	33.1	33.1	36.3
Standard deviation	5.3	5.5	5.9	4.8	7.0	5.4	5.3	5.6	6.7

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about child abuse and neglect and to measure their experience with maltreatment cases. Almost 40% (218 of 559) of the sample reported having little or no knowledge about child abuse and neglect. Operating room nurses claimed to have the least knowledge (67% [42 of 63] with "little or none"), while community health and pediatric nurses claimed to have the most knowledge (95% [70 of 74] and 83% [68 of 82], respectively, claiming "some or a great deal"). Over 20% (116 of 559) of the sample reported that they had never worked with a child officially designated as abused or neglected.

Reliability coefficients were calculated (using Cronbach's alpha) for the seriousness vignettes used in the analysis portion of the study. The standardized item alpha was found to be 0.967.

Factor analysis

For a more parsimonious handling of the data, principal components factor analysis with varimax rotation was carried out using 0.40 as the cutoff point and a minimum of three variables per factor for inclusion. Thirty-seven of the 78 seriousness vignettes met inclusion criteria and were used for further analysis. The resulting factors were named as follows: factor 1, drug-alcohol; factor 2, medical and nutritional neglect; factor 3, failure to provide appropriate environment, supervision, or education; factor 4, sexual abuse; factor 5, parental sexual mores; and factor 6, physical abuse. The six factors with eigenvalues in excess of 1.0 accounted for 68% of the total variance.

MANOVA was undertaken using the six factor scores as dependent variables and specialty groups ($k = 8$) as independent variables. The results (Table 3) were found to be significant ($F = 2.59$; $df = 7/549$; $p = .0001$).

The null hypothesis that no significant difference existed among nurse groups in how they define the seriousness of child maltreatment was rejected in favor of the alternative hypothesis: Nurses define child maltreatment differently according to their specialty. However, because group sizes were unequal, and because multiple comparisons are questionable in MANOVA, the data were interpreted conservatively.[24]

In an attempt to distinguish exactly which of the factors were causing the statistical difference, further analysis was done using one-way ANOVAs. Four vignettes in factor 5, parental sexual mores, and one vignette in factor 6, physical abuse, were found to be significantly different ($p < 0.01$). Using an a posteriori contrast procedure (Sheffe), only the factor parental sexual mores demonstrated a significant among-group difference at $p < 0.01$. This difference was between anesthetists and community health nurses.

Interaction effects

Because both anesthetists and community health nurses have a skewed gender distribution, a one-way ANOVA was performed to determine whether there was an interaction effect between gender and nursing specialty on the parental sexual

Table 3. MANOVA* table of differences among nursing specialty groups (n = 8) on six seriousness vignette factors

Serious vignette factors	*df*	Mean square between	Mean square within	*F*	*p*	R^2
Drug and alcohol	7/549	1.35	0.79	1.71	0.104	0.021
Medical and nutritional neglect	7/549	1.57	0.79	1.46	0.178	0.018
Failure to provide	7/549	1.16	0.80	1.45	0.182	0.018
Sexual abuse	7/549	1.76	0.82	2.16	0.036†	0.027
Parental sexual mores	7/549	3.89	0.83	4.67	0.0001‡	0.056
Physical abuse	7/549	3.11	0.83	3.76	0.0006‡	0.046

*Multivariate analysis of variance.
†$p < 0.05$.
‡$p < 0.01$.

mores factor. No interaction effect was found. A significant main effect was demonstrated both for specialty of practice ($F = 3.47$; $df = 7/540$; $p = 0.001$) and gender ($F = 5.39$; $df = 1/540$; $p = 0.01$). This confirmed that, controlling for gender, the seriousness attached to vignettes comprising this factor remained significantly different for the specialties as described earlier. These main effects are a function of the male members of the sample (X = 0.26) assigning a higher seriousness value to the vignettes comprising this factor than the female members (X = −0.12). Likewise, anesthetists (X = 0.46) attached more seriousness to the parental sexual mores factor than did the community health nurses (X = −0.37).

To place the ratings of child maltreatment into perspective, the final section of the questionnaire measured the seriousness ratings assigned to 11 categories of possible child abuse and neglect. Whereas the seriousness vignettes presented respondents with specific instances or cases without an overall construct, the goal of this section was to assess concordance among nurses given a construct and its operational definition.

Eleven categories of child abuse and neglect were chosen to encompass the nine categories derived from the Giovannoni and Becerra vignettes as well as two additional categories (medical neglect and nutritional neglect) believed to be important to nursing.[17,18] Table 4 provides the rank findings for each category; their operational definitions are given below the table. For comparison, results of the category rankings were analyzed using nonparametric statistical techniques.

Agreement among raters

Kendall's coefficient of concordance (W), a measurement of agreement among raters, was calculated. Ranking by the eight specialty groups on the 11 categories produced a W of 0.567. The significance of this finding ($\chi^2 = 45.36$; $df = 10$;

Table 4. Ranking of 11 categories of possible child abuse and neglect by all nurses combined*

Category	Mean rank score†	Rank‡	Modal rank
Physical abuse	1.55	1	1
Sexual abuse	2.48	2	2
Emotional mistreatment	4.21	3	3
Medical neglect	5.29	4	5
Nutritional neglect	5.49	5	4
Drug-alcohol misuse	6.38	6	7
Failure to provide	6.66	7	6
Supervision	7.60	8	8.5
Fostering delinquency	8.25	9	8.5
Educational neglect	8.81	10	10
Parental sexual mores	9.21	11	11

*n = 564

†Lower scores indicate more serious status.

‡Based on rank of mean score.

NOTE: Operational definitions of categories of child abuse and neglect

1. *Physical abuse:* Physical assault with an instrument, closed fist, or open hand, all of which leave physical evidence of trauma.
2. *Sexual abuse:* Sexual activity between parents and child ranging from fondling or verbal suggestion to intercourse.
3. *Emotional mistreatment:* Verbal abuse, avoidance, or threats of abandonment.
4. *Medical neglect:* Failure to obtain medical care for a sick child or failure to provide routine medical, dental, or optical care. Does not include acts of "failure to provide medical care" based on religious beliefs.
5. *Nutritional neglect:* Parental failure to feed children properly, ranging from under- or overfeeding to not feeding at all.
6. *Drug-alcohol misuse:* Parental use of alcohol or illicit drugs with the child's knowledge or use of the substances.
7. *Failure to provide:* Failure to provide adequate or proper food, shelter, or clothing.
8. *Supervision:* Leaving a young child alone or with unreliable "care providers."
9. *Fostering delinquency:* Stealing by household members about which the child is knowledgeable. The child may or may not be involved in the acts.
10. *Educational neglect:* Frequent absences of the child from school and failure in school, with or without the parents' knowledge.
11. *Parental sexual mores:* Sexual activities by the parents, such as prostitution, promiscuity, and homosexuality.

$p < 0.001$) suggested that the agreement among the raters is higher than would be expected by chance. The groups were apparently applying the same standard in ranking the categories.

A Kruskal-Wallis one-way analysis of variance was performed on the rankings. Only one category, parental sexual mores, was found to be significant ($p < 0.01$). Again, community health nurses and anesthetists were most divergent on the parental sexual mores category, indicating that the community health nurses assigned a significantly lower (ie, less serious) rank to the category than did the anesthetists. Finding a significant difference on the parental sexual mores category is consistent with findings already presented in the discussion of the seriousness ratings of vignettes.

DISCUSSION

Statistical *v* substantive differences

Nurses in this study were found to differ among specialty groups in their assignment

of seriousness ratings to vignettes describing child maltreatment. However, statistically significant differences are not necessarily indicative of substantive differences. A closer examination of the study results revealed that in only five of a potential 37 vignettes were there significant differences among specialty groups. Of these five vignettes, four fell within parental sexual mores, with the differences being most evident between the group-means of only two of eight specialty groups—community health nurses and anesthetists. Actual differences are further minimized when viewed contextually with the overall ranking of parental sexual mores. When the nursing aggregate (n = 564) ranked classes of possible child maltreatment, parental sexual mores was deemed to be the least serious.

Nurses defined the seriousness of child maltreatment in a like manner, notwithstanding the considerable disparity in the groups' clinical experience and knowledge about it.

Therefore, although a statistically significant difference in seriousness ratings was demonstrated among the groups, the findings fail to demonstrate a substantive difference in the definition of child abuse and neglect that would likely make a difference in clinical nursing. These findings provide evidence that nurses in this sample defined the seriousness of child maltreatment in a like manner, notwithstanding the considerable disparity in the groups' clinical experience and knowledge about child abuse and neglect. The research failed to demonstrate a relationship between seriousness factors and religion or race. Although gender and specialty of practice had a significant main effect on the parental sexual mores factor, there was no interaction effect between them. The inference is that a more subtle interaction is the basis for the rating, thus confirming the complexity of child abuse and neglect; ie, one variable may not be discussed appropriately in isolation of other variables.

Degree of discrimination

Nurses more closely resembled Giovannoni and Becerra's community sample than their professional sample (Table 1).[17] Nurses do not differentiate among vignettes with as much detail as other professionals studied by Giovannoni and Becerra. Nurses subsumed vignettes under six significant factors, in contrast to other professionals, who subsumed them under nine. Nurses did this by combining the categories of environmental safety, lack of supervision, and educational neglect under the single factor, failure to provide. This affords insight into what Gelles terms the "cognitive lens" used in conceptualizing child maltreatment.[18]

In contrast, as can be seen in Table 1, the lay community group studied by Giovannoni and Becerra subsumed the vignettes under only five significant factors. It is possible to speculate on the reasons for the nurses being more similar to the community group than to the professional groups. Whereas Giovannoni and Becerra's non-nurse professionals were closely involved in child abuse and neglect services, most of the nurses in this study were not. In fact, more than 20% of the sample reported they

had never worked with a child who had officially been designated a victim of child abuse or neglect. Furthermore, almost 40% of the nurse sample admitted they had little or no knowledge about child abuse and neglect.

Therefore, the difference in the number of discrete factors among the three groups would appear logical. The lay group had an unknown involvement with victims of child abuse and neglect. The nurse groups, on the other hand, contained a mixture of those with high levels of involvement and those with little involvement. It might be conjectured that professionals with the most involvement discriminate more clearly between types of child abuse.

Again referring to the seriousness vignette factors, nurses, unlike other professional or lay groups, were found to identify a combination of medical and nutritional neglect, which emerged with the second highest significant eigenvalue. Furukawa and Lena and Warkov have found that nurses have high concerns about nutritional neglect.[23,25] It was not surprising that nurses would generate a separate factor in the statistical analysis since medical and nutritional concerns surely fall within the nursing domain. In addition to spending a considerable amount of time assisting patients in maintaining their nutritional status, nurses are concerned with patients complying with "doctors' orders."

It is possible to argue that, had the seriousness vignette variables been more unidimensional and thus not had a factor complexity greater than one, more vignettes might have been retained in the final factor analysis, thereby possibly producing more factors. However, multidimensionality is realistic in the clinical setting. Problems usually are not unidimensional; nor are all other variables controlled. Professionals make judgments in uncertain contexts and often without full knowledge of a priori factors. When the findings of this study are compared with the conceptual framework adapted from McKirnan, it is obvious that child maltreatment is a complex problem contextually interrelated with several background and attitudinal variables.[21]

Finally, one might conjecture that one reason nurses have not reflected on child maltreatment in a serious manner is a lack of enforcement of reporting laws. With increased media coverage, awareness, and emphasis of social services on child abuse and neglect, more cases are likely to come to the attention of nurses. A method is needed for nurses to explore their attitudes and feelings about child abuse and neglect. One of the covert purposes of this study was to allow sample nurses to reflect on their professional decisions and, one hopes, to stimulate their personal planning of them. Other nurses need this opportunity.

Although nurses substantively define child maltreatment in a like manner, continuing education courses may be needed for nurses in practice to increase not only their awareness of child abuse and neglect but their assessment and intervention capabilities. The study demonstrated that nurses consistently discern the most and least serious incidents. It is apparent, however, that nurses need to be made aware that suspicion does not require proof. Although never to be taken lightly, reporting an incident should help a family receive services and should not be viewed as "family wrecking." Courts do not remove

children from families without sufficient proof of danger. Nurses as well as other professionals need to know this to help overcome a tendency toward noninvolvement and nonreporting.

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In the final analysis, nursing must determine its role in treatment and prevention programs for child maltreatment. There is a real need to provide nursing services to the abusive and neglectful families. However, a complex issue like child maltreatment should be treated only by professionals who are properly trained and whose training has provided them an opportunity to examine their own feelings and biases. Even those nurses unqualified or unwilling to deal with child abuse and neglect at the treatment level nevertheless are professionally obligated to at least be aware of the referral networks and legal responsibilities. Denial of the problem's existence and feelings of discomfort about the topic should not be accepted as reasons for noninvolvement. In an era in which nurses claim to be interested in total patient care, primary nursing, and a family-centered nursing approach, nurses need to make decisions prior to being confronted with the issue in practice. As educational and treatment regimens and definitional debates take place, it is helpful to know that the seriousness of potentially abusive and neglectful acts is rated similarly by all nursing specialty groups.

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