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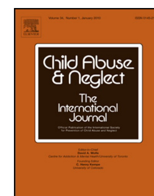

Provider ambivalence about using forensic medical evaluation to respond to child abuse: A content and discourse analysis☆

Marian Morris[a,*], Stephanie Rivaux[b], Monica Faulkner[b]

[a] School of Nursing, The University of Texas at Austin, United States
[b] School of Social Work, The University of Texas at Austin, United States

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ABSTRACT

Forensic medical evaluation rates for child abuse victims in Texas are low relative to national rates. In exploring reasons, researchers collected quantitative and qualitative interview and focus group data from multidisciplinary child abuse response team members across the state. This paper presents results of a secondary analysis of (N = 19) health care providers' interview and focus group transcripts, looking specifically at experiences with conducting forensic evaluations – thoughts, struggles, and ethical issues. The analysis was conducted from a critical realist perspective using content and discourse analysis. A theme of ambivalence was identified and explored. Three discursive themes were identified: ambivalence about the legal role, the health care role, and about unintended outcomes of evaluations. Extra-discursive elements related to the physical body, resource distribution, and funding policy were examined for their interaction with discursive patterns. Implications of findings include addressing issues in the current approach to responding to child abuse (e.g., uniting around common definitions of abuse; refining parameters for when FME is helpful; shoring up material resources for the abuse response infrastructure) and considering modification of providers' roles and activities relative to forensic work (e.g., deploying providers for prevention activities versus reactive activities).

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1. Introduction

Child abuse is a significant problem in the United States. In 2014, there were 702,000 confirmed cases of child abuse or neglect in the United States (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, & Children's Bureau, 2016; p. x). Child abuse can have significant short- and long-term impacts on a child's physical and emotional/behavioral health and can also increase the risk for substance abuse, criminal justice involvement, social problems, and revictimization (Administration for Children and Families, 2012; ChildHelp, 2012; Howard & Wang, 2005; White & Smith, 2001).

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* Correspondence to: 1710 Red River Street, Austin, TX, 78701, United States.
E-mail address: marian.morris@utexas.edu (M. Morris).

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At its best, the system response to child abuse results in a safe, healing, and growth-enhancing situation for a child and family. Many social systems are charged with intervening after an incident of child abuse, including Child Protective Services and criminal justice and health care systems. Child Advocacy Centers (CACs) work with these various organizations and systems to coordinate response to child victims through multi-disciplinary teams (MDTs). There is some question as to whether and how CAC and MDT formations help improve the quality and effectiveness of care for children in child abuse situations (Brink, Thackeray, Bridge, Letson, & Scribano, 2015; Dubowitz, Christian, Hymel, & Kellogg, 2014; Edinburgh, Saewyc, & Levitt, 2008; Elmquist et al., 2015; Faller & Palusci, 2007; Herbert & Bromfield, 2015; Jones, Cross, Walsh, & Simone, 2007; Walsh, Cross, Jones, Simone, & Kolko, 2007). One task of a MDT is assessing whether alleged child abuse victims should receive a forensic medical evaluation (FME) and, if so, facilitate this evaluation; access to FME is a standard created by national organizations dedicated to eradicating child abuse (U.S. Department of Justice, Office of Justice Programs, & Office of Juvenile Justice and Delinquency Prevention, 2015). FMEs serve two important functions: (a) assess a child's physical and emotional health, and (b) document possible forensic findings for substantiating and prosecuting child abuse (Atabaki & Paradise, 1999).

In 2011 the Midwest Regional Children's Advocacy Center (MRCAC) reported that, nationally, 34% of alleged child abuse cases referred to non-profit CACs received a FME. In comparison, medical evaluation rates in Texas are lower, relative to that national average, with 25% of cases referred for evaluation in large/urban areas, 14% in mid-sized areas, and only 8% in small/rural areas (Midwest Regional Children's Advocacy Center, 2011). In 2012 a statewide agency partnered with researchers at The University of Texas to explore how MDTs manage FME in child abuse cases. Particular foci of this project included studying procedures for determining the need for and obtaining FMEs, barriers to obtaining FMEs, and possible strategies to address barriers.

This paper is a secondary analysis of some of the data obtained in that mixed-methods study, using a critical realist epistemology and a content and discourse analysis approach. We explore how providers discuss working within a system of responding to child abuse, including how they reckon with conducting FMEs, describe the functioning of the systems within which they work, and balance multiple agendas and tasks of responding to abuse reports. This paper is organized as follows. First we describe the primary study's project background, sample, procedures, and source material to give context. Then we delineate the secondary study's transcript analytic process. We then discuss findings as content themes and in their extra-discursive (physical, material) and discursive elements – patterns of conversation or distinctive moments of language use – in the transcripts. Finally, we discuss implications in light of current evidence and practices.

2. Primary study details: statewide agency-contracted study of lower FME rates

2.1. Background, sample, and procedures

2.1.1. Contextualizing a forensic medical evaluation. Forensic evaluation is examination for legal purposes (Merriam-Webster Inc, 2013), and in this instance, is specifically for the purpose of collecting evidence to use in child abuse investigations. It involves close inspection of the clothing and body of a patient, often using magnification, to see evidence of physical or sexual abuse – injuries and body fluids, or scars from incidents in the past. Tools may include cameras to document injury, and a special type of camera mounted on a stand, called a colposcope. While often used non-forensically, in this situation colposcopes are used differently – to examine and photograph any body part, and also to examine closely a victim's genitals and reproductive organs for evidence of sexual activity or injury from physical or sexual abuse.

2.1.2. Sample. The primary study included both quantitative surveys and qualitative focus groups or interviews with professionals in the CAC system: health care providers, law enforcement, prosecutors, child protective services workers, and CAC staff. The qualitative study used a modified maximum variation sampling approach resulting in focus groups or interviews with professionals working on child abuse response MDTs from 12 communities across Texas. The sampled communities were evenly distributed by community size categories (small-sized/rural, mid-sized/suburban, and large-sized/urban) and rates of FME (high or low, relative to MRCAC statistics, and purposely including locations with highest and lowest rates).

2.1.3. Procedures. Researchers conducted a total of 5 two-to-four-person focus groups and 6 individual interviews (so 11 transcripts in total) with health care providers (individual interviews occurred only when there was only 1 provider for a particular location), resulting in a sample of 19 health care providers from 12 different geographic locations. Two locations shared a provider, so there were 12 locations, but 11 transcripts, because they did not interview the same provider twice. Of the 19 interview or focus group respondents, 7 were men and 12 were women. Respondents were 5 pediatricians with child abuse specialization, 2 medical doctors without child abuse specializations, 11 sexual assault nurse examiners (SANEs) or ER nurses, and 1 other unknown type of registered nurse.

The team obtained university IRB approval. Doctorate-level researchers conducted interviews or focus groups, led by the project's principal investigators (PIs), after obtaining written informed consent. One of the PIs is a former therapist with experience in dealing with interpersonal violence, while the other has extensive background in child welfare casework and sexual assault crisis intervention. They (PIs included) conducted the focus groups and interviews between November 2012 and February 2013. The research team created a guide to direct interviews and focus groups but had latitude to follow up lines of questioning with probes. Planned questions focused on describing a community's MDT, its functioning and effectiveness;

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