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ABSTRACT

The annotated bibliography on Physically Handicapped--Social Emotional Adjustment/Personal Experiences contains approximately 85 abstracts and associated indexing information for documents or journal articles published from 1960 to 1975 and selected from the computer files of the Council for Exceptional Children's Information Services and the Education Resources Information Center (ERIC). It is explained that titles were chosen in response to user requests and analysis of current trends in the field. Abstracts include bibliographic data (identification or order number, publication date, author, title, source or publisher, and availability); descriptors indicating the subject matter covered; and a summary of the document's contents. Also provided are instructions for using the bibliography, a list of journals from which articles were abstracted, and an order form for ordering microfiche or paper copies of the documents through the ERIC Document Reproduction Service. (PM)

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Physically Handicapped—Social Emotional Adjustment/ Personal Experiences

A Selective Bibliography

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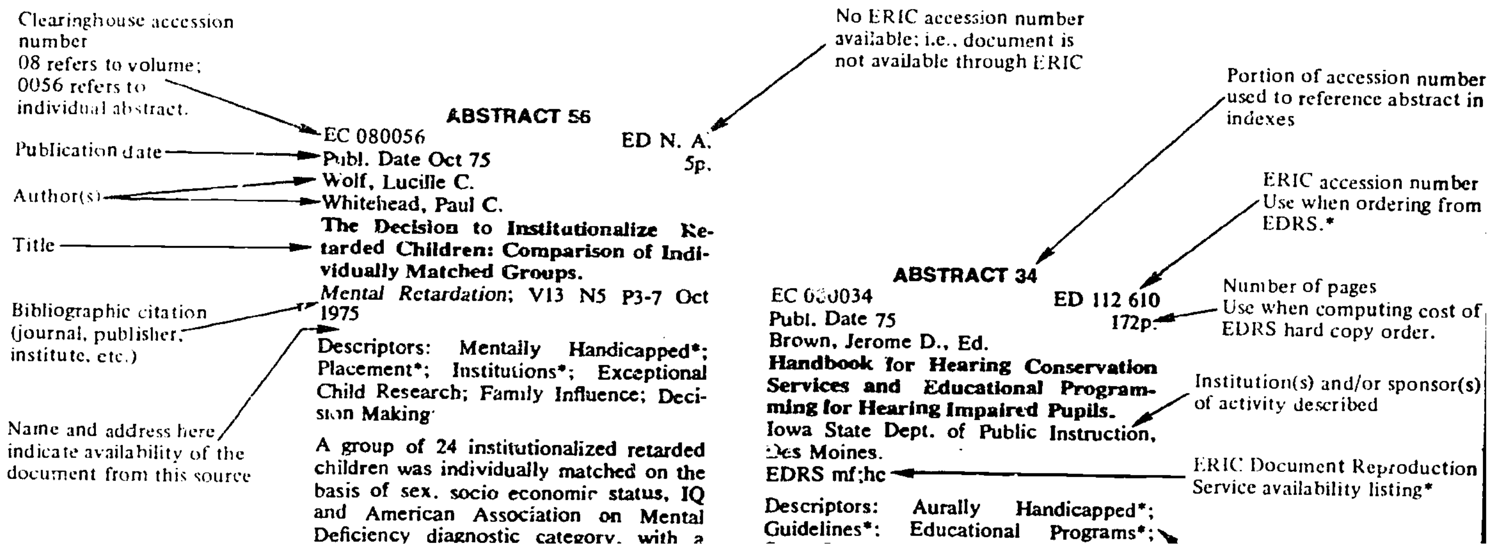

ERIC

The CEC Information Center regularly receives more than 200 journals which are examined for material concerning exceptional children. Articles judged to meet established criteria are abstracted, indexed and published in *Exceptional Child Education Abstracts (ECEA)*. Some of these articles are indexed and submitted also for announcement in *Current Index to Journals in Education (CIJE)*, an Educational Resources Information Center (ERIC) publication. The following list (current May 1976) is *representative* of journals currently received.

*Academic Therapy, 1539 Fourth Street, San Rafael, California 94901

ACTA Symbolica, University of Akron, Akron, Ohio 44304

Adolescence, PO Box 165, 391 Willets Road, Roslyn Heights, New York 11577

*American Annals of the Deaf, 5034 Wisconsin Avenue NW, Washington DC 20016 **

American Education, 400 Maryland Avenue SW, Washington DC 20202

American Educational Research Journal, 1126 16th Street NW, Washington DC 20036

American Journal of Art Therapy, 6010 Broad Branch Road, Washington DC 20015

American Foundation for the Blind Research Bulletin, 15 West 16th Street, New York, New York 10011

**American Journal of Diseases of Children, 535 North Dearborn Street, Chicago, Illinois 60610

*American Journal of Mental Deficiency, 49 Sheridan Avenue, Albany, New York 12210 **

American Journal of Nursing, 10 Columbus Circle, New York, New York 10019

**American Journal of Occupational Therapy, 6000 Executive Boulevard, Suite 200, Rockville, Maryland 20852

*American Journal of Orthopsychiatry, 1790 Broadway, New York, New York 10019 **

Archives of Otalaryngology, 535 North Dearborn Street, Chicago, Illinois 60610

Arithmetic Teacher, 1201 16th Street NW, Washington DC 20036

ASHA, 9030 Old Georgetown Road, Washington DC 20014

Audecibel, 24261 Grand River Avenue, Detroit, Michigan 48219

Auditory & Hearing Education, 15300 Ventura Boulevard, Suite 301, Sherman Oaks, California 91403

Audiovisual Instruction, 1201 16th Street NW, Washington, DC 20036

Australian Children Limited, Box 91, Brighton 5048, South Australia

*Australian Journal of Mental Retardation, P.O. Box 255, Carlton, South Victoria 3053, Australia **

AVISO, Newark State College, Union, New Jersey 07083

British Journal of Physical Education, Ling House, 10 Nottingham Place, London W1M 4AX, England

Bulletin of the Orton Society, 8415 Bellona Lane, Suite 204, Towson, Maryland 20402

Bulletin of Prosthetics Research, US Government Printing Office, Washington DC 20402

*Bureau Memorandum, 126 Langdon Street, Madison, Wisconsin 53702

CSMR Bulletin, 345 Campus Towers, Edmonton, Alberta, Canada

Canada's Mental Health, Information Canada, Ottawa K1A 0S9, Canada

CEDR Quarterly, Phi Delta Kappa, PO Box 789, Bloomington, Indiana 47401

Child Care Quarterly, 2852 Broadway, Morningside Heights, New York 10025

Child Development, 5750 Ellis Avenue, Chicago, Illinois 60637

**Child Psychiatry & Human Development, 2852 Broadway, Morningside Heights, New York 10025

Child Welfare, 67 Irving Place, New York, New York 10003

Childhood Education, 3615 Wisconsin Avenue NW, Washington DC 20016

Children Today, US Government Printing Office, Washington DC 20402

Children's House, Box 111, Caldwell, New Jersey 07006

Colorado Journal of Educational Research, University of Northern Colorado, Greeley, Colorado 80631

Communication Education (formerly Speech Teacher) Speech Communication Association, Statler Hilton Hotel, New York, New York 10001

Compact, 300 Lincoln Tower, 1860 Lincoln Street, Denver, Colorado 80203

Day Care & Early Education, 2852 Broadway, New York, New York 10025

Deaf American, 5125 Radnor Road, Indianapolis, Indiana 46226

Deficience Mentale Mental Retardation, York University, 4700 Keele Street, Downsview, Ontario M3J 1P3, Canada

Developmental Medicine and Child Neurology, Spastics International Medical Publica[illegible]

*Education of the Visually Handicapped, 919 Walnut St., Fourth Floor, Philadelphia, Pennsylvania 19107

Educational & Psychological Measurement, Box 6907, College Station, Durham, North Carolina 27708

Educational Forum, 343 Armory Building, University of Illinois, Champaign, Illinois 61820

Educational Horizons, 2000 East 8th Street, Bloomington, Indiana 47401

Educational Leadership, 1201 16th Street NW, Washington DC 20036

Educational Researcher, 1126 16th Street NW, Washington DC 20036

Educational Technology, 140 Sylvan Avenue, Englewood Cliffs, New Jersey 07632

Elementary School Journal, 5801 Ellis Avenue, Chicago, Illinois 60637

English Journal, 1111 Kenyon Road, Urbana, Illinois 61801

*Exceptional Children, 1920 Association Drive, Reston, Virginia 22091 **

*Exceptional Parent, 264 Beacon Street, Boston, Massachusetts 02116

Family Involvement, Canadian Education Programs, 41 Madison Avenue, Toronto, Ontario M5R 2S2, Canada

Focus on Exceptional Children, 6635 East Villanova Place, Denver, Colorado 80222

*Gifted Child Quarterly, 8080 Springvalley Drive, Cincinnati, Ohio 45236

Harvard Educational Review, 23 South Main Street, Uxbridge, Massachusetts 02138

Hearing, 105 Gower Street, London WC1E 6AH, England

*Hearing & Speech Action, 814 Thayer Avenue, Silver Spring, Maryland 20910

Hearing Rehabilitation Quarterly, New York League for the Hard of Hearing, 71 W. 23rd Street, New York, New York 10010

Human Behavior, PO Box 2810, Boulder, Colorado 80302

Humanist, 923 Kensington Ave., Buffalo, New York 14215

Illinois Schools Journal, 6800 South Stewart Avenue, Chicago, Illinois 60621

Indiana Speech & Hearing Journal, Ball State University, Muncie, Indiana 47306

Journal for Special Educators of the Mentally Retarded, 171, Center Conway, New Hampshire 03813

*Journal of Abnormal Child Psychology, **Plenum Publishing Corp., 227 W. 17th Street, New York, New York 10011

**Journal of Abnormal Psychology, 1200 17th Street NW, Washington DC 20036

*Journal of Applied Behavior Analysis, University of Kansas, Lawrence, Kansas 66044

Journal of Applied Rehabilitation Counseling, 1522 K Street NW, Washington DC 20005

Journal of Association for Study of Perception, PO Box 744, De Kalb, Illinois 60115

*Journal of Autism & Childhood Schizophrenia, Plenum Publishing Corp., 227 W. 17th Street, New York, New York 10011

Journal of Child Psychology & Psychiatry, Pergamon Press, Elmsford, New York 10523

Journal of Clinical Child Psychology, 111 South Meramec Avenue, No. 208, St. Louis, Missouri 63105

Journal of Communication Disorders, American Elsevier Publishing Co., 52 Vanderbilt Avenue, New York, New York 10014

Journal of Community Health, Human Sciences Press, 72 Fifth Avenue, New York, New York 10014

**Journal of Consulting & Clinical Psychology, 1200 17th Street NW, Washington DC 20036

Journal of Creative Behavior, 1300 Elmwood Avenue, Buffalo, New York 14222

Journal of Developmental Disabilities, PO Box 9470, Gentilly Station, New Orleans, Louisiana 70182

Journal of Education, Department of Education, Halifax, Nova Scotia

**Journal of Educational Psychology, 1200 17th Street NW, Washington DC 20036

**Journal of Educational Research, Box 1605 Madison, Wisconsin 53701

Journal of General Education, 215 Wagner Building, University Park, Pennsylvania 16802

*Journal of Learning Disabilities, 5 North **Wabash Avenue, Chicago, Illinois 60602

Journal of Marriage & the Family, 1219 University Avenue SE, Minneapolis, Minnesota 55414

*Journal of Mental Deficiency Research, 86 Newman Street, London WIP 4 AR, England

Journal of Music Therapy, Box 610, Lawrence, Kansas 66044

Journal of Rehabilitation of the Deaf, 814 Thayer Avenue, Silver Spring, Maryland 20910

Journal of School Health, American School Health Association, Kent, Ohio 44240

**Journal of School Psychology, 51 Riverside Avenue, Westport, Connecticut 06880

*Journal of Special Education, Grune and **Stratton, 111 Fifth Avenue, New York, New York 10003

*Journal of Speech & Hearing Disorders, 9030 Old Georgetown Road, Washington, DC 20014

*Journal of Speech & Hearing Research, **9030 Old Georgetown Road, Washington DC 20014

Journal of Teacher Education, One Dupont Circle, Washington DC 20036

*Language Speech & Hearing Services in Schools, 9030 Old Georgetown Road, Washington DC 20014

Lantern, Perkins School for the Blind, Watertown, Massachusetts 02172

Learning, 530 University Avenue, Palo Alto, California 94301

Mathematics Teacher, 1906 Association Drive, Reston, Virginia 22091

*Mental Retardation, 5201 Connecticut Ave**nue NW, Washington DC 20015

Merrill Palmer Quarterly, 71 East Ferry Avenue, Detroit, Michigan 48202

Momentum, 350, One Dupont Circle, Washington DC 20036

Music Educators Journal, 1902 Association Drive, Reston, Virginia 22091

NASSP Bulletin, 1904 Association Drive, Reston, Virginia 22091

National Elementary Principal, 1801 North Moore Street, Arlington, Virginia 22209

The New Beacon, 224 Great Portland Street, London WIN 6AA, England

*New Outlook for the Blind, 15 West 16th Street, New York, New York 10011

Notre Dame Journal of Education, PO Box 686, Notre Dame, Indiana 46556

Nursing Outlook, 10 Columbus Circle, New York, New York 10019

Optometric Weekly, 5 North Wabash Avenue, Chicago, Illinois 60602

Parents Voice, Journal of the National Society of Mentally Handicapped Children, Pembridge Square, London W2 4EP, England

Psychology Today, PO Box 2990, Boulder, Colorado 80302

Quarterly Journal of Speech, Speech Communication Association, Statler Hilton Hotel, New York, New York 10001

**Reading Research Quarterly, 6 Tyre Avenue, Newark, Delaware 19711

Reading Teacher, 6 Tyre Avenue, Newark, Delaware 19711

Rehabilitation Digest, One Yonge Street, Suite 2110, Toronto Ontario M5E 1E8, Canada

Rehabilitation Gazette, 4502 Maryland Avenue, St. Louis, Missouri 63108

*Rehabilitation Literature, 2023 West Ogden **Avenue, Chicago, Illinois 60612

Rehabilitation Teacher, 88 St. Stephen Street, Boston, Massachusetts 02115

Remedial Education, 5 Netherlee Street, Glen Iris, Victoria 3146, Australia

Review of Educational Research, 1126 16th Street NW, Washington, DC 20036

**Scandinavian Journal of Rehabilitation Medicine, Gamla Brogatan 26, Box 62, S-101 20 Stockholm 1, Sweden

Schizophrenia Bulletin, 5600 Fishers Lane, Rockville, Maryland 20852

School Media Quarterly, 1201-1205 Bluff Street, Fulton, Missouri 65251

*Sight Saving Review, 79 Madison Avenue, New York, New York 10016

Sign Language Studies, Linstock Press, 9306 Mintwood St., Silver Spring, Maryland 20901

*Slow Learning Child, St. Lucia, Brisbane 4067, Australia

**Social Work, 49 Sheridan Avenue, Albany, New York 2210

Southern Journal of Educational Research, Box 107, Southern Station, Hattiesburg, Mississippi 39401

Special Children, American Association of Special Educators, 107-20 125th Street, New York, New York 11419

*Special Education: Forward Trends, National Council for Special Education, 12 Hollycroft Avenue, London NW3 7QL, England

Special Education in Canada, Parkway V S, 1 Danforth Avenue, Toronto, Ontario, Canada

Speech Monographs, Speech Communication Association, Statler Hilton Hotel, New York, New York 10001

ABSTRACT 3244

EC 001 961 ED 010 896
Publ. Date Dec 64 73p.
Kinnane, John F.; Suziedelis, Antanas
Sources of Interpersonal Anxiety in the Physically Handicapped.
Catholic University Of America, Washington, D. C.
EDRS mf,hc

Descriptors: exceptional child research; adjustment (to environment); attitudes; tests; personality; special health problems; visually handicapped; aurally handicapped; anxiety; physically handicapped; test construction, occupational levels; age; interpersonal relationship; cardiac (person); social adjustment; interpersonal problems, psychological evaluation; psychological tests; Schedule of Interpersonal Concerns

In order to measure the sources of interpersonal concerns among the physically handicapped, the Schedule of Interpersonal Concerns was developed, based on Schulz's three-dimensional model. The instrument contained 59 items divided into five factors: rejection, responsibility, personal intrusion, social enmeshment, and independence. Three groups of the physically handicapped were chosen for application of the instrument. The two groups with sensory handicaps, including 56 deaf and 42 blind, were predicted to show concern over rejection. The third group of 38 cardiovascular handicapped was expected to show concern over the control dimension of independence. Control samples of 71 normal people were matched to each of the handicapped groups. Data analysis showed significant support of the hypotheses, despite some limitations of the instrument or sampling procedures with the deaf. Intragroup analysis indicated that the psychological meanings of a physical handicap were related to life stages and occupational levels. (NS)

ABSTRACT 1703

EC 004 186 ED N.A.
Publ. Date Apr 69 5p.
Sutherland, Prudence A.
On the Need of the Severely Handicapped to Feel That They Are Human.
EDRS not available
Top Of The News; V25 N3 P263-7 Apr 1969

Descriptors: exceptional child services;

the Physically Disabled; Disability Factor Scales--Amputation, Blindness, Cosmetic Conditions.
New York University, New York, School Of Education
Social And Rehabilitation Service (DHEW), Washington, D. C., Division Of Research And Demonstration Grants
EDRS mf,hc

Descriptors: exceptional child research; physically handicapped; attitudes; negative attitudes; amputees; blind; demography; factor analysis; attitude tests; stereotypes; test construction; internal scaling; item analysis

To describe and to develop instruments to measure attitudes toward amputees, the blind, and those with cosmetic conditions, three groups of subjects responded to one of three large pools of items tapping attitudes toward the three disability conditions. Three new groups of about 500 subjects of diverse demographic characteristics were given one of three revised and reduced questionnaires. The returns were factor analyzed and scales were derived from the resulting factors. The seven virtually identical factors which emerged from the amputation and blindness analysis were interaction strain, rejection of intimacy, generalized rejection, authoritarian virtuousness, inferred emotional consequences, distressed identification, and imputed functional limitations. The cosmetic conditions item set contained two factors which were identical (interaction strain, rejection of intimacy); two which were analogous (reluctant aversion and superficial empathy), and two unique dimensions (qualified aversion and proximate offensiveness). A review of related research and data on each item of the scales are included. (LF)

ABSTRACT 1173

EC 004 758 ED N.A.
Publ. Date 65 373p.
Spock, Benjamin; Lerrigo, Marion O.
Caring for Your Disabled Child.
EDRS not available
Crowell Collier And Macmillan, Inc., 866 Third Avenue, New York, New York 10022 ($4.95).

Descriptors: handicapped children; physically handicapped; parent child re-

actual school situations. Information is also presented on possible employment, parental influence in choosing a vocation, attainment of goals, suggestions for recreation and play activities, and sexual and social development problems from childhood through adulthood. Also discussed are problems in home management, some self help aids, and suggestions for the easier management of braces, wheelchairs, crutches, artificial limbs, and elimination processes. Suggested readings and a list of helpful agencies are provided. (JM)

ABSTRACT 1764

EC 004 804
Publ. Date Oct 66
Young, Howard D.
Independent Living: A Study of Rehabilitation of Physically Handicapped Adults Living in Foster Homes; Social Work Intervention in the Adaptation to Family Environment. Final Report.
New York Service For Orthopedically Handicapped, New York
Social And Rehabilitation Service (DHEW), Washington, D. C.
EDRS mf,hc

Descriptors: exceptional child services; physically handicapped; program evaluation; foster family; rehabilitation programs; adults; orthopedically handicapped; family environment; institutionalized (persons); social services; social adjustment; social workers; success factors; counseling effectiveness; interpersonal relationship; family influence; vocational counseling

As an alternative to unnecessary inpatient care of adults with orthopedic disabilities, the Independent Living Project (ILP) placed persons who were institutionalized without need and persons who were living in the community under unsatisfactory circumstances in foster homes. Information is presented on the intake procedures, homefinding techniques, matching client to foster home problems, counseling services, and the employment procedures used in the project. The characteristics of the ILP clients and foster families and the effects of social work intervention are enumerated with summary tables of data clarifying the placement results. Nine major

EC 005 454 ED N.A.
Publ. Date Mar 70 15p.
Noonan, J. Robert And Others
Personality Determinants in Attitudes toward Visible Disability.
Florida University, Gainesville, Regional Rehabilitation Research Institute

Rehabilitation Services Administration (DHEW), Washington, D. C.
EDRS not available
Journal Of Personality; V38 N1 P1-15 Mar 1970

Descriptors: exceptional child research; negative attitudes; females; college students; amputees; physically handicapped; psychological characteristics; personality; authoritarianism; attitudes

A battery of nine tests were administered to 240 female college students to examine attitudes of nondisabled persons toward the visibly disabled (amputation, wheelchair confinement, or facial disfigurement). Intercorrelation of personality measures with the Granofsky Pictures Test (GPT) and the Attitudes Toward Disabled Persons Scale (ATDP) showed authoritarianism is inversely related to positive attitudes toward disability (p less than .01 with GPT and ATDP) and conscious body satisfaction is positively related to acceptance of the disabled (p less than .05 with GPT and ATDP). It was also found that both ego strength and field independence are positively related to acceptance of the disabled (p less than .05 on ATDP). In the canonical correlation, authoritarianism received highest weighting of the predictors. Significant inverse relationships were found between authoritarianism and attitudes toward disabled when subjects showed low body satisfaction, moderate somatic concern, moderate or low social conformity needs, high ego strength, or moderate or low field independence. Authoritarianism was consistently found to best predict attitudes of nondisabled persons toward visibly disabled. (MS)

ABSTRACT 2230

EC 005 499 ED 037 882
Publ. Date 70 224p.
Finnie, Nancie R.
Handling the Young Cerebral Palsied Child at Home.
EDRS not available
E. P. Dutton And Company, Inc., 201 Park Avenue South, New York, New

thing, toilet training, dressing, feeding, transporting devices, sleeping, play, and linking play with everyday activities. Also provided are lists for additional reading, terminology, and suppliers of accessories and equipment. (JM)

ABSTRACT 2109

EC 005 513 ED 023 143
Publ. Date Jun 68 143p.
Muthard, John E.; Hutchinson, Jack
Cerebral Palsied College Students, Their Education and Employment.
Florida University, Gainesville
Social And Rehabilitation Service (DHEW), Washington, D. C.;
United Cerebral Palsy Association, New York, New York
EDRS mf,hc
CPCS Study, United Cerebral Palsy Association, Inc., 66 East 34th Street, New York, New York 10016.

Descriptors: exceptional child research; cerebral palsy; college attendance; employment opportunities; physically handicapped; adjustment problems

Investigated were the problems of college students who have cerebral palsy, and the barriers which may confront them during post-college employment years. Investigated were situations encountered in college and the methods used to overcome difficulties, the student's evaluation of a college education, and the effect of educational experiences and personal characteristics on post-college employment. A group of young cerebral palsied college students provided the data, describing their post-college and employment experiences. The responses of these individuals were tabulated to secure normative data or permit comparisons with findings from other college student groups. Personal, educational, and vocational characteristics of these students were compared with those of nonimpaired students. Personal, educational, and vocational characteristics of those cerebral palsied students employed in jobs related to education were compared with those employed in jobs not related to education. The major findings and implications are discussed in terms of student characteristics, college problems, education and employment, and parental attitudes. The instruments used in this series of studies and tabulations of statistical findings are appended. (Author/JM)

ability are shown to have behavioral consequences. Reasons for the lack of honest interaction between the disabled person and normal persons are explained. The creation of facilitative conditions (an honest environment) and an effective confrontation technique by a rehabilitation counselor are shown to be necessary for the treatment of psychological problems of the physically disabled. (KW)

ABSTRACT 2264

EC 005 945 ED N.A.
Publ. Date May 67 105p.
Siller, Jerome And Others
Studies in Reactions to Disability, XI: Attitudes of the Nondisabled Toward the Physically Disabled.
New York University, New York, School Of Education
Rehabilitation Services Administration (DHEW), Washington, D. C.
EDRS not available
Jerome Siller, Ph.D., Press Annex Building, Room 71, 26 Washington Place, New York University, New York, New York 10003.

Descriptors: exceptional child research; physically handicapped; attitudes; amputees; cerebral palsy; blind; deaf; discriminatory attitudes (social); negative attitudes; social attitudes; attitude tests; projective tests; adults; demography; personality tests; handicapped; special health problems

Three studies which examined attitudes of nondisabled persons toward the disabled are reported. A study which used college, high school, and junior high school subjects in order to examine the relationships among measures of attitude toward the disabled (Attitude Toward Disabled Persons Scale, Feeling Check List, Social Distance Scale), demographic variables, and indices of personality traits obtained from self report questionnaires is described. Also reported is a study examining the relationship between personality structure and attitude toward the disabled by use of interviews, Rorschach Test, Thematic Apperception Test, and Draw-A-Person Test with 65 persons. Another study reported presents data obtained from the Feeling Check List, the Social Distance Scale, and interviews and also summarizes reactions of subjects to amputation, blindness, body deformations, cerebral palsy, deafness, muscular dystrophy, paralysis, and skin disorders. Appendix-

ment problems; adolescents; self concept; psychological characteristics; individual development

The crises of adolescence affecting the physically handicapped adolescent are explored. Psycho-social development is discussed as it contributes to ego identity. Patterns of specific difficulties are examined. Also noted are the physical characteristics of adolescence and the implications for identity. Suggested are three ways to help the physically handicapped adolescent achieve self identity and ego identity. (MS)

ABSTRACT 284

EC 03 0284 ED N.A.
Publ. Date Sep 70 8p.
Richardson, Stephen A.
Age and Sex Differences in Values toward Physical Handicaps.
EDRS not available
Journal Of Health And Social Behavior; V11 N3 P207-14 Sep 1970

Descriptors: exceptional child research; physically handicapped; social attitudes; age differences; sex differences; majority attitudes

Pictures of a child with various physical handicaps were shown to children from kindergarten through high school and their parents to determine their values toward the disabilities. Results showed that the values changed with increasing age--at grade 12 the values of boys and girls resembled those of parents of the same sex. Older females conformed more to peer values than older males. From first grade on up, all subjects liked the non-handicapped child best (after third grade the average remained consistent at 59% for males and 71% for females). The least liked picture choice is less consistent by age and sex. In general, the obese child is least liked by both males and females. The child with a leg brace and crutches and the child in the wheelchair become more liked with increasing age of the subjects, while the child with the missing hand and the facially disfigured child become less liked. The primarily cosmetic handicaps (obesity and facial disfigurement) are less liked by girls than by boys. The functional handicaps (children on crutches and in the wheelchair and the amputee) are less liked by boys than by girls. Discussed are inferences concerning the mechanisms of the learning of values toward disabilities. (KW)

visually handicapped; aurally handicapped; employment trends; somatopsychology

The review of research relating to adjustment to physical handicaps and illness presents a general description of the somatopsychological problem, methodological problems of somatopsychological research, and limitations of the review itself. The significance of somatopsychological aspects is reviewed in the following areas: differences in physical size, strength, and attractiveness; crippling conditions; impaired hearing; tuberculosis; impaired vision; acute illness; and employment considerations with the physically disabled. Information provided in each area includes social effects, personality development, behavioral characteristics, research summaries, attitudinal traits, and additional data pertaining to the specific condition. Bibliographies are provided relating to each area. (RD)

ABSTRACT 372

EC 03 0372 ED 043 187
Publ. Date 70 176p.
Ludwig, Edward G.
Patterns of Adjustment to Disability.
Ohio State University, Columbus, College Of Medicine
Social And Rehabilitation Service (DHEW), Washington, D. C.
EDRS mf,hc

Descriptors: welfare recipients; physically handicapped; followup studies; older adults; adjustment (to environment); retirement; welfare agencies; social welfare; human services; Social Security

Designed to assess the validity of the determinations among applications for Social Security disability benefits, a comprehensive evaluation of each applicant was made including medical, psychological, social, and vocational data on each subject and his family. A followup study was conducted for 705 applicants from Ohio two to six years after the initial application was made for disability benefits. Results of the followup showed that 66.7% were receiving retirement benefits, 11.1% were substantially gainfully employed, and 53% had personal incomes of less than $150 per month. The agency participation and applicant characteristics (health status, economic and employment status, family situation, and general activities and situation) are fully described. (RD)

Designed to be particularly useful to those interested in rehabilitation counseling, at either the undergraduate or graduate level of instruction, the book on the psychology of disability deals with the skills and theories of adjustment to disability. Theoretical foundations are surveyed. Following chapters examine attitudes (of employers, family, and professionals) toward disability, emotional factors in illness and disability, sensory and perceptual processes (body image, phantom perceptions, sensory compensation), motivation and the organization and direction of behavior, and the regulation and control of behavior (learning and skilled performance, occupational performance). A summary to the preceding discussion of the behavioral effects of structural and functional changes resulting from illness and disability includes theoretical considerations. (KW)

ABSTRACT 1784

EC 03 1784 ED 048 680
Publ. Date Jan 71 197p.
Deschin, Celia S.; Nash, Marygold V.
Children Together: The Effect of Integrated Group Experiences on Orthopedically Handicapped Children.
New York Service for the Handicapped, New York
National Institute of Mental Health (DHEW), Bethesda, Maryland
EDRS mf,hc

Descriptors: exceptional child research; physically handicapped; mental health; recreational programs; group relations; peer relationship; self concept

To study the effect on physically handicapped children's mental health of organized group activities in community centers and settlements, 230 children participated in a 2 year demonstration project. Mental health was defined as the child's social functioning in home and school and as reflected in the child's self image; and it was hypothesized that the mental health of mildly physically handicapped children improved through recreational activities with their nonhandicapped peers. It was also speculated that no special or additional staff would be needed. Data was obtained through interviews with the children, families, teachers, group leaders, and placement counselors. Researchers felt that, after comparing factors concerning the families, the school and the children's self evaluations, the children showed improvement attributed to associating with their non-

psychophysiology; psychological characteristics; personal adjustment; personality; behavior patterns; emotional problems; emotional adjustment; attitudes; interpersonal competence, social problems; somatopsychology

Written for the practitioner in the field of rehabilitation and the professional in training, the volume deals with the phenomenal and instrumental connections between the psyche and the soma, and, in particular, the somatopsychological problem as seen in disablement. Emphasis is on the kinds of social-psychological problems confronting a person with an atypical physique and how he copes with them. How environmental and personal factors aid or hinder psychological adjustment is considered. The role of physical disability in determining personality and behavior is discussed in terms of available data, relevant theories, and new concepts and interpretations. Some of the specific topics covered are inferior and salutary status positions, frustration and uncertainty, value changes in acceptance of disability, self-concept, perception of interpersonal relations, adolescents, everyday relationships, public attitudes, training in social skills, parents, and motivation. (KW)

ABSTRACT 2337

EC 03 2337 | ED N A
Publ Date Jun 71 | 7p
Kolin, Irving S and Others
Studies of the School-Age Child with Meningomyelocele: Social and Emotional Adaptation.
EDRS not available
Journal of Pediatrics: V78 N6 P1013-9 Jun 1971

Descriptors: exceptional child research; physically handicapped; anomalies; emotional adjustment; family attitudes, parent attitudes; social adjustment; meningomyelocele

Thirteen school-age children with meningomyelocele and their families underwent intensive social service interviews and psychiatric evaluation. A good to fair adaptation was found in seven of the children and in five of the parents. Divorce or separation occurred in six of the families studied. Both parents and children used a wide variety of adjustment mechanisms. Social and emotional factors appeared to be stronger determinants of adaptation than severity of physical impairment. Communication between the physician and the family

Columbia University Press, 440 West 110th Street, New York, New York 10025 ($8.75).

Descriptors: physically handicapped; personal adjustment; psychological characteristics; adjustment (to environment); rehabilitation; physical characteristics

The role of personal adjustment to the total life situation of the physically disabled is discussed. Emphasis is placed on the common problems distinctive to the respective disabilities discussed and on the variety of reactions to these problems. Such disabilities as amputation, arthritis, cardiovascular disability, hemiplegia, cerebral palsy, language disorders, cancer, facial disfigurement, auditory or visual disability, deaf-blindness, and severe chronic illness are included. The authors have sketched some of the disability influences and problems in terms of medical physical aspects, psychological implications in regard to individual as well as family and sociocultural milieu, special considerations in psychological appraisal and rehabilitation, and suggestions for research as well as for improvement in psychological management and rehabilitation. (CD)

ABSTRACT 2506

EC 03 2506 | ED N A.
Publ. Date Jun 71 | 3p
Fox, Joshua
Sex Education--But for What.
EDRS not available
Special Education; V60 N2 P15-7 Jun 1971

Descriptors: exceptional child education; physically handicapped; sex education; sexuality; cerebral palsy; maturation

The article deals with the issue of sex education for the severely physically handicapped. Differences in the approach to sex education as a result of a handicapping condition such as the dependance on others, the bodily hinderances, and community attitudes on sex that the handicapped cannot avoid are pointed out. Understanding the underlying anxieties, the importance of sexual fantasies, and the problems in attaining maturity are considered. Three aspects of how sex education can prepare the physically handicapped for the kind of life they are to lead as adults (sexual behavior, personal relationships, substitutes) are also discussed. (CD)

ABSTRACT 3202

it within a sociological and sociopsychological theoretical framework. The book deals primarily with physical disability and physical rehabilitation. The discussion of societal response to disability examines the status of the disabled historically and cross-culturally. The process by which a person may go from health to illness to disability is studied as well as the variety of behavioral alternatives open to him. The cultural, social and sociopsychological factors influencing his choice of alternatives at each stage are examined as well as the consequences of each choice for rehabilitation outcome. Theoretical aspects of disability and rehabilitation are dealt with in analyses of the sociology and social psychology of each, in which disability and rehabilitation are examined at three analytical levels: personality, social system, and culture. The meaning of work and its relevance for the identity of persons in different occupational categories is explored. A look at the successful rehabilitant considers medical, demographic, sociopsychological, and vocational factors related to rehabilitation success, both physical and vocational. The fate of rehabilitated patients after discharge from a rehabilitation facility is examined. Finally, recommendations to improve present rehabilitation schemes are made. (KW)

ABSTRACT 19

EC 04 0019 | ED N.A.
Publ. Date Sep 71 | 6p
Richardson, Stephen A.
Children's Values and Friendships: A Study of Physical Disability.
EDRS not available
Journal of Health and Social Behavior: V12 N3 P253-8 Sep 1971

Descriptors: exceptional child research; physically handicapped; values; behavior patterns; group norms; peer relationship, childhood attitudes

The relation between value and behavior was examined, using children's values toward physical handicaps and their choice of best friend in a summer camp where children with and without physical handicaps lived together. It was hypothesized that children whose individual values toward handicaps were similar to the group value would choose as best friend someone who was not handicapped, whereas children with individual values that were atypical of the group value would choose someone who was handicapped. For children without handi-

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Perceptual and Motor Skills; V33 N3 P907-10 Dec 1971

Descriptors: exceptional child research; physically handicapped; personal adjustment; social adjustment; psychology; personality; personality assessment

Twenty orthopedically disabled hospital patients responded to a self-ideal discrepancy scale and the Eysenck Personality Inventory. The severely disabled Ss were more self-accepting and less neurotic than the marginally disabled Ss. A direct relationship was obtained between age and a composite measure of maladjustment (r equals .42, p less than .001), but this was not due simply to the duration of the disabilities. The results were interpreted as supporting the role-conflict hypothesis rather than the social-rejection hypothesis concerning the psychological consequences of physical disability. (Journal)

ABSTRACT 1178

EC 04 1178 ED N.A.
Publ. Date Fall 71 18p.
English, R. William
Correlates of Stigma Towards Physically Disabled Persons.
EDRS not available
Rehabilitation Research and Practice Review; V2 N4 P1-17 Fall 1971

Descriptors: research projects; research reviews (publications); physically handicapped; social attitudes; discriminatory attitudes (social)

Research was reviewed concerning social attitudes toward the physically handicapped, and in particular, concerning the anatomy of prejudice toward the physically handicapped. The following demographic correlates of stigma toward the physically disabled persons were reviewed briefly: sex, socioeconomic status, age, education, disability, religion, and occupation. The salient personality correlates of social discriminatory attitudes toward physically handicapped persons studied were said to be motivation, self concept, anxiety, interests, and intelligence. Research indicated that less aggressive persons with high self concept, low levels of anxiety, high needs for social approval and greater ability to tolerate ambiguity were the most accepting of the physically handicapped. Also reviewed were attitudinal correlates of stigma towards physically disabled persons. (CB)

handicapped. Suggested plans of action include increasing amount of meaningful contact among disabled and non-disabled, improving behavioral skills of physically handicapped persons in their relations to non-disabled, influencing mass media to present more realistic views of disability and disabled persons, presenting stimuli over mass media to reduce stigma, including disabled person's family and his significant others in his treatment program, organizing physically disabled politically, pressuring elected officials to review and repeal legislation that restricts lives of disabled persons, promoting and participating in citizen advocacy programs, changing concept and design of institutions, and further professionalizing human services. (CB)

ABSTRACT 1378

EC 04 1378 ED N.A.
Publ. Date Feb 72 5p.
Eiseman, Russell
Attitudes Toward the Physically Disabled: Report of a Research Program, with Implications for Psychotherapy.
EDRS not available
Training School Bulletin; V68 N4 P202-6 Feb 1972

Descriptors: physically handicapped; attitudes; social attitudes, personality; negative attitudes; research projects

A 3-year study of personality and attitudes associated with prejudice against the physically disabled is described. Some findings are presented, as well as the design of the research program, which should lead to important clues associated with rejection of the physically disabled by non-disabled persons, as well as by the physically disabled themselves (self-hatred). Since deviance can be thought of as socially defined, the research, findings, and conceptualizations have implications for the way various scapegoated people are perceived. Social discrimination, it is said, may cause a severe loss of self-esteem, which should be dealt with by therapists of rejected individuals. (Author)

ABSTRACT 1407

EC 04 1407 ED N.A.
Publ. Date 72 203p.
Viscardi, Henry, Jr.
But Not on Our Block.
EDRS not available
Hill and Wang, Inc., 72 5th Avenue, New York, New York 10011 ($6.95).

this proposed expansion of facilities already existing for the preschool through high school level handicapped students. At book's end, it is reported that the community's appeal to the New York State Supreme Court was rejected and, despite further litigation pending, construction was ready to begin on the new facility. (KW)

ABSTRACT 1792

EC 04 1792 ED N.A.
Publ. Date 71 12p.
Hopkins, Mary T.
Patterns of Self-Destruction Among the Orthopedically Disabled.
EDRS not available
Rehabilitation Research and Practice Review; V3 N1 P5-16 Win 1971

Descriptors: physically handicapped; suicide; research reviews (publications); death; incidence; statistical data; amputees; emotional adjustment

The review of research presents existing information on self-destructive behavior among the orthopedically disabled. The term suicide is used to include not only the accomplished act, but also such actions as self neglect leading to infection and death; alcoholism, drug addiction, and other incidious self-destructive acts are seen as a kind of chronic suicide. The term orthopedically disabled is defined to include persons with spinal cord injuries and amputees. Studies reviewed cover incidence of suicide; general facts about suicide; physical illness and suicide; suicide among amputees, paraplegics, and quadriplegics; and other forms of self-destruction. Studies show that the suicide rate is higher for the disabled than for the general population, that suicide rate is inversely related to severity of disability, and that suicide rate is higher for amputees than for the spinal cord injured, possibly due to more effective use of denial by the latter group. (KW)

ABSTRACT 1794

EC 04 1794 ED N.A.
Publ. Date 71 13p.
English, R. William
Thr Application of Personality Theory to Explain Psychological Reactions to Physical Disability.
EDRS not available
Rehabilitation Research and Practice Review; V3 N1 P35-47 Win 1971

disablement, the sociological or social impact of disablement, and the prognosis for rehabilitative treatment and attitude change. (KW)

ABSTRACT 1940

EC 04 1940 ED N.A.
Publ. Date 72 2p
Young, B. M.
Sex and the Handicapped Adolescent.
EDRS not available
Rehabilitation Digest: V3 N4 P12-3 Spr 1972

Descriptors: exceptional child education; physically handicapped; sex education; sexuality; counseling; marriage; physicians; adolescents; young adults

A physician discusses the need for sex education and marriage counseling among handicapped adolescents and young adults. Recounted are two cases in which he advised a 19-year-old girl with muscular dystrophy and a quadriplegic 17-year-old boy. Given are the physician's answers to the physically handicapped adolescents' answers concerning ability to have sexual relations and to produce or bear a child. The two cases are cited as illustrations of the handicapped adolescent's desire for knowledge in the area of sex and sexuality. Urged is the need to provide frank and honest discussion and to help families understand that their handicapped children have thoughts of sex and marriage similar to those of the nonhandicapped. (KW)

ABSTRACT 236

EC 05 0236 ED N.A.
Publ. Date Nov 72 5p.
Rapier, Jacqueline and Others
Changes in Children's Attitudes toward the Physically Handicapped.
EDRS not available
Exceptional Children: V39 N3 P219-23 Nov 1972

Descriptors: exceptional child research; physically handicapped; elementary school students; changing attitudes; peer acceptance; regular class placement; age differences; sex differences

An assessment was made of changes in attitude of 152 elementary school children toward orthopedically handicapped children as a result of an integrated school experience. After integration nonhandicapped children had developed a more positive attitude toward the orthopedically handicapped. Before inte-

John Day Company, Inc., 257 Park Avenue South, New York, New York 10010 ($9.00)

Descriptors: exceptional child education; physically handicapped; special health problems; diseases; epilepsy; diabetes; allergy; asthma; minimally brain injured; adolescents; rehabilitation counseling; medical case histories

Intended for nonmedical personnel who counsel physically handicapped adolescents, the book provides answers to questions the adolescent may have about his disability and how to best live with it. A chapter each is given to epilepsy, hemophilia, sickle cell anemia, diabetes, allergies and asthma, and brain injury. Each chapter is structured to present medical data including the definition of the disease, its symptoms, etiology, care, and prognosis and rehabilitation patterns as seen in several case histories. There are said to be two million epileptic children suffering from petit mal, grand mal, and psychomotor seizures. Rehabilitation is illustrated by Peter who overcame effects of an overprotective mother. Hemophilia is described as being of two common varieties with an hereditary pattern. Cooperation of school personnel is seen in the case of Kenneth, a high school aged hemophiliac. Sickle cell anemia is thought to be characterized by pervasive public ignorance and inadequate screening programs. In the case of Howard, family, teachers, and the boy himself behaved as if he did not have sickle cell anemia, resulting in the death of the boy at the age of 18 years. Contrasted is the diabetic's condition prior to and following the discovery of insulin. The case of Karen is said to show the development of responsible self care. Discussed are skin allergies resulting in, hives, contact dermatitis, and eczema, hay fever and allergic rhinitis; and asthma. Counseling to release suppressed feelings of anger and hostility is said to have contributed to the physical improvement of Millie, an adolescent suffering from dermatitis and asthma. Brain injury is seen to be a difficult handicap to define. Misdiagnosis is illustrated by the case of Richie who was diagnosed as schizophrenic and mentally retarded before being correctly diagnosed and treated as brain injured. (DB)

ABSTRACT 1445

EC 05 1445 ED N.A.
Publ. Date 72 79p.

factory adjustment include reasonable parental demands and optimum social integration with normal children. Handicapped adolescents are seen to need help in achieving independence from parents and more social opportunities. The attitudes of parents and nursing staff to the sexual development and behavior of children and adolescents are examined. Recommended is sexual education by informed and sensitive teachers. Architectural, cultural, and financial obstacles are seen to limit the social contacts of orthopedically handicapped adults. Increased public recognition of the sexual needs of handicapped persons is suggested. M. or problems in the handicapped woman's sexual life are said to be physical capability and pregnancy. It is reported that most paraplegic men are able to perform sexually. The suitability of various contraceptive methods for the physically handicapped is evaluated. Encouraged are measures which would permit the severely handicapped to live together in their own homes. (DB)

ABSTRACT 1737

EC 05 1737 ED N.A.
Publ. Date Apr 73 56p
Pilling, Doria
The Orthopaedically Handicapped Child Social, Emotional and Educational Adjustment: An Annotated Bibliography.
EDRS not available
Fernhill House, Ltd. 450 Park Avenue South, New York, New York 10016 ($2.75).

Descriptors: exceptional child research; physically handicapped; emotional adjustment; social adjustment; educational needs; abstracts; research reviews (publications); attitudes; academic achievement; annotated bibliographies

The booklet summarizes 128 research reports (published from 1958 to 1972) concerning the emotional, social, and educational aspects of physical handicap in childhood. The main conditions covered are congenital amputations and deformities (including those due to thalidomide), post-poliomyelitis defects, Perthes disease (a hip disorder), and muscular dystrophy. The research reviews are organized into four sections: attitudes to disability (37 reports), emotional and social adjustment (51 reports), family adjustment (11 reports), and educational attainments (29 reports). Listings are by date of study and include authors,

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physically handicapped; young adults; adults; sexuality; foreign countries; social attitudes; civil liberties; civil rights

Summaries of reports from Sweden, Israel, and the United States concern the sexuality of physically handicapped persons. The report from Sweden indicates widespread ignorance of orthopedically handicapped persons' need and ability to function sexually; and further stresses that sexuality involves both biological drive and love; that society's attitude toward beauty, stimulated by the mass media, reinforces public ignorance of handicapped persons' sexuality; and that only 50% of paraplegics have reported sexuality problems. The Israeli report cites human concern about bodily function as the source for extensive folklore about disability, which, when combined with attitudes on sexuality, raises fears in parents, staff workers, and the public. Also, the Israeli report discusses handicapped persons' rights to be informed, to be educated, to have sexual expression, to marry, to be parents, and to receive community services. From the United States a summary of a study on spinal cord injured males considers sexual experience in terms of individual differences, cites five aspects of sexual satisfaction, and asserts that genital sexual performance is possible and psychologically beneficial for most spinal cord injured males. (MC)

ABSTRACT 2593

EC 05 2593 ED N.A.
Publ. Date Oct 73 1p
Banham, Katharine M.
Social and Emotional Adjustment of Retarded CP Infants.
Exceptional Children; V40 N2 P107 Oct 1973

Descriptors: exceptional child research; physically handicapped, cerebral palsy; infancy; early childhood; emotional adjustment; social adjustment; behavior rating scales

The behavior of 37 retarded cerebral palsied children (aged 18 to 60 months) was evaluated by means of two behavior rating scales. The scores correlated fairly consistently with age and intelligence of the cerebral palsied children and with teachers' ratings, suggesting the use of the scales to be appropriate for the measurement of social and emotional adjustment in infants and preschool children. (DB)

natory attitudes (social); residential care; death; values

The study investigated psychological and sociological aspects of five residential institutions for the physically handicapped and the chronically ill in Great Britain. Material was gained through visits, interviews, and observation. It was stressed that the cripple is an outsider to normal society and discrimination experiences lead to psychological consequences related to the cripple's experience of others and also of his own body. The five institutions were described and compared. The authors maintained that the essential characteristic of institutionalized persons is that they have been written off by society and are socially dead and that the primary task of the institutions is to care for the patients during the interval between social death and physical death. It was suggested that the 'warehousing' ideology based on humanitarian values and the 'horticultural' ideology based on liberal values are both inappropriate defense mechanisms. The material was analyzed in terms of concepts of an open system which exists by exchanging materials with the environment. Discussed was the import process in terms of ways institutions control admissions to protect selectors from the problem of rejecting needy persons. The conversion process in institutions was defined as providing for both physical and psychological dependency. Effective institutions were thought to provide inmates the opportunity to contribute back to the wider society. Noted was the lack of professional, interpersonal, or religious supports in adjusting to the realities of their situation. The point was made that the realistic export process is death, though such a process was thought to have led to a defensive search for other kinds of export. The leadership of institutions was seen to bridge the gap between the institution's values and the wider society's values, and inmates themselves were urged to move into leadership positions. It was concluded that, though residential care can be improved, major changes cannot take place until there is a radical change in society's values. (DB)

ABSTRACT 552

EC 06 0552 ED N.A.
Publ. Date Nov-Dec 7 3p.
Graden, Hank and Others
The Campus Scene: Attendants

demic success, physical strength, and personal commitment. The students attend a 2-day training program at a hospital. The following topics are considered: physiology of spinal cord lesions (presented by an orthopedic surgeon); emotional adaptations to physical disabilities (presented by a psychiatrist); physical exercise, wheelchair management, and proper lifting techniques (presented by a physical therapist); basic nursing concerns (presented by a registered nurse on the spinal cord ward); maintenance of the urinary system (presented by a registered nurse on the catheter care team); assistance in activities of daily living (presented by an occupational therapist); and awareness of the environment (presented by a successfully employed paraplegic). (DB)

ABSTRACT 758

EC 06 0758 ED N.A.
Publ. Date 73 1:6
Washam, Veronica
The One Hander's Book: A Basic Guide to Activities of Daily Living.

EDRS not available
John Day Company, Inc., 257 Park Avenue South, New York, New York 10010 ($10.00)

Descriptors: exceptional child education; physically handicapped; daily living skills

Intended for individuals who have lost the use of one hand or arm, the book illustrates and explains techniques in daily living which do not require supplementary aids or equipment. The following skills are examples of techniques taught (general categories are in parentheses): managing a newspaper on public transportation (everyday activities), tying shoelaces (dressing and grooming), hair setting (hair styling and care), avoiding short sleeves (fashion), manicuring (caring for the good hand), sweeping (jobs around the house), peeling vegetables (kitchen jobs), folding clothes (laundry), sewing on a button (sewing skills), bathing the infant (infant and child care), buttering bread (dining out), typing (working skills), carrying books (school skills), social dancing (social occasions), shuffling cards (recreation), and serving the tennis ball (sports). (DB)

ABSTRACT 1147

EC 06 1147 ED N.A.

MONTGOMERY COUNTY PUBLIC SCHOOLS	Regulation 525-10
Subject: CHILD ABUSE AND CHILD NEGLECT	Date of Issue: October 1, 1974
Preparing Office: Associate Superintendent for Administration Department of Supplementary Education and Services	Rescission:

I. PURPOSE

To publish the policy statement of the Board of Education which provides guidelines and procedures for the identification and referral of abused and neglected children

II. POLICY

The Montgomery County Board of Education, recognizing the serious local, state, and national problems of child abuse and child neglect, affirms its position that the Montgomery County Public Schools shall cooperate vigorously to expose these problems by early identification of abuse or neglect and by reporting suspected cases to duly constituted authorities whether or not substantial corroborative evidence is available. School employees are in a unique position to discover potential cases of abuse and/or neglect of children and youth through the age of seventeen years. Employees are required by Maryland law to report suspected cases of child abuse to the Department of Social Services or Juvenile Section of the Montgomery County Police Department. Suspected child neglect is to be reported to the Department of Social Services.

Effective action by school employees can be achieved through recognition and understanding of the problem, knowing the reporting procedures, and participating in the information programs in child abuse provided for Montgomery County Public Schools employees. Guidelines have been developed to provide direction for staff members in reporting suspected child abuse or child neglect cases. Staff personnel should be aware that by statute they are immune from any civil and/or criminal liability when reporting suspected child abuse, and from any civil liability when reporting suspected child neglect. Failure to report, on the other hand, might result in legal action being brought against a staff member and disciplinary action by the school system. Any doubt about reporting a suspected situation should be resolved in favor of the child, and this situation should be reported immediately. Any Montgomery County Public Schools employee who has reason to believe that a child has been abused or neglected, shall report this information in the form and manner provided.

To maintain awareness on the part of all professional staff members, the Montgomery County Public Schools will provide periodic staff development on the subject of child abuse and neglect.

INFORMATION ON AND PROCEDURES FOR REPORTING SUSPECTED ABUSED AND NEGLECTED CHILDREN

A. REPORTING CASES OF CHILD ABUSE

An abused child is any child under the age of eighteen who a) has sustained physical injury as a result of cruel or inhumane treatment or as a result of malicious acts by his parent or any other person responsible for his care or supervision; b) has been sexually molested or exploited, whether or not he has sustained physical injury, by his parent or any other person responsible for his care or supervision.

xxx

The abuse of children can cause permanent physical damage, and may be fatal. Researchers have found a very significant number of abusing parents were themselves abused as children. Perpetrators of violent crimes against persons – even teenage offenders -- have frequently been found to have a past history of abuse by their parents or guardians.

Once considered a syndrome that affected only children under three, child abuse today is found as frequently among school-age children. Half of the known cases at the present time are school-age children, with the number who are adolescents rapidly increasing. Educators are in a unique position to identify and report child abuse. Every effort must be made to identify abused children and to prevent repeated abuse.

All Montgomery County Public Schools employees are required by law to report suspected cases of child abuse. As soon as an employee has reason to believe that a child may have been abused, he must call the Protective Services Section of the Montgomery County Department of Social Services, 279-1758, or the Juvenile Section of the Montgomery County Police Department, 762-1000. Simultaneously, the reporting person shall notify the principal that a report has been made. The obligation of the principal to report cases of suspected child abuse brought to his attention by his staff is not discretionary, and he shall assure that the case is duly reported if the reporting person has not done so.

When a report of suspected abuse has been made, a police officer accompanied by a social services worker will respond at once.

Within forty-eight hours, the person making the original oral report must send a written report of the incident to the Department of Social Services, with copies to the Montgomery County State's Attorney, the Juvenile Section of the Montgomery County Police Department, and the Supervisor of Pupil Personnel at the central office. Once copy of the report will be kept in a confidential file by the principal but not placed in the pupil's folder. Montgomery County Form 335-44 is to be used for this written report.

1. **Immunity**

   Anyone who reports suspected child abuse in good faith, or who participates in any investigation or judicial proceeding which results from a report of suspected child abuse is immune from civil liability or criminal penalty. Failure to report could result in a lawsuit with the possibility of substantial damages should an injured or murdered child's guardian be able to establish that the school employee had prior knowledge or suspicions which, if reported, might have prevented further injury to the child.

2. **Reporting Cases Not Involving Apparent or Obvious Physical Injury**

   It is not necessary that the reporting employee observe any external physical signs of injury to the child. It is sufficient merely to presume that abuse has occurred when a child complains of having been sexually molested or of pain, which he says has resulted from an inflicted injury. In such cases the report should be made.

   Employees should be aware that abused children typically explain injuries by attributing them to accidents in play or to sibling conflict. In any case, no employee should attempt to press a child on the subject of parental or guardian abuse to validate the suspicion of child abuse. Validation of suspected abuse is the responsibility of the Department of Social Services, assisted by the police. Any doubt about reporting a suspected situation is to be resolved in favor of the child and the report made immediately.

3. **Purpose of Intervention**

Reports of suspected child abuse are carefully investigated jointly by the Police Department's Juvenile Section detectives and social workers from the Department of Social Services. Each case receives a professional evaluation leading to whatever civil action may be necessary to ensure treatment for the family. Treatment may include a full range of therapeutic programs. The abuser is not subject to indiscriminate criminal prosecution. The State's Attorney and the police work closely with all involved professional personnel and authorities to establish alternatives to prosecution, whenever possible.

B. REPORTING CASES OF CHILD NEGLECT

The Montgomery County Department of Social Services has the legal responsibility for evaluating reports of suspected child neglect and for taking legal action to protect a child where necessary. Under Article 77, Section 116A of the **Annotated Code of Maryland,** *any educator who acts upon reasonable grounds in the making of any report required by law, rule, or regulation or who participates in judicial proceedings which result from such report shall be immune from any civil liability which occurs. A neglected child may be one of the following:*

1. *Malnourished; ill-clad; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care*
2. *Unattended; without adequate supervision*
3. *Ill and lacking essential medical care*
4. *Denied normal experiences that produce feelings of being loved, wanted, secure (Emotional neglect)*
5. *Unlawfully kept from attending school*
6. *Exploited; overworked*
7. *Emotionally disturbed due to continuous friction in the home, marital discord, mentally ill parents*
8. *Exposed to unwholesome and demoralizing circumstances*

All suspected child neglect cases should be reported on Montgomery County Form 335-44 to the Department of Social Services and the Supervisor of Pupil Personnel. If there is any doubt or question in reporting such cases, it should be resolved in favor of the child.

C. CONTENT OF REPORTS

Oral and written reports shall contain the following information, or as much data as the person making the report can provide:

1. *The name(s) and home address(es) of the child(ren) and the parent or other person reponsible for the care of the child(ren)*
2. *The present wherabouts of the child(ren) if not at home*
3. *The age(s) of the child(ren)*
4. *The nature and extent of the abuse or neglect suffered by the child(ren), including any evidence or information that may be available to the person making the report concerning previous physical or sexual abuse or neglect.*

(**Board Resolution No. 378-74,** *July 9, 1974, amended by* **Board Resolution No. 452-74,** *August 26, 1974)*

OUTLINE OF CURRICULUM CONTENT

for

UNDERSTANDING CHILD MALTREATMENT: HELP AND HOPE

Unit I. The Phenomenon of Child Maltreatment

A. The phenomenon of child maltreatment is rooted in a long history of child abuse and child neglect in society.

1. Forms of child maltreatment in the past
2. Suggested reasons for child maltreatment in the past

B. Evidence today indicates that the phenomenon of child maltreatment is widespread in contemporary society.

1. Medical evidence of child maltreatment today
2. Psychological evidence of child maltreatment today
3. Statistical evidence of child maltreatment today
4. Sociological evidence of child maltreatment today

C. The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologically damaged.

1. Suggested areas of dysfunction within society
2. Suggested areas of dysfunction within the family
3. Suggested areas of dysfunction within the individual

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Unit II. The Nature of Child Maltreatment

A. Child maltreatment is described as acts of physical abuse and/or neglect and acts of psychological abuse and/or neglect on the part of a caretaker.

1. Federal definition of child maltreatment
2. Identity of the caretaker
3. Typical acts of physical and psychological abuse
4. Typical acts of physical and psychological neglect which may result in damage to the child
5. Typical acts of psychological abuse and/or neglect (without physical abuse and/or neglect) which may result in damage to the child.

B. Child Maltreatment is manifest in physical and psychological damage in the child.

1. Typical manifestations (results) of physical abuse and neglect. in the child.
2. Typical manifestations (results) of psychological abuse and neglect in the child

C. Child maltreatment is distinguishable from acceptable or usual child-rearing practices in society today.

1. Characteristics of acceptable child-rearing practices today
2. Characteristics of child maltreatment today

Unit III. The Episode of Child Maltreatment

A. The episode of child maltreatment is attributed to a potentially abusive or neglectful caretaker, to a potentially vulnerable child, and to stress as the "triggering" mechanism.

B. The episode may also include a passive partner and/or sibling on-looker(s).

   1. The role of the potentially abusive or neglectful caretaker
   2. The role of the potentially vulnerable child
   3. The role of stress as the "triggering" mechanism
   4. The role of the passive partner
   5. The role of the sibling on-looker(s)

C. The potentially abusive or neglectful caretaker is representative of a cross-section of any community in terms of race and/or social or economic status.

   1. The potentially abusive or neglectful caretaker
   2. Characteristics of the potentially abusive or neglectful caretaker

D. The potentially vulnerable child may be an exceptional or demanding child or a normal child.

   1. The potentially vulnerable child
   2. Characteristics of the potentially vulnerable child
   3. Characteristics of the potentially vulnerable child from the viewpoint of the caretaker

E. Stress, the "triggering" mechanism may originate within society. the family, or the individual.

   1. Definition of stress
   2. Characteristics of stress in relation to time (duration)
   3. Kinds of stress
   4. Origins of stress

Unit IV. The Psychodynamics of Child Maltreatment

A. Child maltreatment is attributed to the psychodynamic interaction among the caretaker, the child, and the stress factor or stressor.

1. The definition of psychodynamics
2. Interaction viewed as an action (or reaction) in response to an influence, an event, or a person (past or present)
3. Psychodynamic interaction viewed as action (or reaction) of the child or the caretaker in response to
   a) An influence or influences (past or present)
   b) An event or events (past or present)
   c) A person or persons (past or present)
4. Psychodynamic interaction between the child and the caretaker viewed in relation to stress
   a) Within society
   b) Within the family
   c) Within the individual

B. The psychodynamic dimension of child maltreatment may be measured by the caretaker's conscious and/or unconscious actions or reactions to the child.

1. Conscious (re)actions viewed as (re)actions of the caretaker which are aware, deliberate, planned
2. Unconscious (re)actions viewed as (re)actions of the caretaker which are not consciously realized, planned, or done
3. Conscious and unconscious (re)actions of the caretaker in relation to stress
4. Typical conscious and unconscious (re)actions of the caretaker to the child

C. The psychodynamic dimension of child maltreatment may be measured by the child's conscious and/or unconscious actions or reactions to the caretaker (i.e., to maltreatment).

1. Conscious reactions defined as (re)actions of the child which are deliberate, planned, aware
2. Unconscious reactions defined as (re)actions of the child which are not consciously realized, planned, or done
3. Conscious and unconscious (re)actions of the child in relation to stress (i.e., maltreatment)
4. Typical conscious and unconscious (re)actions of the child to the caretaker (i.e., to maltreatment)

D. The psychodynamic dimension of child maltreatment may be measured in the recurring pattern or cycle of abuse and neglect within the same family from one generation to the next.

1. The potentially abusive or neglectful caretaker is often one who was abused or neglected in infancy or childhood:
   a) Deprived of a mothering or nurturing experience
   b) Conditioned toward violence in human behavior
2. The abused or neglected infant or child will frequently in adult life:
   a) Experience difficulty in the adult nurturing role
   b) Adopt violence as a way of life

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Unit V. The Problem of Child Maltreatment

A. Child maltreatment may be described as circumstantial.

1. Circumstantial child maltreatment, i.e., child maltreatment belonging to, consisting in, or dependent upon circumstances
2. Circumstantial child maltreatment viewed in relation to dysfunctions within society
3. Circumstantial child maltreatment viewed in relation to dysfunctions within the family
4. Circumstantial child maltreatment viewed in relation to dysfunctions within the individual
5. Circumstantial child maltreatment viewed in relation to individual ability to cope with stress

B. Child maltreatment may be described as incidental.

1. Incidental child maltreatment, i.e., child maltreatment occurring merely by chance or without intention or calculation
2. Incidental child maltreatment viewed in relation to dysfunctions within society
3. Incidental child maltreatment viewed in relation to dysfunctions within the family
4. Incidental child maltreatment viewed in relation to dysfunctions within the individual
5. Incidental child maltreatment viewed in relation to individual ability to cope with stress

C. Child maltreatment may be described as intentional.

1. Intentional child maltreatment, i.e., child maltreatment which is done by intention or design

2. Intentional child maltreatment viewed in relation to dysfunctions within society

3. Intentional child maltreatment viewed in relation to dysfunctions within the family

4. Intentional child maltreatment viewed in relation to dysfunctions within the individual

5. Intentional child maltreatment viewed in relation to individual ability to cope with stress

D. Child maltreatment -- whether circumstantial, incidental. or intentional -- is defined by law.

1. Child maltreatment legislation

2. Current child maltreatment laws

 a) State law

 b) Local law

3. The local process for reporting child abuse

 a) Mandatory by law

 b) Identity not required

 c) Provision for immunity

 d) Authorized agencies

 e) Methods of investigation

 f) Registration of case

  1) Local

  2) Central

4. The local process for reporting child neglect

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Unit VI. Child Maltreatment: Help and Hope

A. Through the individual's response to the problem of child maltreatment, there is help for the maltreated child.

1. How to respond:

a) Recognize child maltreatment.

1) Indicators of child maltreatment

2) Problems inhibiting personal involvement

b) Report child maltreatment.

2. Kinds of responses: Help for the child

a) Treatment or hospitalization

b) Individual and/or family therapy

c) Supervision at home

d) Court protection

e) Provision for alternative care

B. Through the individual's response to the problem of child maltreatment, there is help for the caretaker.

1. How to respond

a) Recognize child maltreatment.

1. Indicators of child maltreatment

2. Problems inhibiting personal involvement

b) Report child maltreatment.

2. Kinds of responses: Help for the caretaker

a) Counseling by the helping professional

1) Medical practitioner, psychiatrist

2) Social worker, mental health assistant

3) Pastor, trained lay person

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b) Government Services

1) Protective Service Agency

2) Department of Welfare

3) Department of Health

4) The Judiciary

5) Law enforcement agency

c) Community support

1. Parental Stress Service, Hot Lines

2. Parents Anonymous, Families Anonymous

3. Group therapy programs

4. Residential programs

d) Education

1) Increased knowledge of self and others

2) Parenting skills

3) Home management skills

4) Financial management skills

5) Job training skills

6) Other

C. Through society's response to the problem of child maltreatment, there is hope for prevention.

1. Those who must respond:

a) Enlightened parents

b) Concerned citizens

c) Alerted medical practitioners

d) Informed social workers, teachers, and law enforcement authorities

e) Dedicated legislators and social policy makers

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2. Kinds of responses: Hope for prevention

a) Recognition and protection of the rights of children

b) Improved environment for children

c) Greater dissemination of knowledge about child maltreatment

d) Adequate funding for child maltreatment prevention programs

e) Increase in available community resources and services for both the maltreated child and the caretaker

f) More compassionate understanding of the problem of child maltreatment

ERIC

The Phenomenon of Child Maltreatment

UNIT I

I. The PHENOMENON of CHILD MALTREATMENT

--- What Is It?

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UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Performance Objectives for Generalization A

1. DESCRIBE forms of child maltreatment in the past
2. LIST possible reasons for child maltreatment in the past.

Generalization A

THE PHENOMENON OF CHILD MALTREATMENT IS ROOTED IN A LONG HISTORY OF CHILD ABUSE AND CHILD NEGLECT IN SOCIETY.

Sample Content

1. Forms of child maltreatment in the past
   a) Accepted (or current) child-rearing practice
   b) Exploitation
   c) Mutilation
   d) Abandonment

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective for Unit I

THE STUDENT WILL BE ABLE TO COMPARE THE HISTORICAL AND CONTEMPORARY PHENOMENON OF CHILD MALTREATMENT IN SOCIETY.

Generalizations for Unit I

A. The phenomenon of child maltreatment is rooted in a long history of child abuse and child neglect in society.

B. Evidence today indicates that the phenomenon of child maltreatment is widespread in contemporary society.

C. The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologically damaged.

Performance Objectives for Unit I

1. DESCRIBE forms of child maltreatment in the past.
2. LIST possible reasons for child maltreatment in the past.
3. CITE medical and psychological evidence of child maltreatment in society today.

Suggested Classroom Activities and Procedures for Performance Objectives 1 and 2

1. Have students read and discuss in class "Our Forebears Made Childhood a Nightmare" (I.2).
2. Clarify student understanding of the terms phenomenon and maltreatment in the Definition of Terms (I.1).
3. Introduce Ceneralization I A and write on board for students.
4. List on board the forms of child maltreatment in the past as noted in I A Sample Content 1.
5. Have students suggest examples from history for each of the forms of child maltreatment noted in the past.
6. Discuss nursery rhymes and fairy tales in oral tradition as evidences of child maltreatment in the past.
7. Correlate for students forms of child maltreatment in the past with the corresponding reason, or reasons, for child maltreatment as noted in I A Sample Content 2.
8. Have students read and discuss in class "Who Owns the Child?" (I.3).
9. Relate current child protection laws to forms and suggested reasons for

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12. Emphasize that since 1960 new child maltreatment legislation has been passed in an effort to cope with forms of the phenomenon which exist today.

13. Students may

- Write summary paragraphs of I.2, I.3, or I.8.
- Research and write a brief paper on fairy tales or nursery rhymes as evidences of child maltreatment in the past. Example: Hansel and Gretel (abandonment/competition for food)
- Research and write a brief paper on child labor laws in relation to child maltreatment in the past.
- Survey teachers in appropriate subject areas for examples of child maltreatment in art, literature, history.
- Invite Child Development teacher to talk about child-rearing practices in the past which are now thought harmful and are no longer practiced.
- Debate the following: Is Child Maltreatment Today the Same as, or Different from Child Maltreatment in History?
- Pursue in-depth study of recent child abuse and child neglect legislation. See Unit V D.

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UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Performance Objectives for Generalization B

3. CITE medical and psychological evidence of child maltreatment today.

4. CITE statistical evidence of child maltreatment today.

5. CITE sociological evidence of child maltreatment today.

Generalization B

EVIDENCE TODAY INDICATES THAT THE PHENOMENON OF CHILD MALTREATMENT IS WIDESPREAD IN CONTEMPORARY SOCIETY.

Sample Content

1. Medical evidence of child maltreatment today (For in-depth study, see Unit II.)

   a) Definition of the "child maltreatment syndrome"

   b) Pathological evidence in the child

   c) Radiological evidence in the child

2. Psychological evidence of child [illegible]

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Suggested Classroom Activities and Procedures for Performance Objective 3

1. Use a brief lecture to introduce students to the contemporary phenomenon of child maltreatment. Discuss the role of the x-ray in diagnosing child maltreatment.

2. Have students view film Children in Peril.

3. Introduce Generalization I B Sample Content 1. and 2. Write on board for students.

4. Clarify student understanding of the term "syndrome." See Definition of Terms (I.1). Explain "signs" as objective evidence; "symptoms" as subjective evidence.

5. Clarify student understanding of the terms "pathological," "radiological," and "psychological." See Definition of Terms (I.1).

6. Restate the definition of the child maltreatment syndrome as "a group of /pathological, radiological, and/or psychological/ signs and symptoms /in the child/which characterize a particular abnormality /maltreatment/."

7. Show Transparency 10 for examples of pathological and radiological evidence (signs or symptoms) in the maltreated child.

8. Show Transparency 11 a and b for examples of psychological evidence (signs

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- Invite a member of the Montgomery County Child Protection Team to talk about Characteristics of the Vulnerable Child (III.5).
- Interview a member of the Special Child Abuse Team, Children's Hospital, on how to recognize child maltreatment.

10. Conclude with assessment measures for Performance Objective 3.

Suggested Classroom Activities and Procedures for Performance Objectives 4 and 5

1. Restate Generalization I B and write on board for students.
2. Write I B Sample Content 3 and 4 in outline form beneath Generalization I B.
3. Conduct class discussion, using Questions and Answers (I.4).
4. Show Transparency 1, depicting national statistics.
5. Analyze for students the methods used by the Mershon Center to obtain national statistics. See "Child Abuse and Neglect Programs: A National Overview" (I.5).
6. Discuss the possible relationship of statistics on accidental death of children to national statistics for unreported cases of child maltreatment.
7. Emphasize that statistics on child maltreatment vary with public awareness of the problem. Refer students to "Child

10. Discuss sociological aspects, I B Sample Content 4, of child maltreatment in relation to sociological characteristics of Montgomery County. See also Questions and Answers (I.4).

11. Write Unit III Generalization C. on board. Use as basis to summarize discussion: "The potentially abusive or neglectful caretaker is representative of a cross-section of any community in terms of race and/or social or economic status."

12. Students may:

    - Read and discuss in class "Child Abuse and Neglect Programs: A National Overview" (I.5).
    - Make a collage illustrative of the sociological aspects of child maltreatment.
    - Draw color charts illustrative of statistics for the State of Maryland.
    - Read and write a brief summary of selected articles from the classroom learning center for child maltreatment.
    - Research current statistics (previous months) for reported cases of suspected child maltreatment in Montgomery County.
    - Group discuss the question: "Why is child maltreatment a widespread phenomenon in contemporary society?" and report conclusion to class.

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UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Performance Objectives for Generalization C

6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.

7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.

8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child.

Generalization C

THE PHENOMENON OF CHILD MALTREATMENT IS ASCRIBED TO BE THE SYMPTOM OF A DYSFUNCTION WITHIN SOCIETY, THE FAMILY, OR THE INDIVIDUAL WHICH MANIFESTS ITSELF WHEN A CHILD IS PHYSICALLY OR PSYCHOLOGICALLY DAMAGED.

Sample Content

1. Suggested areas of dysfunction within society:

Suggested Classroom Activities and Procedures for Performance Objectives 6, 7, and 8

1. Review Generalization I A, Sample Content 1 and 2.
2. Introduce Generalization I C and write on board for students.
3. Clarify student understanding of the term dysfunction in relation to society, the family, and the individual.
4. Write "Historical Phenomenon of Child Maltreatment" on board.
5. Have students suggest:

   Dysfunctions of society (in the past) which resulted in the phenomenon of child maltreatment

   Dysfunctions of the family (in the past) which resulted in the phenomenon of child maltreatment

   Dysfunctions of the individual (in the past) which resulted in the phenomenon of child maltreatment
6. Write "Contemporary Phenomenon of Child Maltreatment" on the board.
7. Suggest class divide into three discussion groups to represent society, the family, and the individual. Have a volunteer or assigned leader for each group.

10. Have students read instructional material I.9 through I.14.

11. Have each group report and compare its list with the list on board of dysfunctions in the past which resulted in the historical phenomenon of child maltreatment.

12. Show Transparency 16 a, b, c and Transparency 17 a, b as a check list.

13. Students may roundtable discuss:

    - If child maltreatment is ascribed to be the symptom of a dysfunctioning of society, what positive actions can society take today to prevent child maltreatment? See Generalization V D and Generalization VI C.
    - If child maltreatment is ascribed to be the symptom of a dysfunctioning of the family, what positive actions can be taken by families today to prevent child maltreatment? Generalization V D and Generalization VI A and V B.
    - If child maltreatment is ascribed to be the symptom of a dysfunctioning of the individual, what positive actions can be taken by the individual today to prevent child maltreatment? See Generalization V D and VI A, B, C.

14. Have students survey psychology, history, or sociology teachers for further examples of dysfunction in society, the family, or the individual which

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EVALUATION

for

I. The Phenomenon of Child Maltreatment

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. DESCRIBE forms of child maltreatment in the past.	Listed below are _______ forms of child maltreatment in the past. Describe _______ examples for each form listed.	The student will give correct information by utilizing the resources listed below: I A Sample Content 1 I.1 I.2 I.3 I.8
2. LIST possible reasons for child maltreatment in the past.	Listed below are ______ examples of child maltreatment in the past. Suggest a possible reason or reasons for each example. 1. Begging ____________ 2. Tattooing ____________ 3. Killing ____________ 4. Swaddling ____________ 5. Wet nursing ____________ 6. Abandoning ____________ 7. Foot binding ____________ 8. Others	I A Sample Content 2 I.1 I.2 I.3 I.8

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 3 AND 4 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 3. CITE medical and psychological evidence of child maltreatment today.	Define the child maltreatment syndrome. Name and define two kinds of medical evidence observable in the maltreated child. Give ____ examples of each. Give _____ examples of psychological evidence observable in the maltreated child.	The student will give correct information by utilizing the resources listed below: I B Sample Content 1 and 2 I.1 III.5 Transparency 10 Transparency 11 a, b Film *Children in Peril*
4. CITE statistical evidence of child maltreatment today.	Arrange in order of importance the following causes of childhood deaths annually: 1. 4. 2. 5. 3. a) cancer b) accidents c) heart disease d) influenza e) child abuse Fill in blanks: a) National statistics on child maltreatment vary because ____________. b) ___________ reported (State/County) _____ cases of suspected (number) child abuse in _____.	I B Sample Content 3 and 4 I.4 I.5 I.7 III C Transparency 1, 2, 3, 4

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVE 5 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 5. CITE sociological evidence of child maltreatment today.	TRUE/FALSE 1) There is more abuse than neglect of children. 2) More women than men abuse younger children. 3) Older children are more likely than younger children to be maltreated. 4) Child maltreatment occurs more often in lower socio-economic levels. 5) Children in rural areas are less likely to be maltreated than those in urban areas.	The student will give correct information by utilizing the resources listed below: I B Sample Content 3 and 4 I.4 I.5 I.7 III.3 III C Transparency 1, 2, 3, 4

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 6, 7, AND 8 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.	Identify _____ broad areas of dysfunction within society which could result in a physically or psychologically damaged child. Give _____ examples of each.	The student will give correct information by itemizing the resources listed below: I C Sample Content 1 I.1 I.6 I.9 through I.14 V D VI A VI B VI C Transparency 16 a, b, c Transparency 17 a, b
7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.	Identify _____ broad areas of dysfunction in the family which could result in a physically or psychologically damaged child. Give _____ examples of each.	I C Sample Content 2 I.1 I.6 I.9 through I.14 V D VI A VI B VI C Transparency 16 a, b, c Transparency 17 a, b
8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child	Identify _____ broad areas of dysfunction in the individual which could result in a physically or psychologically damaged child. Give _____ examples of each.	I C Sample Content 3 I.1 I.6 I.9 through I.14 V D VI A VI B VI C Transparency 16 a, b, c Transparency 17 a, b

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CLASS RECORD FORM

S = SATISFACTORY
U = UNSATISFACTORY

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

CLASS ____________________ PERIOD __________

INSTRUCTIONAL OBJECTIVE: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

	PERFORMANCE OBJECTIVE								AVERAGE %	
NAME	1	2	3	4	5	6	7	8	S	U

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

TOTAL % SATISFACTORY for COURSE ______

TOTAL % UNSATISFACTORY for COURSE ______

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives	
																		S	U
nal	1	2	3	4	5	6	7	8											
nal	1	2	3	4	5	6	7	8	9	10									
nal	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
nal	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
nal One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
nal Two	1	2	3	4	5														
nal One	1	2	3	4															
nal Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIAL

for

I. The Phenomenon of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (I.1)
2. "Our Forebears Made Childhood a Nightmare" (I.2)
3. "Who Owns the Child?" (I.3)
4. Questions and Answers About Child Maltreatment (I.4)
5. "Child Abuse and Neglect Programs: A National Overview" (I.5)
6. Dysfunctions in Society, the Family, and the Individual (I.6)
7. "Child Abuse Reports Have Increased Since 1972" (I.7)
8. "Good Children' (Our Own), 'Bad Children' (Other People's), and the Horrible Work Ethic" (I.8)
9. "Is U.S. Becoming Less Child-Oriented?" (I.9)
10. "Imprisoning Our Children" (I.10)
11. "They've No Right To Destroy the Children" (I.11)
12. "Medical Care Lacking for Children of Poor" (I.12)
13. "Shipping Children South" (I.13)
14. "Child-Snatching" (I.14)
15. Classroom Learning Center for Child Maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

1. Table 1, Mershon Study Center
2. Age Profile 1974-75, Reports of Suspected Child Abuse, MCPS
3. Sex and Mean Age of Children Reported, MCPS

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FILM

Children in Peril. Discusses causes of child abuse and programs developed for treatment of child abusers. S. T 22 min. color 1. Child abuse. EMC 362.7 5684 Media Concepts 1972.

Fragile, Handle with Care. A film of stark realism which tells of the death of an infant brought to the emergency ward time after time by its young parents before finally succombing to maltreatment. The film delves into the reasons why parents abuse their children, and what happens to the children mentally and physically. It also looks into ways of preventing child abuse, the legal considerations involved, and the professional help that is available for children.

A KTAR TV film produced in cooperation with The Independent Order of Foresters 16mm color 26 min. Available on loan from Independent Order of Foresters, 10215 Reisterstown Road, Owings Mills, Maryland 21117.

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I. THE PHENOMENON OF CHILD MALTREATMENT

*DEFINITION OF TERMS (I.1)

	Term		Definition
1.	Phenomenon	n.	- 3.b. an exceptional, unusual, or abnormal person, thing, or occurence
2.	Maltreat Maltreatment	vt. n.	- to treat cruelly or roughly
3.	Syndrome	n.	- a group of signs and symptoms that occur together and characterize a particular abnormality
4.	Radiological	adj.	- of or pertaining to the use of radiology (X-ray)
5.	Pathological Pathology	adj. n.	- 2: altered or caused by disease 2 a: anatomic and physiologic deviations from the normal that constitute disease or characterize a particular disease
6.	Dysfunction	n.	- impaired or abnormal functioning

* Webster's New Collegiate Dictionary. Springfield, Massachusetts: S & C Merriam Co.

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Empathy for Children

Our Forebears Made Childhood a Nightmare

From antiquity's infanticide to 19th-century manipulation, the human track record on child-raising is bloody, dirty and mean. Only lately, and only now in small numbers, do parents feel that children need aid and comfort, not brutality.

by Lloyd DeMause

For most people in our society, infants and children are small people to whom we should try to offer aid and comfort whenever possible. This attitude is new. A search of historical sources shows that until the last century children were instead offered beatings and whippings, with instruments usually associated with torture chambers. In fact, the history of childhood is a nightmare from which we have only recently begun to awaken.

The newness of the ability to feel empathy toward children is clear from a five-year study that my colleagues and I have just completed. The further back in history we went, the lower the level of child care we found, and the more likely children were to have been killed, abandoned, whipped, sexually abused and terrorized by their caretakers.

A child's life prior to modern times was uniformly bleak. Virtually every child-rearing tract from antiquity to the 18th century recommended the beating of children. We found no examples from this period in which a child wasn't beaten, and hundreds of instances of not only beating, but battering, beginning in infancy.

One 19th-century German schoolmaster who kept score reported administering 911,527 strokes with a stick, 124,000 lashes with a whip, 136,715 slaps with his hand and 1,115,800 boxes on the ear. The beatings described in most historical sources began at an early age, continued regularly throughout childhood, and were severe enough to cause bruising and bloodying. It took centuries of progress in parent-child relations before the West could begin to overcome its apparent need to abuse its children.

Personality, Not Technology. I believe that the major dynamic in historical change is ultimately neither technology nor economics. More important are the changes in personality that grow from differences between generations in the quality of the relationship between parent and child. Good parenting is something that has been achieved only after centuries as generation after generation of parents tried to overcome the abuse of their own childhoods by reaching out to their children on more mature levels of relating.

Throughout history, an adult has had [illegible]

empathize with and satisfy the child's needs.

The first two reactions occurred simultaneously in parents in the past, producing a strange double image of the child in which it was at once both bad (projective) and needed (reversal). The further back in history you look, the more evident are these reactions and the more bizarre the prevailing attitudes toward children.

Century after century of battered children grew up and battered their own children in turn. John Milton's wife complained that she hated to hear the cries of his nephews as he beat them. Beethoven whipped his piano pupil with a knitting needle. Even royalty was not exempt—little Louis XIII was whipped upon awakening for his previous day's misdemeanors.

Even infants were often beaten. John Wesley's wife Susannah said of her babies, "When turned a year old (and some before), they were taught to fear the rod and to cry softly." Rousseau reported that young babies were often beaten to keep them quiet. An early American mother wrote of her battle with her four-month-old infant. "I whipped him 'til he was actually black and blue, and until I *could not* whip him any more, and he never gave up one single inch."

Salted and Swaddled. If the newborn was allowed to live, parents would salt it and then bathe it in ice water to "harden" it. The baby was tied up tightly in swaddling bands for its first year, supposedly to prevent it from tearing off its ears, breaking its legs, touching its genitals or crawling around like an animal. Traditional swaddling, as one American doctor described it, "consists in entirely depriving the child of the use of its limbs by enveloping them in an endless bandage, so as to not unaptly resemble billets of wood, and by which the skin is sometimes excoriated, the flesh compressed, almost to gangrene . . ."

Swaddled infants were not only more convenient to care for, since they withdrew into themselves in sleep most of the day, but they were also more easily [illegible] for hours behind hot ovens, hung on pegs [illegible] the wall and wrote one doctor [illegible] a parcel, in every convenient [illegible]

bands were necessary because they could not "be tossed about without them."

Adults in the past, like contemporary child batterers, regularly succumbed to urges to mutilate, burn, freeze and drown infants. The Huns used to cut the cheeks of newborn males, Italian Renaissance parents would "burn in the neck with a hot iron, or else drop a burning wax candle" on newborn babies, and it was common to cut the string under the newborn's tongue, often with the midwife's fingernail. In every age, the deliberate mutilation of children's bones and faces prepared them for a lifetime of begging.

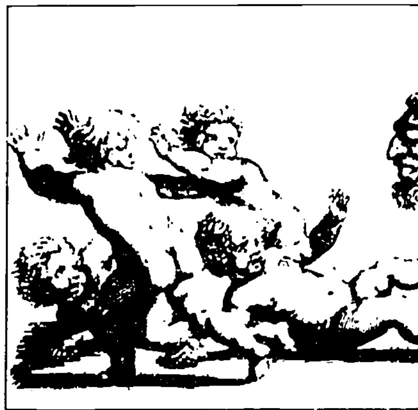
As late as the 19th century in Eastern Europe, baptism was not a matter of simple sprinkling, but an ice-water ordeal that often lasted for hours and sometimes caused the death of the infant. The regular practice of the plunge bath involved nearly drowning the infant over and over again in ice-cold water "with its mouth open and gasping for breath." The dipping of infants in cold rivers has been considered therapeutic since Roman times and, as late as the 19th century, children were often put to bed wrapped in cold wet towels to make them hardy. With such beginnings, it is not surprising that 18th century pediatrician William Buchan said "almost one half of the human species perish in infancy by improper management or neglect."

Although there were many exceptions to the general pattern, the average child of parents with some wealth spent his earliest years in the home of a wet nurse, returned home at age three or four to the care of other servants, and was sent out to service, apprenticeship, or school by age seven, so that the amount of time parents of means actually spent raising their children was minimal.

Since antiquity, wet nurses have been acknowledged to have been thoroughly unreliable—Jacques Guillimeau described how the child at nurse might be "stiffled, overlaid, be let fall, and so come to an untimely death, or else may be devoured, spoiled, or disfigured by some wild beast." A clergyman told one British doctor about his parish which was "filled with suckling infants from London, and yet, in the space of one year, he buried them all except two." Of 21,000 children born in Paris in 1780, 17,000 were sent into the country to be wet-nursed, 3,000 were placed in nur-

who had moved from an area in which nursing infants was common, was called "swinish and filthy" by her Bavarian neighbors for nursing her child herself, and her husband threatened to stop eating if she did not give up this "disgusting habit."

Terrors of the Night. As the child grew out of swaddling clothes, parents found it terribly frightening to care for, having projected their own unconscious needs into the child. As a result, children were always felt to be on the verge of turning into actual demons, or at least to be easily susceptible to "the power of the Devil." To keep their small devils cowed, adults regularly terrorized them with a vast army of ghostlike figures, from the Lamia and Striga of the ancients, who ate children raw, to the witches of Medieval times, who would steal bad children away and suck their blood. One 19th-century tract described in simplified language the tortures God had in store for children in



Hell: "The little child is in this red-hot oven. Hear how it screams to come out . . . It stamps its little feet on the floor." The need to personify punitive figures was so powerful that this terrorizing of children did not stop at imaginary figures. Dummies were actually made up to be used in frightening children. One English writer, in 1748, describes how:

"The nurse takes a fancy to quiet the peevish child, and with this intent, dressed up an uncouth figure, makes it come in, and roar and scream at the child in ugly disagreeable notes, which grate upon the tender organs of the ear, and at the same time, by its gesture and near approach, makes as if it would swallow the infant up."

Another method that parents used to terrorize their children employed corpses

witness hangings, and parents would often whip their children afterwards to make them remember what they had seen.

Sexual Abuse. The sexual abuse of children was also far more prevalent in the past than it is today. Growing up in Greece and Rome often included being used sexually by older men. Boy brothels flourished in every city in antiquity, and slave boys were commonly kept for homosexual use. Sexual abuse by pedagogues and teachers of small children was a common complaint, and even Aristotle thought that adult homosexuality must be a result of "those who are abused from childhood."

Erotic drawings often show nude children waiting on adults in sexual embrace, and Quintilian said that even noble children "hear us use such words, they see our mistresses and minions; every dinner party is loud with foul songs, and things are presented to their eyes of which we should blush to speak." Tiberius "taught children of the most tender years, whom he called his *little fishes*, to play between his legs while he was in his bath. Those which had not yet been weaned, but were strong and hearty, he set at fellatio." Castrated children were considered as especially arousing in antiquity, and infants were often castrated in the cradle for use in brothels.

The sexual use of children continued until early modern times. Servants were

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commonly known to be child molesters, and even parents would masturbate their children "to make their yards grow longer." Little Louis XIII was often hauled into bed by his parents and others and included in their sexual acts. By the 18th century, however, parents began instituting severe punishments for childhood sensuality, perhaps in an unconscious maneuver to control their own sexual desires. By the 19th century, parents and doctors began waging a frenzied campaign against childhood masturbation, threatening to cut off the child's genitals, performing circumcision and clitoridectomy without anesthesia as punishment, making children wear spiked cages and other restraints, and opening anti-masturbation sanatoria all over Europe.

Good News. Despite the bleakness of this general historical picture of childhood, there is good evidence that childrearing modes have continuously evolved over the past two millennia in the West. An independent source of change lies within the parent-child relationship itself, as each generation of parents attempts anew to go beyond the abuses to which it has been subjected, producing a psychological advance in each period of history.

Consider, for instance, the long struggle against infanticide. In antiquity infanticide was so common that every river, dung-heap and cesspool used to be littered with dead infants. Polybius blamed the depopulation of Greece on the killing of legitimate children, even by wealthy parents. Ratios of boys to girls in census figures ran four to one, since it was rare for more than one girl in a family to be spared. Christians were considered odd for their opposition to infanticide, although even that opposition was mild, with few penalties. Large-scale infanticide of legitimate babies continued well into Medieval times with boy-girl ratios in rich as well as poor families often still running two to one. As late as 1527, one priest admitted that "the latrines resound with the cries of children who have been plunged into them." Yet infanticide was increasingly confined to the killing of illegitimate babies and there is similar evidence of a continuous decrease in beating and other abusive practices through the centuries.

Evolutionary Trends. The following six evolutionary modes seem to describe the major trends of parent-child relations in the more advanced parts of the West.

INFANTICIDAL MODE (ANTIQUITY). The image of Medea hovered over childhood in antiquity not only because parents resolved their anxieties about taking care of children by infanticidal acts, but also because the lives of those children who were allowed to live were constantly threatened by severe abuse.

ABANDONMENT MODE (MEDIEVAL). The parents who accepted the right of the child to live but whose immaturity made them still unable to care for it abandoned the child either to a wet nurse, foster family, monastery, nunnery, other home (as servants) or simply through severe emotional neglect by the parents themselves.

AMBIVALENT MODE (RENAISSANCE). A closer relationship with the child produced ambivalent parents, fearful that their child's insides were full of evil so that they had to be purged with continuous enemas, yet close enough to express both love and hate, often in bewildering juxtaposition.

INTRUSIVE MODE (18TH CENTURY). A d

crease of ambivalence now enabled the parent actually to make the intrusive control of the child's insides part of their own defense system. The child was no longer so full of dangerous projections, and was therefore not swaddled, nor sent out to wet-nurse, nor given enemas, but was instead toilet-trained, prayed with but not yet played with, and disciplined as much through guilt as by beating. As empathy grew, pediatrics could be invented, and the general improvement in child care reduced infant mortality greatly.

SOCIALIZING MODE (19TH CENTURY TO NOW): Still the major mode of parents today, socializing involves thinking of the child as someone who needs continuous training and guidance in order to become civilized. Most discussions of child care still take place within the socializing mode, and it has been the source of all contemporary models of the psyche from Freud to Skinner. In practice, it involves giving up most of the severe beating and other overt forms of abuse while using covert methods of manipulation, guilt, and a general detached quality of parenting to sustain the long periods of contact with children whose increasing needs are simply too much for the parents.

HELPING MODE (JUST BEGINNING): The helping mode starts with the proposition that the child knows better than the parent what it needs at each stage of its life, and involves both parents fully in the child's daily life as they help it with its expanding needs. The helping mode requires enormous time, energy and emotional maturity on the part of both parents, especially in the first six years of the child's life, as they play with it, tolerate its regressions, and discuss its needs and conflicts in an effort to keep pace with its emotional and intellectual growth.

Studies of contemporary American families show children being cared for by parents included in all six of these modes. In fact, when psychiatrists arrange family types on a scale of decreasing health, they are actually listing historical modes of childrearing, with the lower part of the scale describing parents who behave like evolutionary arrests, psychological fossils stuck in personality modes from a previous historical period when most parents used to batter children. The finding that most child abusers were themselves abused as children supports this picture.

Even though childhood for many is now more humane than at any other time in history, functional equivalents of earlier modes remain with us. Children are not sent out to wet nurses at birth, or to be servants at seven, but we do abandon them to hosts of nurseries, teachers, camps, and baby sitters for major portions of their young lives. Intrusive parents still find ways to restrict their baby's movements, much as swaddling and corsets did, and parents continue to emotionally abandon, betray, manipulate and hurt their children both overtly and covertly.

Because psychic structure is passed from generation to generation through the narrow gap of childhood, the childrearing practices of a society are more than just another item on a list of cultural traits. The history of childhood in fact determines which elements in all the rest of history will be transmitted and which will be changed. By studying the history of childhood we can gain an understanding of the personality traits on which our adult society rests, and perhaps even alter those historical group fantasies like war that threaten us most. ■

Lloyd deMause is Founder and Editor of *History of Childhood Quarterly The Journal of Psychohistory*. DeMause studied history at Columbia University and psychoanalysis at the National Psychological Association for Psychoanalysis. He is also on the training staff at the New York Center for Psychoanalytic Train-

No Battered-Baboon Syndrome

Infant T.L.C., Simian Style

Lunchtime with your local baboons is pretty much a free-for-all. Dominant animals corral and consume their favorite foods while the more submissive ones lose out and display their disgust by threatening and chasing each other. Eventually everyone eats, but often there is more fighting than feeding.

This kind of chaos could be deadly for young baboons, who are at birth almost as dependent as a human infant. But it is not. The battered-baboon syndrome does not exist.

Baby baboons are equipped with built-in protection against adult aggression. Unlike their all-brown parents, they have pink skin and black hair. These characteristics do more than add a little color to baboon life. They are a hands-off sign to all baboons that allows the youngsters to enjoy safety and relative tranquility in a society where violence is the rule.

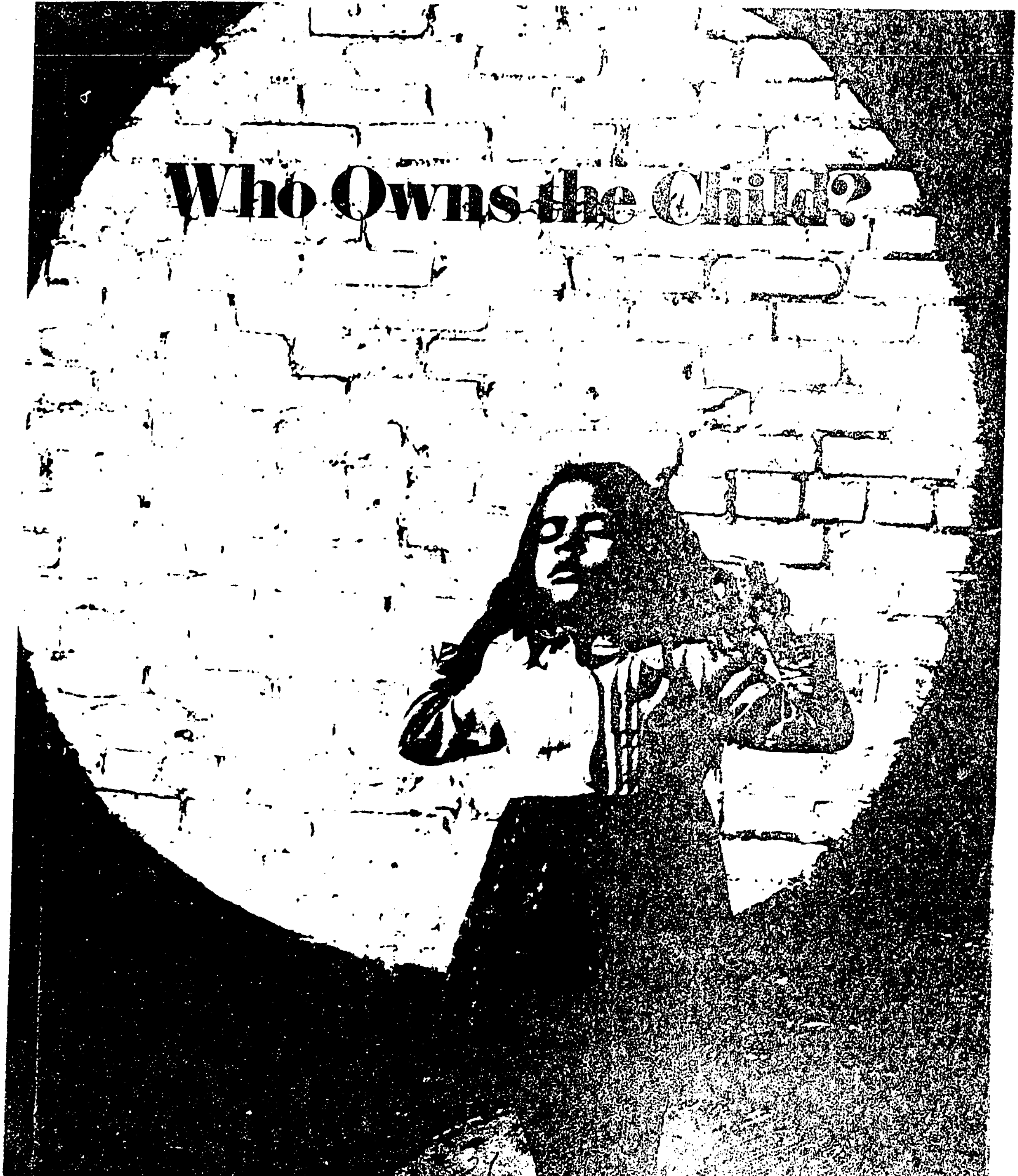
Chimpanzees are not nearly as violent as baboons. In fact, violence seems too strong a word for their infrequent fights. But, just in case, chimp children are equipped with an aggression inhibitor, a tuft of white hair on each little black bottom. These cotton tails render the infants immune to adult aggression and buy a large chunk of tolerance for childlike behaviors. They get away with murder.

Many primate species have this kind of

signal. It disappears when the individual is mature enough to be part of society, subject to all the regular rules and retributions of proper primate existence.

It would be nice if the romantic myths about how human babies make everyone feel kind and loving were true. Unhappily, both DeMause and common knowledge tell us they are not. *Homo sapiens* are among the very few primates who are unable to keep abusive paws off the defenseless young.

According to DeMause, it looks as if we may be catching up with our more civilized relatives. But just think how much



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*An insightful background paper on one of the critical social issues of our time.**

Mary Van Stolk, author of The Battered Child in Canada *(Toronto/Montreal: McClelland & Stewart, Ltd., 1972), resides in Montreal. She is currently working on a book about violence in the family.*

Mary Van Stolk

Physical abuse of children is the intentional, non-accidental use of physical force, or intentional, non-accidental acts of omission, on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring, or destroying that child.[1]

A RECENT CONFERENCE on the battered child, sponsored by the Canadian Department of National Health and Welfare, recognized that at present, in Canada, only a portion of child battering is correctly diagnosed and that, in addition, many children suffer because of failure of family, neighbours, teachers, physicians and others to report. The conferees expressed the belief that reporting, diagnosis and treatment could be improved through education and an interdisciplinary approach to the problem. They emphasized that battering is the discernible tip of a much larger question, and on that basis advised the government that child battering should be recognized as but part of the serious overall problem of abused children in Canada.[2]

THE ROOTS OF ABUSE

Diagnosed physical injuries to children are the visible signs of a problem that, in its hidden forms (neglect, abandonment, emotional abuse), can be equally serious and costly to the child, the family and the society. One hidden portion of child abuse was pointed out recently by Dr. Karl Evang, Director-General of Health Services of Norway, who reported to the World Health Organization that an increasing number of Scandinavian children have been wrongly diagnosed as mentally retarded when their condition was actually the result of deprivation of love.[3] Undiagnosed brain damage is another part of the hidden problem of child abuse. The number of children who suffer brain damage as a result of battering can be statistically tallied, but the number who suffer brain damage as a result of physical abuse that is never diagnosed is probably much higher.[4,5]

Identifying the Abused

Identification of incidences of child battering usually rests on a diagnosis of the injuries, which most frequently are broken bones, single and compound fractures, concussions and skull fractures, internal injuries, bruises, multiple welts, swelling, split lips, blackened eyes, lost teeth and burns.

Sometimes only one child is singled out as the recipient of these crippling, maiming or lethal assaults. However, all the children in

* Adapted from a presentation to the American Orthopsychiatric Association at its Fiftieth Annual Meeting, held in New York City (May 1973). By permission of the Association.

Coordinating bodies varied in composition, functions and administrative location. Most commonly, department heads and supervisors participated in coordinating efforts, which may indicate that the major function for the majority of coordinative mechanisms is interagency relations rather than actual case management. Emphasis upon the latter would require the participation of policemen, caseworkers, nurses and others directly engaged in the delivery of services. Teams and liaison groups usually met once a month, which also indicates agency coordination, not case management.

The lack of coordination is reflected in responses to a number of other questions. One question, for instance, sought to discover whether the ways other agencies handle cases of child abuse and neglect delay or cause problems to the respondent's own agency. The proportion of population represented by protective agencies encountering difficulties ranged from 29 percent for prosecuting attorneys offices to 57 percent for the schools.

Another question asked: "Considering the various facets of child abuse and neglect and the many agencies involved, what problems do you see in the way child abuse and neglect is handled in this area?" Here the most frequently mentioned problem was limitations in interagency cooperation.

Agencies' Performance

In many respects, the foregoing discussion indicates the levels of performance. For example, not all agencies necessarily make home visits during the same day cases of child *abuse* are reported. The equivalent proportion for child *neglect* is 82 percent. On the other hand, police departments representing 96 percent of the population conduct a home visit during the same day for cases they consider to be emergencies, and 78 percent for other cases. When asked about the proportion of families that continue to abuse their children after protective services have become involved with them, respondents for agencies representing only one-third of the population answered "almost none" while respondents representing 14 percent of the population indicated a belief that one-half or more of the families continue abusing their children after protective services become involved.

Opinions were also sought concerning the effectiveness of programs. For example, respondents were asked to react to the statement, "Treatment for parents who mistreat their children is largely ineffectual." Agencies that agreed with this statement ranged from public health and protective services (representing 28 percent of the population) to the police and sheriff departments (representing 48 percent). When asked to evaluate the effectiveness of their own agencies, the police were most optimistic and public health departments most pessimistic. Similarly, the police were most generous in their assessment of the effectiveness of other agencies in the community, and the courts next. Public

Counselling was the service most often mentioned as lacking by respondents from all agencies. The need for home support, placement facilities and financial support were also frequently indicated. Problems in interagency coordination and inadequacies in manpower and staff qualifications have already been pointed out as two major impediments to program effectiveness.

It is premature to attempt to draw conclusions during this initial stage of analysis of such an extensive and complex set of data. Rather, the objective was to present some of the important trends and to share some of the thoughts they provoked. The figures presented and the statements made are subject to further refinement and qualification as we proceed with future reports on this study. However, I hope that this report has provided some overview of programs on child abuse and neglect in this nation.

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[1] Sampling and data collection were carried out by the Survey Research Center of the University of Michigan's Institute for Social Research. The methodology for this sample is provided in Kish L. and Hess, I., *The Survey Research Center's National Sampling of Dwellings*. Ann Arbor: Institute for Social Research, University of Michigan, 1969.

All percentage responses are carefully weighted to reflect the proportion of population they serve. Thus, the opinion of a judge or court worker in a metropolitan area is given more weight than that of a judge in a rural area wh[illegible]

I. THE PHENOMENON OF CHILD MALTREATMENT

DYSFUNCTION IN SOCIETY, THE FAMILY, AND THE INDIVIDUAL (I.6)

The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologic damaged.

Suggested Areas of Dysfunction	Suggested Examples of Dysfunction
1. Society	
a) Economic conditions	Poverty
b) Environmental conditions	Racism
c) Social values	Violence
d) Institutions	War
	Moral decline
2. The Family	
a) Intra-familial relationships	Marital problems
b) Child-rearing practices	Child delinquency
c) Family structure	Isolation
d) Life style	Financial problems
	Addiction

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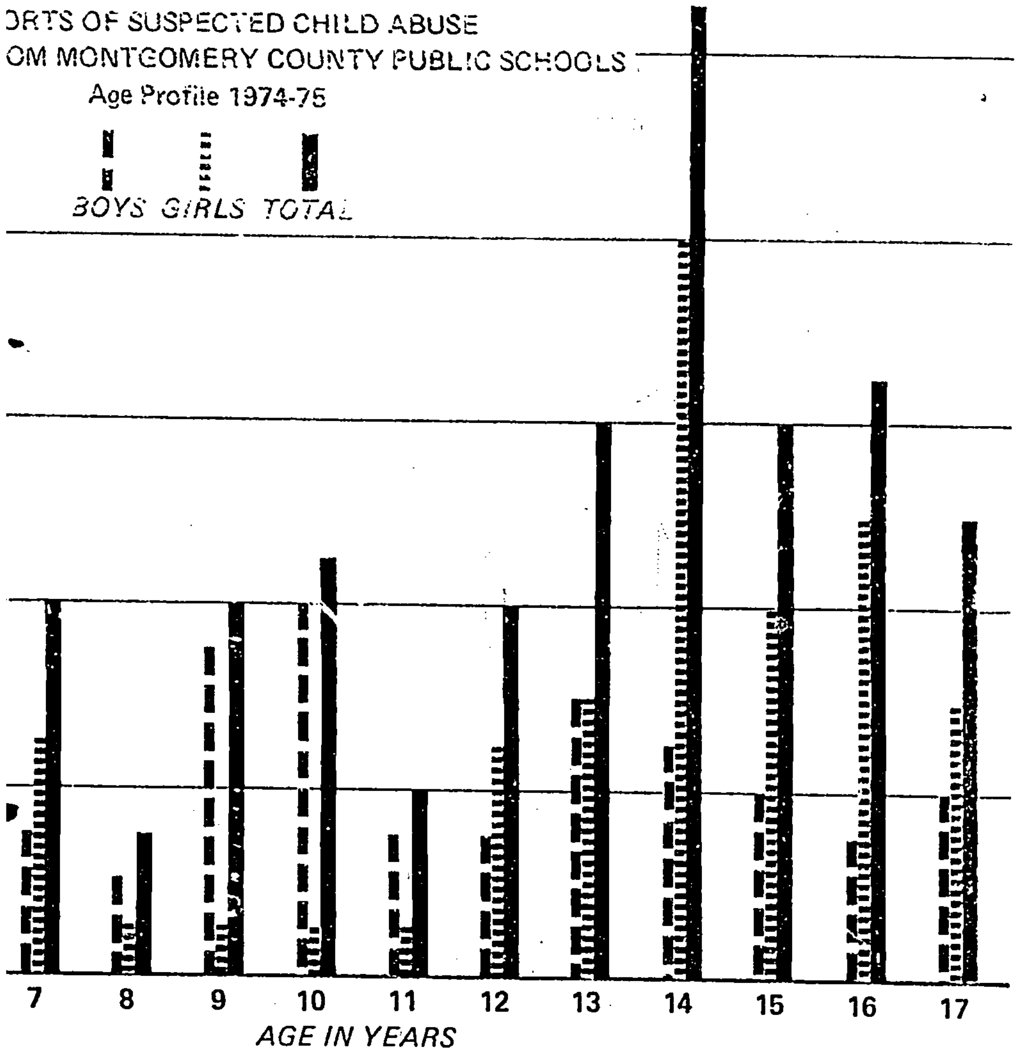
(Transparency 1)

Table 1

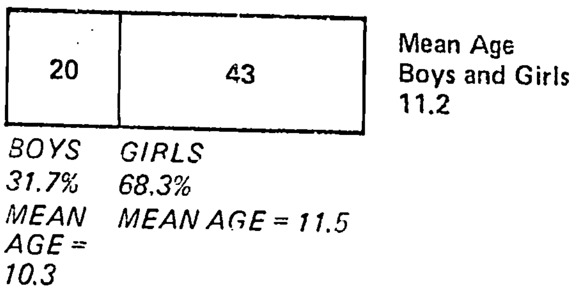
Mershon Study Center

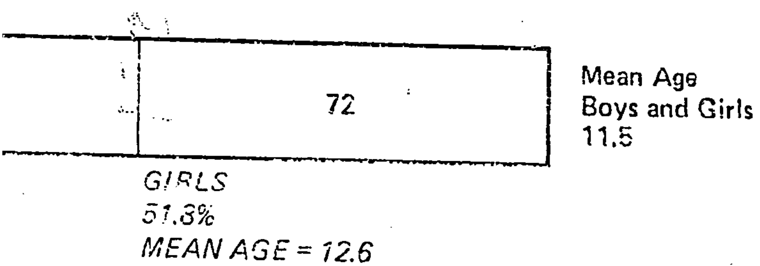
Table I Mershon Center Estimate			
	Reportable	Reported	Not Reported
Abuse & Neglect	925,000	600,000	325,000
Substantiated		360,000	195,000
Abuse Only		167,500	91,000
Cohen & Sussman Estimate*			
Confirmed Abuse, 1973		41,104	
Light Estimate**			
Abuse Only	200,000 to 500,000		
Abuse & Neglect	465,000 to 1,175,000		

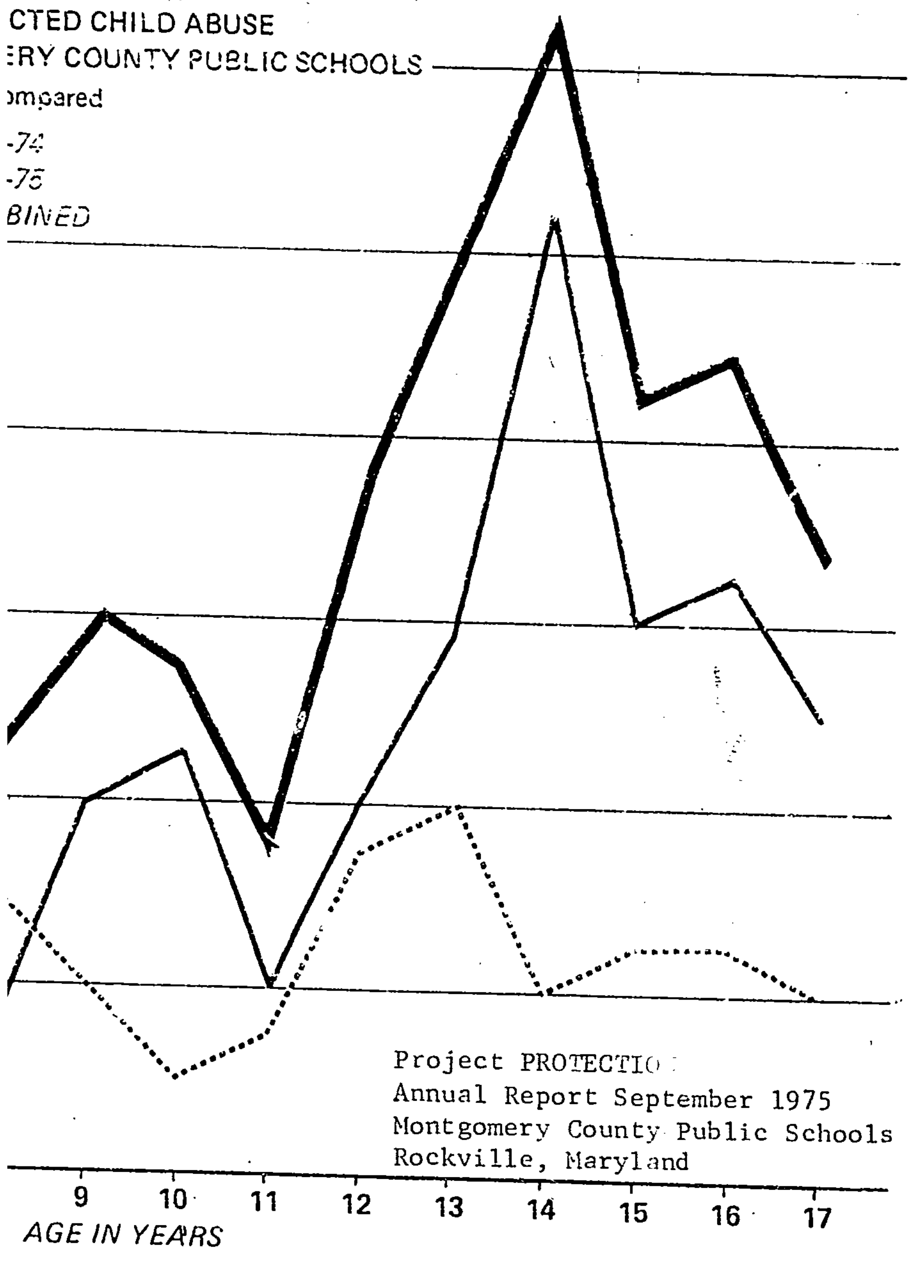
* This estimate, based on actual reporting in the 10 most populous states and projected to the national population, is reported in Cohen, Stephan J. and Sussman, Alan, "The Incidence of Child Abuse in the United States," unpublished report submitted to OCD, 1975.


ORTS OF SUSPECTED CHILD ABUSE
OM MONTGOMERY COUNTY PUBLIC SCHOOLS
Age Profile 1974-75
BOYS GIRLS TOTAL
7
8
9
10
11
12
13
14
15
16
17
AGE IN YEARS

'S OF SUSPECTED CHILD ABUSE
IONTGOMERY COUNTY PUBLIC SCHOOLS
I Mean Age of Children Reported






CTED CHILD ABUSE
ERY COUNTY PUBLIC SCHOOLS
ompared
-74
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AGE IN YEARS
Project PROTECTIO
Annual Report September 1975
Montgomery County Public Schools
Rockville, Maryland

A-12 MONTGOMERY COUNTY SENTINEL Thursday, November 7, 1974

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Child abuse reports have increased since 1972

By Roberta Wyper
Sentinel Staff Writer

The Montgomery County Department of Social Services received 477 reports of child abuse and neglect between Jan. 1 and Aug. 31, 1974, according to statistics released last week by the county Child Abuse Task Force.

Schools were the single largest reporting source (24 per cent), followed closely, by private citizens (22 per cent).

The Department of Juvenile Services and the courts reported the least number of cases (3 per cent) followed by hospitals (4 per cent).

In between were the police department's juvenile section. (13 per cent) and relatives (16 per cent).

During the last three years there has been a sharp increase in the number of child abuse cases reported in the county, according to the report. In March of 1974, there were approximately 300 validated cases on the rolls of the Social Services Department, compared to 199 in June 1973 and 47 in June 1972.

The increase in reported cases, the report says, is due mainly to such recent Child Abuse Task Force accomplishments as:

- A 24-hour reporting line with follow up investigations of reports within one hour.
- A public education program using the news media, a speakers bureau and public meetings.
- The passage of state legislation requiring physicians to examine children brought to them by a policeman or social services worker, with or without parental consent, and granting immunity from civil liability and criminal penalty to doctors when parental consent is not obtainable.
- Establishment of a permanent seven-member Child Protection

By Kenneth Keniston
Yale Alumni Magazine 37(1974)
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'Good Children' (Our Own), 'Bad Children' (Other People's), And the Horrible Work Ethic

A little over a year ago I became part of a project—the Carnegie Council on Children—whose objective is to assess the needs of American children in coming generations and to present recommendations designed to increase the chance that those needs will be met. Perhaps because many members of our staff have been strongly influenced by psychological thought, some of us instinctively turned toward an analysis of the past as a way of understanding the present and of knowing how to influence the future. For example, in the reports of White House Conferences on Children over the past 60 years, we found a litany of complaints and recommendations. What is striking is how frequently the same complaints and recommendations have been repeated and how little action has been taken to correct obvious abuses.

As everyone knows, America's record in child health is abysmal. Especially for children of minority groups and of the poor, our infant mortality rates are a national disgrace. We are the only industrialized nation in the world that has not adopted some policy of direct family support or child allowance. Of all industrialized nations, we have made the least adequate public provision for the care of young children whose mothers work, even though one-third of all mothers with children under six are now in the paid labor force. Even today significant numbers of American children are malnourished. Mental health services for children are largely unavailable, and

A scene from "McGuffey's Second Eclectic Reader" (1879).

THE FIRESIDE.

1. One winter night, Mrs. Lord and her two little girls sat by a bright fire in their pleasant home. The girls were sewing, and their mother was busy at her knitting.

fined children as future producers and have valued or disvalued them accordingly. The qualities that we have tried to implant in them have been the traits thought necessary for power and status in our economic system. The question that we confront today is whether it is possible for our society to begin to define children in some other way—a way that emphasizes the fulfillment of their potential, not merely as future producers, but as unique individuals with a diversity of talents.

Ever since the American Revolution, the prevailing rhetoric about children has been dominated by the work ethic. But work has been valued not because it was a way of maintaining the natural order, nor a form of service to God, nor a way of demonstrating through success that a person was one of the Elect.

First, work was seen as the only way of escaping from scarcity and want. Perhaps for the first time, a large number of people did not accept poverty as man's natural condition, but rather as a disgraceful situation that could be overcome by hard work.

Second, the work ethic presupposed the idea of equal opportunity for the industrious. Admittedly, a large majority of the population has always been excluded from success through work: slaves, Indians, women and almost every dependent minority did not have an "equal chance." Yet historically a number of white working-class and middle-class Americans believed in the vision.

Third, the work ethic is closely related to the American vision of this continent as a vast, and unpopulated area (Indians are invisible) which man can exploit to produce wealth. Without the notion of a limitless frontier of rich land wait

eras, hard work in school was defined as essential for later success.

"Good children," then, are above all those who promise to be industrious. "Bad children"—usually the children of other people, of other races, classes, nationalities, or ethnic backgrounds—are idle, lazy, apathetic, undisciplined and lacking in self-control. In other words, they are *not* industrious.

At a psychological level, the absence of industry is associated with several dangers. First, the idle child runs a constant risk of falling into vice, which in American history means sexuality, self-indulgence, intemperance, addiction and immorality. The possibility that idleness might promote constructive play, or the development of imagination or fantasy or any virtuous quality, has simply not been entertained until the last 20 or 30 years.

Childhood idleness also has been thought to create what used to be called adult "pauperism," which means deliberate dependency on the industry of others and a tendency not to respect property (the fruit of hard work)—thus, to steal, beg or cheat.

At a social level the absence of industry is associated with urban disorder. Especially in the 19th century, after the great waves of immigration began, the intensity of our American fear of social anarchy is striking. Writer after writer justifies his proposals for child training on the grounds that otherwise a total breakdown of social order will result. The emergent cities of the 19th century were viewed with particular alarm, for their influence on children was invariably seen as pernicious. The evil city, as historians have noted, was starkly contrasted with the good country.

tested that the vast majority of indigent children were in no sense delinquent or depraved. But the practice continued—and, with some modifications, still does.

Given the American belief that a man through hard work could rise to the top, it followed that those who remained on the bottom were less virtuous than those on the top. The poor in America have traditionally been seen as wanting in character or merit, and often as a dangerous influence even on their own children, who would be better trained in "good families," where prosperity attested to virtue, or in schools dominated by the values of the well-to-do.

Our prevailing American fears about children have been similar to our fears of other dependent groups. The qualities feared in children were also thought to be embodied in blacks, Indians and other minorities—they were seen as shiftless and intemperate—and similar epithets have been applied to most immigrant groups. Indians, in fact, were seen as so barbarous that even enlightened missionaries confronted them with the choice of "civilization or extinction." The only way to "save" Indian children was—and often still is—to remove them from the corrupting circumstances of tribal family life where they do nothing but play and thus learn idleness and vice.

The vices of indolence and sensuality were automatically assumed to be far more attractive than the virtues of industry. There is a pessimistic view of human nature inherent in our work ethic. Again and again, one "vicious companion" is seen as "contaminating" all other children. Rarely was the opposite suggested: that one virtuous child might uplift idle companions.

Implicit in this idea is an undercur-

require that "farmed out" or indentured children should go to school, not be overworked and be given minimal rights.

These rights largely consisted in protecting children from the cruelty and greed of their guardians. Yet efforts to protect these rights were generally ineffective because mechanisms for inspection, follow-through or appeal by the child were lacking. Until recently most legislatures were unwilling to enforce protective legislation, and some still are.

But during the late 19th century, Americans began to realize that children could be misused not only by Irish, Italian or East European immigrants, but also by old-stock, native Americans. The early 20th century saw the first American recoil from the most exploitative aspects of industrial capitalism and the call for more humane treatment of dependent minorities, including not only children, but the aged, the poor, and (to a much lesser extent) blacks and other non-North European Americans. The first White House Conference on Children in 1909 is a very pure—indeed classical—expression of the new spirit of Progressivism as applied to children. Nevertheless, federal laws outlawing child labor were deemed unconstitutional, and in the 1920's a constitutional amendment to forbid child labor failed to be ratified. Even today, Americans resist efforts to define the child as other than a productive-industrious citizen of society. Erik Erikson argues that industry is the great theme of later childhood.

Although the stress on psychological industry is a constant in our history, the meaning we have attached to the concept of industry has changed with the changing needs of the economy. In 1790 America was overwhelmingly

not see why we are happier now than we were then: for last night cousin Jane was here, and we played 'Puss in the corner' and 'Blind man' until we all were tired."

6. "I know! I know why!" said Katie. "It is because we have all been doing something useful to-night. We feel happy because we have been busy."

7. "You are right, my dear," said their mother. "I am glad you have both learned that there may be something more pleasant than play, and, at the same time, more instructive."

different qualities from the farmer: punctuality, obedience and discipline. He also needed skills of a higher level for success in an industrial society—literacy, for example. And if he were to move to a still higher level of entrepreneurship, still other qualities were required: drive, ambition, competitiveness, even a certain ruthlessness. Thus not only new technical skills but a new kind of social character was required on a mass scale.

Turning to the present, we are entering still another kind of society, one which is knowledge-based and which requires still different human qualities. Educational criteria are a prerequisite for entry into higher positions. Meanwhile, thrift, drive and ambition have receded in a corporate industrial state, their place taken by skill in interpersonal management and manipulation, the capacity to integrate large amounts of information, to deal with abstractions and complex technology. So again our society has changed both in the skills that it rewards and the social character that it must "produce."

What has this meant in terms of the qualities that we deem desirable in children? I have stressed the enduring emphasis on hard work. In the agrarian era this meant hard work on farms and in fields—a kind of muscle power. But with industrialization the meaning of industry shifted, emphasizing what can be called willpower.

For example, in the 19th century there appeared in the literature on child-rearing a new emphasis on self-control and a fear of its absence. Writings on childhood became increasingly psychological: they emphasized the importance in

views the greatest problem among the poor as that of cultural deprivation, which means poor performance in school, cognitive understimulation, bad reading scores, and so on. A child who is valued, thought likely to succeed and rewarded by being "tracked" into the higher levels of school, is a child who performs well cognitively. Despite protests from those interested in other aspects of human development, our "intervention programs" with other people's children have stressed with monotonous uniformity the importance of cognitive and intellectual stimulation in the early years. And in middle-class families and schools the greatest terror and most common problem is "the learning problem." In two centuries we have moved from muscle power to willpower to brainpower.

This has been accompanied by a fundamental shift in the economic meanings of children to their families. In an agrarian society, children were an essential source of free labor. In the later industrial era they became either a source of cash income or a form of social insurance—they would provide support when their parents were old. Today, from an economic point of view, children are an unlimited liability. They consume large resources, none of which can be expected to be repaid. Whatever payoff a family receives from children must be derived from the intrinsic satisfaction that adults derive from the process of rearing children. Thus children have shifted during two centuries from being a source of free labor to being a source of income and social insurance to being an economic disaster.

Another changed issue is the relationship of children to the parental generation. On the pre-industrial farm they ture. If we did, we would see it as inevitable that our society would continue to to value children primarily as productive participants in the economic process and to disvalue them if they were not considered potentially industrious.

The second use of history, familiar from the practice of psychotherapy, views an understanding of the past as a necessary precondition for change. The past is coercive only when we fail to appreciate its power—we can be freed from its compulsiveness if we can appreciate its meaning, and re-direct ourselves toward a future that does more than simply recapitulate.

Whether we should continue to define our children primarily in terms of their future productive roles is a question to which I have no simple answer. Let me only suggest a few thoughts.

First, we live in a nation which, whatever its faults and current mood of despair, has achieved a higher level of prosperity than any society in world history. Some people would deprecate this, or point to the price that we have paid. Nevertheless I do not think we can merely dismiss it. Nor should we be oblivious of the fact that most of today's children will work in an economic system that will be highly technological and will need to be prepared for a productive role. In other words, however easy it is for us to mock the virtues of industry and the extraordinary stress we have placed on it, it will be important to continue to place at least *some* emphasis on these qualities. It is hard to imagine any livable society in which children are not brought up to value and be capable of productive work.

Yet we pay an enormous price for our emphasis on industry as the supreme virtue of childhood, and this price is one proach both individuals and society pay a high price. Even for those who play the cognitive game well, the price is too often an atrophy of other human qualities which I suspect are, in God's eyes, far more important: morality, kindness, empathy, feeling, joy, imagination, playfulness, grace, artistic ability—to say nothing of love. And the price paid by those at the bottom is all too well known — children who by second grade have accepted the label of "losers" and who carry it with them forever.

What we lose is the extraordinary diversity which might flourish in this nation of diverse origins. If all other human qualities are neglected before intellectual-cognitive precocity, then all the individual endowments, the diversity of cultural traditions that make up this country, will remain unrealized.

One cannot consider children without considering adults and society, and one cannot consider the future of children without considering the future of mankind. There is no escaping the question of our deepest values. At the Carnegie Council we differ from Michael Young's negative utopia of a meritocracy in which each person's position will be determined by his I.Q. Our alternative vision is still vague, but some of its components are clear. It is a vision of a society which, without deprecating work, would place equal emphasis on other human qualities such as love, care, compassion, grace and imagination.

It would be a society where the lip service that we now give to the unfolding of individual talent in children would be concretely embodied in families and neighborhoods, child-care centers and schools. It would be a society where instead of asking how good children were at schoolwork, we sought to cultivate

Subtle Neglect

The National Observer
February 22, 1975

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Is U.S. Becoming Less Child-Oriented?

By Sarane S. Boocock

THE PAST decade has witnessed a countertrend away from the Spockian child-centeredness of the 1950s and early 1960s. Not only is there accumulating evidence that many American children are not being adequately cared for, but there are also indications of a general devaluation of children and child rearing.

The available evidence on abuse, neglect, and other indicators of inadequate care are difficult to evaluate. The

Comment

magnitude of the child-abuse problem, for example, can only be estimated. Some 60,000 cases a year are reported in the United States, but on the one hand, part of the apparent increases in the incidence of abuse may be due to fuller reporting; on the other hand, many cases, especially in middle- and upper-income homes, go unreported.

What constitutes neglect of a child is still not clearly defined, and the indicators of neglect take a variety of forms. There have been increases in the number of divorce cases in which *neither* parent wants custody of the children. There are clues that many children ostensibly in the care of their own parents are, in fact, left without care for long periods of time.

This kind of information is difficult to obtain, since few parents willingly admit to leaving young children unattended. A 1966 Swedish study found some 3,000 children under 7 years of age left unsupervised while their parents were at work. A study by the

This article is excerpted from a paper that Dr. Boocock, a sociologist with the Russell Sage Foundation, gave in January at a symposium during the annual meeting of the American Association for the Advancement of Science.

other countries for which time data are available.

Ironically, American women are spending more time than ever on housework, but large amounts of this time are devoted to the care and repair of "labor-saving" appliances and to the shopping that is an important component of a consumption-oriented society. Moreover, a large chunk of many mothers' "child care" time is spent in chauffeuring their children. As Alexander Szalai notes: "Two marked curiosities of the United States data are how little time is spent helping children with homework and how much time is spent transporting them."

Few studies exist of how much and how parent-child time is actually spent, although some informants estimate that even nongainfully employed mothers may spend as little as 15 or 20 minutes a day in actual communication with their preschool children and that many children have no other daily meaningful contact with adults.

Fathers spend even less time with their children. Henry B. Biller's own research and his review of the few studies that have been done indicate that the majority of American fathers spend little more than 10 or 15 minutes a day in one-to-one interaction with their

tribute in any other way to the running of the home, and rarely does a child work with an adult on some project or even observe an adult at his work (in contrast with, say, an Israeli kibbutz, where children not only work in the community themselves, but also daily see their parents and other adults engaged in their regular work).

We did interview some children in small towns and rural areas who regularly ate meals with their parents and who helped around the home in some way, but the large amounts of television viewing and the small amount of time with adults seemed to prevail everywhere.

It seems fair to conclude that the status of children in our society is highly ambiguous. It is clear that the traditional reasons for wanting children —i.e., for economic reasons or to extend the family line or family name—have all but disappeared in modern secularized societies.

It has been argued that as children have lost their economic and familial value to parents, they have become more valued in a qualitative sense, as they provide adults with personal experiences and pleasure of a unique sort. Evaluation of this argument requires an understanding of some very complex demographic trends as well as weighing of what little survey data are available on the subject.

It does seem that there is less wanting of children in America, and in developed nations generally, than in the past and that people who do want children want fewer of them. However, we still know very little about people's reasons for wanting—or not wanting—

THE WASHINGTON POST
B 6 Friday, April 30, 1976

Book World

Imprisoning Our Children

KEEPING IN THE PLAYTIME OF OTHERS: America's Incarcerated Children. By Kenneth Wooden. (McGraw-Hill. 264 pp. $8.95)

Reviewed by
Colman McCarthy

The reviewer writes for The Washington Post's editorial page.

A case is easily made that America, far from doting on its children, actually hates them. Much of this loathing has been institutionalized, so that only the occasionally deranged molester on the street or the child abuser is seen as dangerous. But what of the children who are killed and injured every summer because Congress has failed for 10 years to pass a youth camp safety law? Or the suffering children of runaway fathers? Or the children in rural America who must live in shacks because the government subsidizes housing for the middle class more than for the poor?

The term "child abuse" has a narrow legal definition, but for the victimized child it matters little whether he is brutalized directly by a crazed adult or obliquely by a political system that treats him as worthless.

It is hard to get reporters to examine the methods by which politicians, business interests, bureaucracies and the courts institutionalize

He is clearly angry at what he found—every degradation from solitary confinement to injections with behavior modifying drugs—

but he is interested in being more than a tour guide through another of America's hells. His book's value lies in its examination of causes, and how the decisions of public officials, though remote, are related to the demeaning of children in lone cells. "If one could scrutinize the financial structure of juvenile facilities with their immense budgets and multiple institutional needs, one would find most of them riddled with conflicts of interest and naked corruption. Clear-cut examples of this include some Georgia jails that have 'turn-key fees' and refuse to release children until their parents have paid the local sheriff room and board."

In another state—Illinois, before Gov. Daniel Walker's administration — "memos would come down from the governor's office commanding the Youth Department to send children to select private facilities because their census counts were low. Children were herded off like cattle to enhance profits enjoyed by the business cronies of local politicians."

Wooden knows something about children on whom the schools give up and who turn to violence. In a moving account of his own boyhood, he tells of teachers dismissing him as "dumb and slow." He turned to vandalism, and only after the Army took a chance on him—he was a library assistant — did he go back to school. The same high school that once gave him an IQ rating of 78 hired him years later to teach.

To correct some of the abuses now suffered by imprisoned children, Wooden asks that Congress create a "National Child Health [illegible] Enforcement Agency," [illegible] a "National Suicide [illegible]tion Act for Incarcerated Youth" and that the co[illegible] establish a "Bill of Rights for Children." Wooden is sane and compassionate in advancing such ideas, but he is up against a Congress that is part of the system that institutionalizes hatred for children. It is happy to spend $21 billion on the B-1 bomber but only provides $13 million a year for the National Right to Read program.

Wooden can write that "unless we take drastic and bold steps to improve the

Wrecked Parents, Brainless Love

They've No Right To Destroy the Children

'The dirt will thicken on Bennie's neck and wrists, and in some way it will penetrate his spirit. One day he will explode. . . .'

By Ned O'Gorman

The Washington Star, June 8, 1975
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In New York City, the children of the oppressed are under sentence of death. The very young, babies just born, are thrust from the beginning into a world learned in ways of slaughter. No time for saving them, the die is cast in [illegible] cradle. Death proceeds on its wa[illegible] to [illegible] light their bodies and their s[illegible] Hope, joy,

Ned O'Gorman is a New York poet.

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wonder, all are mauled, wrecked and fated to end in the grave, whether that grave be the streets, jail or some well-tended cemetery.

I write of New York City, Harlem especially. I have worked there nearly 10 years in a nursery school I started in 1966. (I call it a liberation camp. It is privately supported, and we get no government aid. We accept any child who comes to us, feeding each breakfast and lunch.)

I will write of children I know now and have known in the past. They came to us out of torments that would make stones weep. I write of what I have seen. I have added nothing. I have imagined nothing. I have seen poor white children in Kansas, Irish kids in Dublin and boys in Chile slipping as quickly as Harlem children [illegible] the abyss.

The children I see each day are dying. I must ask myself what I can do to release them and their kin from the killers that have pursued and caught them. I am in Harlem, then, to save children from their guardians (blood kin or not), from the streets and the oppressors in all their masks. The law suffers from an overwhelming passivity in the face of this epidemic of child abuse and its attendant horrors. There are not enough investigators to probe into the lives of these children; and once the process is begun, the change sought in their lives takes months of tedious red tape to get underway and often simply peters out. Families move, refuse to give the child up, suffer momentary change of heart, deposit him in the hands of respectable kin for a while and abort investigation.

It is time now for agencies and individuals who hold themselves responsible for the lives of these battered, suffering children to study with vision — and science — the meaning and function of the family, to ask whether a family has the right to impose its destructive manners and style on the innocent and to find ways to bring change into these children's lives with curative intensity. The community, the state, the churches, the courts, the law, politicians, educators must say *No!* to those who cripple children. They must offer them a revolutionary purpose and stop the slaughter.

What we all must seek is a way to speak for the children of the oppressed, a way to become their surrogate will to live. We must seek, too, to tell the oppressed that they are oppressed and that unless they move to change their lives, the state in its work with these children will simply have to become a tyrant to be effective.

In three rooms of an apartment above a dry cleaner, Tommy lived with his mother, her friends and roaches. He was 2. Since his birth, he had been constantly sick. Lead poisoning had landed him in the hospital for a month. His skin was ashen. He slept all day, seldom ate and stagger-

See CHILDREN, B-4

CHILDREN

Continued From B-1

ed into my school now and then, when I could persuade his mother to let him come or when she needed us to babysit The spirit had gone limp in him and from his eyes shone a fabrication of life

One morning, one of our workers told me his mother had sold him to a woman she met in a clinic. I bounded up to Tommy's flat and found him there with his mother and a strange couple The woman had Tommy in her arms. His mother sat by the stove. I asked if she had sold him. She said no: She had given him to those people. How much, I asked, did you get? She said, "I did not sell him."

I went back to my school and asked the workers for more information. She was paid $800 for him, they told me. I phoned a friend in a child-care agency and asked what I ought to do. I phoned Tommy's mother's social worker and asked her to come up to talk to all of us My God, I thought, you simply cannot sell a child.

The social worker investigated and made calls here and there, and by the end of the day some agreement had been reached that the prospective parents in the clinic and Tommy's mother would meet the next day with the Bureau of Child Welfare. They never did. Tommy, mother and couple vanished.

I saw Tommy some months afterward with his natural mother. I asked her where he lived. She said in Brooklyn. I looked in Tommy's eyes. He was dead.

Recently I heard that she had had another child and sold it on her first day home from the hospital.

Why did I have to go through such trouble to get little Tommy out of the clutches of his mother and those buyers? My effort to become Tommy's surrogate will was a failure. I had no power. I had no proof. The social worker seemed bland, bored and so fearful of hurting people's feelings that from the beginning I knew Tommy was going to be sold and there was nothing I could do about it.

Carita loves Lennie. I do not know many mothers who can say, as she does, with such depth of feeling, "I love my son." She would willingly give him all that is good, but she is unhinged, wrecked -- and a victim. Her past was filled with troubles. She drank and seemed to have little will to fend off men. Her apartment was a ravaged horror roaches in the icebox, urine-soaked sheets in piles on the floor, broken glass everywhere.

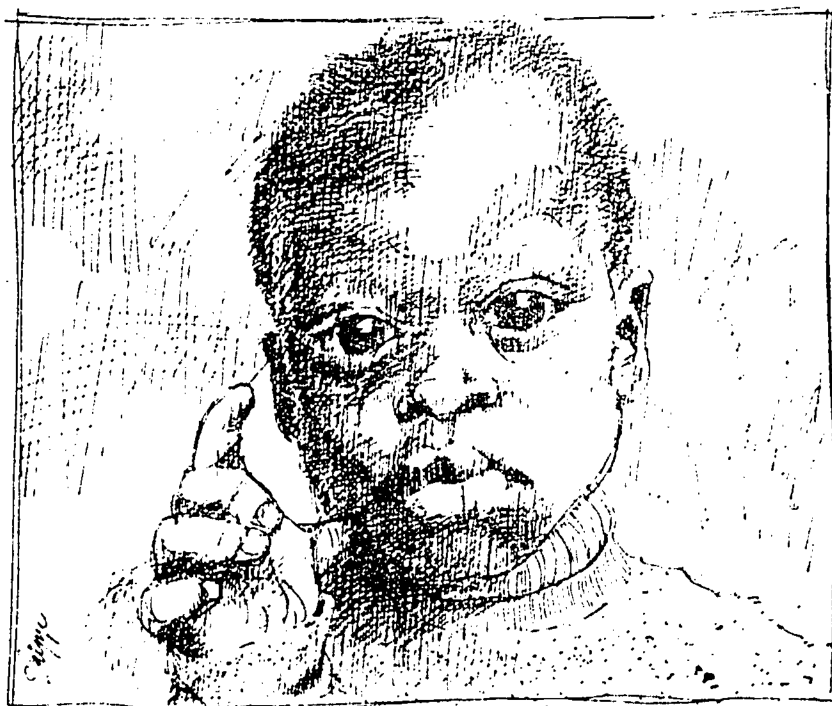
Lennie, 9 years old, fragile, overwhelmingly lucid, wandered around, missing nothing, watching his mother destroy herself. His brother, brain damaged, a hulking 6 year-old child, overweight, stumbling, voiceless, lurched about the rooms. Once, he nearly drowned in a tub filled with filthy water. Twice, Carita set fire to her bed, and twice Lennie called the Fire Department.

Agencies came and agencies went. Men with serious intentions appeared, judged what they saw as horrendous and did nothing. One fellow gave her a month to improve her lot, get to Alcoholics Anonymous and straighten up her flat, but I told him she never would be able to do it, and indeed she didn't.

I said if Carita wanted to go to hell that was her business; it was our business to save Lennie. But everything was covered with a hushed kind of good manners. (" Carita's privacy must be protected," a good lady told me.) I knew it was going to be impossible to do anything. It was as if I stood on board a ship and deliberated with the captain if we ought to throw a life jacket to a drowning child before we got his mother's permission.

Lennie hung on. I picked him up in the mornings to take him to school. His little body and spirit were large enough at that moment to store away the nightmares in some corner of his mind. In a week, though, he began to fly into rages, run away from school, sulk, make up tales, refuse to do class work and weep when I had to return him home. By then, Carita had a new gentleman caller. (One day, Lennie saw a stranger rape his mother.) Lennie spent the hours away from school on the stoop of his apartment house in the midst of one of the worst heroin quarters of the city. Finally, after months of hassling, he was made the ward of a good woman with a house on Staten Island. It took four years to get him there. Carita once said to me, "I love him so, but, Ned, I don't know what to do. Help me, Ned." I could not. No one could.

A few days ago, I discovered that Lennie must now leave his foster home. He will be sent to a therapeutic school in the country. The past has taken its vengeance on him. He is still a vibrant child, but the fabric within him is crumbling. The foster care he received was absurd from



the beginning. His father whom he sees twice a year will not free him for adoption. His surrogate will to live has not been heard. Thus, the agencies and schools responsible for him will have to share the burden of Lennie's fate.

I know that what I have reported, even though I have seen it all happen, will be criticized as being gloomy, as casting doubt on an entire community's ability to care for its children. It think that such a criticism is in part justified. I *am* gloomy. I *do* criticize the people of the community as much as I criticize — attack, I think — the law, the church, the government on every level, in their indifference to this slaughter of the innocent.

Stella is 3 and nearly mute. There is nothing clinically wrong with her. She merely does not know yet how to talk. (Often, the first faculty that has been stricken in the children we meet in our school is their ability to speak. It is usually diagnosed as a speech defect, but most often I have found it to be simply the result of hearing bad English, listening to nothing but television and being spoken to hardly at all.)

Stella's mother stands in the doorway of her apartment like a chained totem. Stella smiles a mute smile when I see her in the morning, jumps up a little and runs toward me. She looks at nothing, recognizes nothing. She has no notion of what to do with toys, blocks, crayons, scissors.

She loves to play with Link, a boy of 3, who, like Stella, has developed over the months, since he has been coming to my liberation camp, from a screaming, weeping mess into a beautiful little boy, stricken but fighting to know his world. Stella, mute. Link, awash with nerves and chaos.

Link's mother, like Stella's, is a woman of intense unhappiness. Her life, her children, her flat, all are in a state of *rigor mortis.* Nothing changes from day to day; her eyes grow duller and duller; she never laughs, and the children take on her morbidity.

I do not doubt that the mothers I write about love their children. Yet it is a love that lacks patience, understanding, science. I love flowers. I do not think any sight in this world delights me more than a crocus. But the intensity of my love does not qualify me to become a curator in the Brooklyn Botanic Gardens. I have not one whit of knowledge of how to preven

blight, how to stem a ravaging weed. Nor do I know the difference between a rare tropical plant and poison ivy. I have a brainless love of flowers, as Stella's mother and Link's have a brainless love for their children.

Stella is a victim, as a flower might be, and her future lies in her mother's power over her. It is absolute power.

Nate rules his household with irrepressible violence. His five children are all broken figures, products of their parents' tragic battles that rage day and night. The household reverberates with barrenness: broken furniture, a refrigerator that does not work and a berserk television set.

Bennie, at 5, is so dirty that when I lift him onto my shoulders dirt flakes off his wrists and neck. None of the children can yet speak one clear sentence. (Their ages are 1 to 11.) Welfare evicted them from their flat. Now they are living in a hotel downtown until they are moved into a housing project. It will be the same there, one house of torment to another. The dirt will thicken on Bennie's neck and wrists, and in some way it will penetrate his spirit. One day, he will explode, do violence to himself, or to another, and the headlong plunge toward death will be over.

Daniel, now 19, came to my school when it first opened. He was 9 then. A year ago, I saw him in a doorway on 128th Street. I had remembered him as one of the loveliest kids on the block. He had a special kind of hilarity about him, a clean, direct presence. But when I said hello he looked at me, eyes and body in an embattled, razor-sharp fury. I walked down the street and turned once toward him, and he heaved a Coke bottle at me. I ducked. He missed me by an inch. I've not seen him since.

I seek in my work the power of the surrogate will. Mute Stella, Lennie, Link, Tommy and others I've known would have survived had some law imposed healing in time. (Am I saying these children are lost? I think I am.) The space that lies between a court's or an agency's awareness of a child's agony and the removal of that child from the locus of destruction is often the space in which the final sickness takes over with such intensity that no matter what happens later the game for that child is up.

What can I suggest as solutions to the calamities mentioned here? Is it, first, perhaps a problem of literacy not merely the ability to read and write but the ability to read one's own place in time? The ability to see what is happening around one's family, within the home, in the streets. I must find a way to teach the oppressed man and woman how to decipher the oppressing world so that they can wage war against it.

What I seek is a revolutionary literacy. Might not a massive effort by the state and city to invade the streets with 24 hour centers of healing be a beginning toward this new awareness of life? I think of storefronts where parents could get quick help in problems of nutrition, rashes, earaches, bruises, colds — all those debilitating crises that can, if never seen to, infect a child's growth; libraries and minischools where people could come to read, talk, draw, even watch television, where the oppressed could begin to come into contact with the bounty — not the debris — of the world. I think of all the space that goes to waste in Harlem.

I think of the block, how it could be such a force for change. If there were some folk on the block who could organize a kind of court where troubled parents could come and seek help, then perhaps the sense of alienation that Carita feels might burn into a sense of hope.

But, in this land, such an act of communal ardor is hard to achieve. In China, where I visited in 1973, it has been achieved, but here in our community where everyone seems to know everyone's business, where not a sparrow which falls or a child who dies goes unrecorded in someone's memory, there is a vast silence, a reticence that allows things to proceed on their deadly course with hardly a sigh to note the carnage.

Would it be possible for the Rockefeller Foundation and the Ford Foundation together to build a community of healing in Harlem, with a staff of doctors, nutritionists, teachers, psychiatrists, ministers (if they were needed), lawyers, judges, scientists who would give their time to discovering [illegible] of creating a revolutionary [illegible]

But such a community of healing must have behind it some clout so that, as I have mentioned before, if Carita refuses to go, it will be made clear to her that Lennie must — or he will be hauled off, now or later, young or old, in a cheap coffin, perfectly dressed, to a grave in an earth that nourished the evils that killed him.

Medical Care Lacking For Children of Poor

United Press International

Nearly half the children of poor families need medical care but most are denied even the free physical exams provided by law, according to a congressional staff report prepared for a House investigations subcommittee.

The report, made public yesterday, said the states provided the required examinations for only 1.9 out of 12.8 million needy children in the fiscal year that ended June 30.

Even among those found to need treatment, the report said, 39.6 percent or 340,000 children were not treated.

OF 1.9 MILLION children examined in fiscal 1975, 45.1 percent needed medical treatment of some kind, it said.

From this finding, it estimated that about 5.8 million of the eligible 12.8 million children need medical aid.

It estimated that 12 percent (1.5 million) of the 5.8 million have vision problems, 5.1 percent (650,000) have hearing problems and 4 percent (510,000) have iron-deficiency anemia.

THE SUBCOMMITTEE is examining state compliance with a 1967 federal law which requires them to provide free health services for children of families with incomes at or below the officially-designated poverty level.

Congress has accused the Department of Health, Education and Welfare of failing to enforce the law, which was designed to cut the taxpayer cost of medical welfare services to needy adults.

The Washington Star, October 12, 1975
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Substandard Homes for Problem Cases

Shipping Children South

DETROIT (UPI) — States with fat welfare budgets are shipping unwanted problem children by the hundreds to expensive but substandard commercial homes in Texas, the Detroit News said today.

The News said welfare records show such states as Michigan, Illinois and Louisiana have sent emotionally disturbed youngsters to private Texas centers accused of child beating, inadequate health care and other abuses.

"AS A RESULT," the newspaper said in a copyrighted story, "the Justice Department has joined in a class-action suit specifically charging that 26 of the private centers in Texas have been violating the constitutional rights of Louisiana children who have been 'forced to undergo excessive sedation and subjected to mechanical restraints, prolonged isolation and corporal punishment.'

"Among the 150 so-called treatment centers licensed by Texas authorities are those that have reaped an estimated $8 million from the state of Illinois and more than $3.5 million a year from the state of Louisiana in the interstate shipment of more than 1,500 children, some of them under 10 years old."

In the report from Austin, Tex., News investigative reporter Seth Kantor said the Justice Department and a civil rights lawyer have also sued one such Texas institution, the Summit Oaks Achievement Center, Inc.

"Michigan is paying up to $57 a day — $20,800 a year — per child at Summit Oaks, where 'bad' children are belt-whipped and the good ones are given 12-gauge shotguns and high-powered rifles to stalk game in the piney woods of East Texas," Kantor said.

Kantor quoted Summit Oaks' co-owner Calvin Jackson as saying the suit, which would force states to bring their children home from the Texas centers, is "unfair" and "like bringing a bunch of preachers into court."

But, Kantor said, Jackson feels federal courts eventually will order states to give emotionally troubled youngsters local care, and he plans a counter-strategy of establishing Summit Oaks franchises in other states "like a Colonel Sanders fried chicken operation."

"The way I see it," Kantor quoted Jackson as saying, "I would be sort of the Colonel Sanders of the children's treatment centers. My people are going to fry it in my batter or not fry it at all."

KANTOR said commercial child care centers have sprung up as a multimillion dollar industry in Texas because the state has few laws on the subject and flimsy licensing requirements.

He quoted Texas Atty. Gen. John L. Hill as saying medical regulations in the centers are "highly inadequate."

Kantor said some institutions also flunked fire and sanitary inspections, and others had been accused of taming violent children with heavy drug doses. Few of the homes measure up to child-care standards required by law in the childrens' home states, Kantor said.

The Washington Star, June 15, 1975
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Ellen Goodman

Child-Snatching

BOSTON — Usually, the cases are less dramatic. They rarely involve a speeding car and a captured gun, or private planes waiting at a New York airport. Usually they don't make the evening news or page one of the morning papers.

Usually the cast of characters isn't as rich or renowned as Pittsburgh millionaire Seward Prosser Mellon and his ex-wife Karen Boyd Mellon.

But aside from the notoriety that surrounded the grubby abduction of two frightened little girls in front of a two-family house in Brooklyn, the event was almost common.

It is a tactic used with appalling frequency in vicious custody battles all over the country. It's called: Take the Children and Run.

It's happened now twice to the Mellon children, ages 5 and 7. The first time it was their mother who snatched them while they were visiting and took them on a four-month journey through 14 hotels, under nine different pseudonyms. The second time it was their father or, rather, their father's hired men who posed as FBI agents and carried them back again.

But the "game" is played by others. As the number of divorces increase, so do the number of vigilante parents who are taking the custody laws into their own hands. And some groups estimate that 100,000 child-snatchings occurred last year alone.

The victimized parent—one who doesn't know where his or her child is —is almost helpless. According to a Washington-based group, Children's Rights, Inc., which handles dozens of these calls every month, the victimized parent gets little support from the police "They consider it a domestic matter. They say, 'We don't want to get involved in family problems,'" says the group's Arnold Miller, who hasn't seen his own 6-year-old son in a year.

The FBI is no help either, although most of the children are taken across state lines. It's "out of their jurisdiction," because parents are specifically exempt from the federal kidnapping statutes. The parent who "steals" his child can't be accused of kidnapping.

On the other hand, the parent who abducts his or her children can often gain legal custody of them in another state. In the confusion of custody laws that change at the borders of states as if they were ancient principalities, a parent can comparison shop until he or she finds the best deal.

There are at least two ways to reduce the attractiveness of this self-help tactic. The first is to make parents legally liable for prosecution if they kidnap their own kids.

A bill sponsored by Rep. Charles E. Bennett (D-Fla.), which has been languishing in the House for three years, would remove the exemption of parents from the kidnapping statutes and would punish them with a $1,000 fine or a year in jail, or both.

It would make federal files—including Social Security information, Internal Revenue returns and prison records—available to police searching for the abducting parent.

Another help would be the adoption of the Uniform Child Custody Act, which is currently used by seven states. This act standardizes custody guidelines and insures jurisdiction rights. A parent who was unhappy with a decision would have to challenge it in the home state instead of simply trying another.

The point is the children, the shuttlecocks in the parents' game plan. The Mellon children are only two of tens of thousands. Child-snatching may be "a family matter," but parents don't own their children, their children's rights, lives or feelings.

We protect children from other kinds of parental abuse—battering, neglect, sexual mistreatment. This case has dramatized another need. We have an equal obligation to protect children from being rustled like cattle back and forth across the borders.

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The Washington Post
March 26, 1976
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UNIT II

The Nature of Child Maltreatment

II. The NATURE of CHILD MALTREATMENT

--- What Is It Like?

ERIC

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective for Unit II

THE STUDENT WILL BE ABLE TO DISTINGUISH THE NATURE OF CHILD MALTREATMENT FROM ACCEPTABLE OR USUAL CHILD REARING PRACTICES IN SOCIETY TODAY.

Generalizations for Unit II

A. Child maltreatment is described as acts of physical abuse and/or neglect and acts of psychological abuse and/or neglect on the part of a caretaker.

B. Child maltreatment is manifest in physical and psychological damage in the child.

C. Child maltreatment is distinguishable from acceptable or usual child-rearing practices in society today.

Performance Objectives for Unit II

1. STATE the federal definition of child maltreatment.
2. IDENTIFY the caretaker.
3. DESCRIBE typical acts of physical and psychological abuse.
4. DESCRIBE typical acts of psychological abuse without physical abuse.
5. DESCRIBE typical acts of physical and psychological neglect.
6. DESCRIBE typical manifestations of physical abuse and neglect in the child.
7. DESCRIBE typical manifestations of psychological abuse and neglect in the child.
8. LIST characteristics of acceptable child-rearing practices today.
9. LIST characteristics of child maltreatment today.
10. COMPARE child maltreatment with acceptable child-rearing practices.

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Performance Objectives for Generalization A

1. STATE the federal definition of child maltreatment.
2. IDENTIFY the caretaker.
3. DESCRIBE typical acts of physical and psychological abuse.
4. DESCRIBE typical acts of psychological abuse without physical abuse.
5. DESCRIBE typical acts of physical and psychological neglect.

Generalization A

CHILD MALTREATMENT IS DESCRIBED AS ACTS OF PHYSICAL ABUSE OR NEGLECT AND ACTS OF PSYCHOLOGICAL ABUSE OR NEGLECT ON THE PART OF A CARETAKER.

Sample Content

1. Federal definition of child maltreatment

2. Identity of the caretaker

3. Typical acts of physical and psychological abuse

4. Typical acts of physical and psychological neglect which may result in damage to the child

5. Typical acts of psychological abuse and/or neglect (without physical abuse and/or neglect) which may result in damage to the child

ERIC

Suggested Classroom Activities and Procedures for Performance Objectives 1 and 2

1. Start with a review of UNIT I. THE PHENOMENON OF CHILD MALTREATMENT, Generalization B Sample Content 1 through 4.
2. Clarify student understanding of the Definition of Terms (II.1).
3. Introduce Generalization II A and write on board for students.
4. Show Definition of Child Maltreatment, Transparency 5, as defined by the Child Abuse Prevention and Treatment Act of 1974. (For further in-depth study of child maltreatment law, see V D.)
5. Discuss what is meant by "the caretaker." Show Identity of the Caretaker, Transparency 6.
6. Explain the identity of the caretaker in terms of III C.
7. Students may:
   - Research and report in class the Maryland State definitions of child abuse and child neglect.
   - Research and report in class the Montgomery County definitions of child abuse and child neglect.
   - Research and write a brief paper on the statistical evidence of child maltreatment in society today.
   - Research and write a brief paper on the sociological evidence of child maltreatment in society today.
8. Conclude with assessment measures for Performance Objectives 1 and 2.

Suggested Classroom Activities and Procedures for Performance Objectives 3, 4, and 5

1. Restate Generalization II A and write on board for students.
2. Clarify the terms "abuse" and "neglect" in terms of "acts of commission" and "acts of omission."
3. Refer students to Definition of Terms (II.1).

ERIC

13. "Beaten, they can't fight back" (II.13)

14. "Mother talks of horror, seeking aid" (II.14)

15. "Law broadened to aid battered" (II.15)

16. "Case History"; "Case History" (II.16)

17. "Don't Shake the Baby" (II.17)

18. "Counter-Culture Kids" (II.18)

19. "Child Care in America" (II.19)

20. "Man's Problem: Learning to Be A Better Parent (II.20)

21. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

5. Definition of Child Maltreatment

6. Identity of the Caretaker

7. Typical Acts of Physical and Psychological Abuse

8. Typical Acts of Psychological Abuse Without Physical Abuse

9. Typical Acts of Physical and Psychological Neglect

10. Characteristics of Child Maltreatment

11. Typical Manifestations of Physical Abuse and Neglect in the Child (a and b)

12. Typical Manifestations of Psychological Abuse and Neglect in the Child (a and b)

Slides (Series 1 through 10)

A color slide series of photographed examples of child maltreatment is in preparation.

Films

Cipher in the Snow This dramatization of psychological abuse is based on the true story of a boy who no one thought was important until his sudden death one snowy morning. The story on which the film was based won first-place award in the N.E.A. Teachers Writing Contest.
Brigham Young University 1973 16mm color 23 min. MCPS Film Library #6571

Growth Failure and Maternal Deprivation This film shows physical and mental retardation in young children which may often result from lack of parental attention, especially from the mother. Two children, one thirteen months old and one almost four years old are shown as examples of failure-to-thrive. The circumstances under which these children lived and those aspects of the mother-child relationship thought to be responsible for their failure to grow and develop normally are discussed.
McGraw Hill 1966 16mm black/white 28 min. MCPS Film Library #4218

THE NATURE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (II.1)

1.	Physical	adj.	- 3: of or relating to the body
2.	Psychological	adj.	- 1: b: MENTAL
3.	Abuse	vt.	- 1: to attack in words 4: to use so as to injure or damage
	Abuse	n.	- 4: abusive language 5: physical maltreatment
4.	Neglect	vt.	- 1: to give little attention or respect to: DISREGARD 2: to leave undone or unattended to especially through carelessness
5.	Damage	n.	- 1: loss or harm resulting from injury to the person SYN: injury
6.	Injure	vt.	- 1a: to inflict bodily harm b: to impair the soundness of
7.	Paramour	n.	- an illicit lover

*Webster's New Collegiate Dictionary, 1974.

ERIC

(Transparency 5)

THE NATURE OF CHILD MALTREATMENT

*DEFINITION OF CHILD MALTREATMENT (II.2)

The Child Abuse Prevention and Treatment Act of 1974 (P.L. 93--247) defines child abuse and neglect as

> ".....PHYSICAL OR MENTAL INJURY, SEXUAL ABUSE, NEGLIGENT TREATMENT OR MALTREATMENT OF A CHILD UNDER THE AGE OF EIGHTEEN BY A PERSON WHO IS RESPONSIBLE FOR THE CHILD'S WELFARE UNDER CIRCUMSTANCES WHICH INDICATE THAT THE CHILD'S HEALTH OR WELFARE IS HARMED OR THREATENED....."

*DHEW Publication No. (OHD) 74-4, p.1

ERIC

(Transparency 6)

THE NATURE OF CHILD MALTREATMENT

*IDENTITY OF THE CARETAKER (II.3)

Natural parent

Adoptive parent

Step parent

Foster parent

Sibling

Parent's paramour

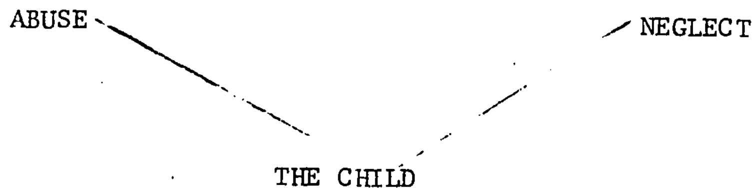
Relative

Babysitter

Staff of institution

Teacher

Other or unknown



*From the National Standard Form--0023, Children's Division
The American Humane Association, Denver, Colorado
Reprinted by permission

(Transparency 7)

THE NATURE OF CHILD MALTREATMENT

TYPICAL ACTS OF PHYSICAL AND PSYCHOLOGICAL ABUSE (II.4)

Burning, scalding or branding

Shaking

Biting

Kicking

Beating with hands

Beating with instruments

Exposing to elements

Locking out

Locking in or tying

Poisoning

Shooting

Drowning

Strangling or suffocating

Sexually abusing

Dismembering

Exploiting

Abandoning

ERIC

(Transparency 8)

THE NATURE OF CHILD MALTREATMENT

TYPICAL ACTS OF PSYCHOLOGICAL ABUSE AND/OR NEGLECT (WITHOUT PHYSICAL ABUSE AND/OR NEGLECT) WHICH MAY RESULT IN DAMAGE TO THE CHILD (II.5)

Unrealistic demands or pressures

Unequal sibling treatment

Consistently negative responses

Threats of extreme physical injury

Threats to withdraw love

Undermining self-esteem

Actively ignoring

Threats to abandon

Others

ERIC

(Transparency 9)

THE NATURE OF CHILD MALTREATMENT

TYPICAL ACTS OF PHYSICAL AND PSYCHOLOGICAL NEGLECT WHICH MAY RESULT IN DAMAGE TO THE CHILD (II.6)

Failure to provide life-sustaining nutrition

Failure to provide adequate medical care

Failure to provide necessary clothing

Failure to provide minimal shelter

Neglect of educational needs

Inadequate safety precautions

Drug addiction or alcoholism during and after pregnancy

Exposure to immoral conduct

Gross indifference or lack of concern

Absence or withdrawal of love

Intermittent or prolonged physical absence

Unequal sibling treatment

Others

130

(Transparency 10)

THE NA URE OF CHILD MALTREATMENT

CHARACTERISTICS OF CHILD MALTREATMENT TODAY (II.7)

Tends to increase in severity and frequenty

Often focusses upcn one child at a time

Inappropriate to the developmental age of the child

Inappropriate for the occasion or circumstance

Disregards the physical and psychological (emotional) needs f the child

RESULTS IN DAMAGE TO THE CHILD

(Transparency 11 a and b)

THE NATURE OF CHILD MALTREATMENT

*TYPICAL MANIFESTATIONS OF PHYSICAL ABUSE AND NEGLECT IN THE CHILD (II.8)

Abrasions

Contusions

Sprains, dislocations

Malnutrition

Ill kempt

Filthy

Improperly clothed for weather conditions

Growth retardation

Lacerations

Congenital drug addiction

Failure-to-thrive

Whiplash

Evidences of medical neglect

Brain damage

Bone fractures

Internal injuries

Subdural hematoma or hemorrhage

Dismemberment

Absence of clothing

Bruises, burns, welts

*NOTE: Similar manifestations may arise from other causes.

(Transparency 12 a and b)

THE NATURE OF CHILD MALTREATMENT

*TYPICAL MANIFESTATIONS OF PSYCHOLOGICAL ABUSE AND NEGLECT IN THE CHILD (II.9)

Disturbed eating habits, e.g., irregular, too much, too little

Nightmares

Bedwetting, soiling

Extreme passivity

Extreme agressiveness

Antisocial behavior, e.g., stealing, fire-setting, addiction, violence

Apathy or withdrawal

Infantile behavior, e.g., infantile speech, thumbsucking

Stuttering

Loss of speech

Growth retardation

Mental retardation

Academic failure

Temper tantrums

Social retardation

Delayed motor development

Hypersensitivity (auditory and/or visual)

Sadomasochistic behavior

Failure-to-thrive

Abnormal fears

*NOTE: Similar manifestations may arise from other causes.

ERIC

Signs of Trouble Preceded Death of Boy, 4

By Elizabeth Becker
Washington Post Staff Writer

The week before 4-year-old Shawn Abbey was killed, a school nurse had treated bruises all over his body and strongly suspected that his was a case of child abuse. During that week his mother took an uncommon four-day absence from work. Relatives were barred from Shawn's apartment at gunpoint by his mother's boyfriend and neighbors heard frequent cries and pleadings from a woman and child in that fifth-floor apartment in City Lane Towers just across the District line in Suitland.

Nearly everyone associated with them appeared to believe that there was serious trouble between Glenda Abbey, her son Shawn and her boyfriend Michael Leonard but before they could move to help out, the boy was dead. On Friday a bloated body weighed down by concrete blocks was fished out of the Potomac River and identified as Shawn Abbey. His mother, Abbey, 23, and Leonard have been charged with Shawn's murder.

GLENDA ABBEY
..."really well liked"

"You can't begin to understand what Shawn's case has done to us," said Austine Fowler, director of the Anacostia Pre-School program where Shawn was enrolled. "We only knew him for a short time but he was a very articulate child, extremely bright, and he loved school."

A week ago Thursday, Shawn came to school with two black eyes and bruises all over his body after a six-day absence. He "wouldn't let his teacher out of his sight" and clung to her skirts when she escorted him to the health office where a nurse examined him and asked how he had been hurt, Mrs. Fowler said.

"He gave us two or three stories — the nurse couldn't shake the truth from him — and he had to stay out of school because he had two black eyes," Mrs Fowler said. "He wanted to come back. We told the gentleman who picked him up we would follow up the next day but the next morning we got a call that Shawn had a fever and wouldn't be coming in."

SHAWN ABBEY
...found in river

When school officials called the D.C. police youth division on Monday with information on Shawn, they were told to contact the missing person bureau.

See ABBEY, B5, Col.1

On Tuesday, while she was directing the volunteer search around the apartment building at 3901 Suitland Rd., D.C. city councilwoman Willie Hardy was told by neighbors that they had heard cries from a woman and child in the Abbey apartment the week before but no one had reported it to the police.

"Most of them told us of screaming and beatings, even people who had known the family for some time," Mrs. Hardy said. "They also said that the mother had told them of her fear for her boy."

A middle child in a family of twelve, Glenda Abbey met with her sisters often but that last week before Shawn's death she didn't appear when two sisters came to call. Instead, Leonard answered the door and refused to let them in, pointing a gun at one of the sisters, Marcella Richardson, when she tried to come in that last Saturday.

"She tried to leave him...but Glenda Abbey said he tied her down on the bed and sliced her thighs and arms with razor blades," an elder sister, Alvina Moore, said.

A Catholic family that has lived in the District for three generations, the Abbeys say they are a close-knit family that cherishes children. There are 36 grandchildren and great-grandchildren living in the area. A woman who worked with Glenda Abbey at Washington's United Planning Organization said Miss Abbey took part in many of the family outings at Ft. Washington Park where the family brought buckets of fried chicken, potato salad, cases of soda but no liquor - "liquor was never put down in their mother's house."

"She was really just starting to get it together. She had entirely too much going for her to do something like that," said her brother Jose Abbey. She is a beautiful person...when I was in Vietnam there wasn't one mail call that I didn't receive a letter from her."

Educated in District public schools, Glenda Abbey has been working as a "girl Friday" at UPO for four years. She coordinated fund raising events, including a clothing drive she directed during her free-time, and was named first runner-up in a Miss UPO beauty contest.

"She was very dependable. She'd only be absent if Shawn was sick or she was sick," said Yvonne Better, the coworker. "She was really well-liked...she'd bring in big bowls of potato salad to work...that's why the whole staff showed up at the courthouse" for her bond hearing last week.

Coworkers and the family knew that Glenda was having problems with her boyfriend and for almost two years Shawn had been living with Glenda Abbey's sister, Patheresa Lewis, about the same time period that Glenda had been with Leonard. Five weeks ago the boy moved in with his mother and her boyfriend.

"Glenda always provided for Shawn, she took good care of him and he got on perfectly with his cousins," said Mrs. Lewis. "Normally most kids have to wait for Christmas or presents but Glenda got him everything he saw on television. Each year she gave him a big birthday party with 40 or 50 children."

It was this affection that her brother Jose believes was a deep problem: "There was a lot of jealousy involved . . . Glenda was showing too much favor to her son and not enough to Mike."

The Washington Post
October 26, 1975
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The Washington Post
April 3, 1976

Boys Taken From Home AfterBeating

An 8-year-old Prince George's boy and his 6-year-old brother have been removed from their home after the boys were apparently beaten with a belt and extension cord, police reported.

Police said the two Seabrook boys were temporarily placed in foster care after appearing at school with severe slash marks. The older boy had 28 marks and the younger had 50, the police said.

The abrasions were reported to police by the boys' elementary school principal. Under Maryland law, educators, social workers, and health practitioners must report to police any case of suspected child abuse. The law grants immunity from liability to those who report such cases, even if no abuse can be proved.

Private citizens who believe a child is being abused may also [illegible] police or social services about the problem without fear of lawsuit, according to Maryland law.

Boy Spurned

LONDON—Spurned by his mother and stepfather in Israel, a 12-year-old English boy returned to Britain for adoption by an uncle.

Lee Borrett, 12, had plaintively asked, "Why does nobody want me?" when he was left to fend for himself after arriving in Israel Sunday to be reunited with his mother, who had remarried there. His father left her before he was born. The boy had been living with his grandmother.

His stepfather, engineer David Bromand, 39, met him at Israel's Lod Airport,

pushed some money down his shirt and, according to witnesses, said. "I don't want you. I'm not interested in you."

The boy's mother, Angela, said, "He has got to go home. He must go back. My husband will not allow Lee to stay here." The grandmother had paid the one-way ticket to Israel because the boy pined for his mother.

Reprinted by permission of The Washington Post

The Washington Post, February 23, 1976

Infant, 2, Dies, Sitter Is Held

RICHMOND, Feb. 23 (AP)—Tunney Lamont Hanks, 2, who suffered third-degree burns Feb. 14 when he allegedly was placed in a bathtub of scalding water, died Saturday of complications from the injuries, police said Monday.

Police said the child allegedly had been beaten with a belt as punishment for unrolling toilet paper, and then was placed in the hot water after soiling his pants.

The child's mother had left him with a friend, who in turn had left him with a 16-year-old youth for the afternoon, according to police. The 16-year-old baby sitter was charged with felonious assault and released in custody of his parents pending an April 1 hearing in juvenile court.

Reprinted by permission of The Associated Press

Child-beating death draws man 10 years

A 24-year-old former police cadet and security guard was given a 10-year prison term yesterday for child abuse and second-degree murder in the beating death of his girl friend's 4-year-old son December 20.

William D. Dove 3d, of the 100 block South Catherine street, admitted causing the death of Darryl Richards, of the 300 block McMechen street, whom he was babysitting at the time the boy was beaten with a belt and received an intestinal perforation.

Dove expressed his grief over the death of the victim and said, "If I could give my life in exchange for his, I would do so."

Judge Solomon Liss replied that he was "sorry that can't be arranged." Judge Liss said he did not believe that Dove is vicious but that he is in need of psychiatric treatment.

Neil [illegible], the prosecutor, told the court that Dove was babysitting for his girl friend, who works in the main Post Office, at 11.30 P.M. when

See COURT, C2, Col. 1

he discovered that the boy had wet the bed.

The boy was ordered to the bathroom, but became nauseated, and the security guard beat him with the belt causing the intestinal injury, it was stated.

Young Darryl then was put back in bed, but he awoke at about 5 A.M. and was found to be cold and barely breathing, Mr. Steinhorn told the judge. The victim died in the University Hospital.

Dore was a police cadet from 1971 and 1973 and thereafter was employed as a security guard.

THE SUN, Tuesday, May 18, 1976

Reprinted by permission of The Sun (Baltimore, Md.)

THE SUN

Tuesday, May 18, 1976

Mother admits failure to feed son, who died a 'vegetable' of 8 pounds

A 27-year-old mother of four children pleaded guilty yesterday to abusing her 7-month-old son by failing to feed the child, causing his death in April, 1975.

"I failed to give him all the attention I was supposed to because I was drinking and drunk all the time," Cynthia Bernice Pitts, of the 1500 block Argyle avenue, had told police in a signed statement offered into evidence by H. Gary Bass, the prosecutor.

The woman, a convicted prostitute, pleaded guilty to child abuse and manslaughter in the death of Kevin Pitts. She contended the death of the boy's father from overeating crabs and watermelon caused her to become angry and despondent and to neglect the boy.

Her three other children, including twins, are 4 and 5 years old and were fathered by James Walter Pitts, 51, with whom she lived, Mr. Bass said. She also had been dating the father of young Kevin at the same time, Judge Solomon Liss was told.

Judge Liss deferred sentencing pending medical and probation reports.

A medical report submitted to Judge Liss disclosed that when the boy was taken to a hospital he was a "living vegetable" and showed no brain action in a brain-wave test. The infant victim weighed 8 pounds when he died at University Hospital.

2 Infants Found In Trash Can

LOS ANGELES (AP) — Two abandoned newborn infants were in good condition yesterday as police sought clues to their identities.

The boy and girl, found abandoned 13 hours apart Frixay, were at County-USC Medical Center. A nursing supervisor said both babies were doing well.

Police in Pasadena, where the girl was found in a trash can, and in suburban Downey, where the boy was found in a paper sack on a lawn, said they had no leads on the identifies of the babies.

Reprinted by permission of the Associated Press.

The Washington Star, June 9, 1975

Newborn Baby Is Found Left In Trashcan

BIRMINGHAM, Ala. (UPI) — A newborn baby girl, found abandoned and struggling for breath in a bathroom trash can at a restaurant, was reported doing "absolutely fine" yesterday and police said they had located the mother.

"We know who the mother is," said police Lt. Francis Sartain, head of the Birmingham Youth Aid Division. "She is a 17-year-old girl. She is a juvenile under Alabama law, and we cannot release her name.

"I don't know her marital status, but she probably was not married," Sartain said. "She has been undergoing medical treatment. We don't know why she abandoned the child."

A spokesman at the University of Alabama Hospital said the mother was "in a local hospital, but I am not allowed to say which one."

Reprinted by permission of United Press International

The Washington Star, June 30, 1975

Beaten, they can't fight back

The Home News, January 12, 1976

By JOAN HRITZ
Home News staff writer

NEW BRUNSWICK — "Abusive parents are not necessarily monsters. They have a need for understanding, compassion, sympathy and help."

Doctors and nurses attending the Protective Services Resource Institute at St. Peter's Medical Center were asked by Dr. Christian M. Hansen to keep that statement in mind as he talked about the victims of child abuse and neglect.

Dr. Hansen, a member of the

parent brings a child to the hospital for aid, it can mean that "the parents are subsequently asking for help."

He referred to the natural repugnance nurses and doctors feel when they confront an abusive parent, but reminded them that the parents may, themselves, have been abused as children.

"The battered child often becomes the battering parent of the next generation," he said of this truly vicious cycle.

The cycle is known officially

The parents have unrealistic expectations of their children, who cannot possibly meet the needs of these troubled adults. The children are constantly being punished for this. Often present is a reversal of roles, with the parent expecting the child to take over his or her role.

The parents display a lack of trust and have a feeling of isolation. They feel they are no good to anyone and cannot help others. Their children are denied a true childhood.

Another had been severely beaten with a strap or belt. Some parents "feel they have a constitutional right" to discipline by beating, the doctor added.

An 18-month-old boy, starved as a punishment, closely resembled the victims photographed in Nazi concentral camps. Three weeks later, after receiv-

NEW BRUNSWICK, N.J. TUESDAY, JANUARY ... Home News 5

Child abuse

Mother talks of horror, seeking aid

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EDITOR'S NOTE: Second in a four-part series on the subject of child abuse. Today's installment is one woman's story on the way she felt when she abused her own child and how she sought help.

By JOAN HRITZ
Home News staff writer

NEW BRUNSWICK — Lee is 27 years

She remembers envying a neighbor who seemed to be able to "handle evrything," including home and children, without getting rattled.

Lee began abusing the boy verbally and physically and to set up situations in which the child would "earn" punishment. "I wanted to throw him down the stairs," she says. On one occasion, a blow from her

...e children and had ... over her actions. ... as you have guilt ...etimes she wanted ...ays had that guilt

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Child abuse

The Home News
January 15, 1976

Law broadened to aid battered

Reprinted by permission

Last in a series of articles on child abuse. Today's installment deals with the legalities involved in protecting the children.

By JOAN HRITZ
Home News staff writer

NEW BRUNSWICK — New Jersey's concern for abused or neglected children dates back to the 19th century, but this concern was translated into action

val with consent of the parents, in which a child may be removed if a complaint is filed in Juvenile and Domestic Relations Court within three court days;

Removal without parental consent, but with a court order, providing a formal complaint is filed within thr3e days unless the child is returned home sooner;

plaint of neglect or abuse it may elect either to return the child to the home, with certain restrictions and conditions imposed upon the parent or guardian for the child's welfare, or to order the child placed in substitute care temporarily, out of the home.

An out-of-home placement order may be issued for 18 months, with successive exten-

DYFS, regardless of whether any attempt is being made to remove the child.

If the incident occurs outside of regular 9 a.m. to 5 p.m hours, it should be reported to the division's Office of Child Abuse Control, which provides a 24-hour emergency hotline for reporting such incidents. The toll-free number is Area Code 800 792-8610

NEW BRUNSWICK, N.J., TUESDAY, JANUARY 13, 1976 [illegible] 5

Case history

Karen J. was a two-year-old who was referred by an orthopedist for an evaluation of multiple fractures of both legs. These were said by the mother to be the result of the child's crib falling to the ground three times at home.

It was apparent that the referring physician never suspected willful battering by the parents. X-rays revealed old, healing fractures of other bones and the radiologist made a definite statement to the effect that these findings were the results of multiple trauma.

from home when she was 14, became pregnant and married a Mr. J., whom she left two years ago because of his heavy drinking and general irresponsibility.

Then she met her present husband, who was separated from his wife after nine years of marriage. She then became pregnant and married her present husband one month after the baby's birth.

The mother attributed their problems to not having enough money, especially since they were expecting a new baby.

Case history

Barbara L. was a three-month-old who was hospitalized because of seizures. She was said to have been found by her parents, twitching at home after a feeding.

Examination showed a comatose infant with large bruises on her l[illegible] and signs of increased intracranial pressure. X-rays revealed old fractures to such a degree that the medical staff felt that they could not have been caused by a fall from a short height.

The parents gave three differing histories of how the injuries occurred, none of which could account for the severity of the clinical picture.

Further history revealed that the parents had adopted this infant and that the mother had been under psychiatric care at the time. This fact had not been mentioned by any of her references. The parents were described as being a nice young couple.

The adoption had been disputed by the physician who delivered the baby, but it was felt that investigation of the new parents was not careful enough by the adoption

Don't Shake the Baby

At the sight of a new baby, some well-meaning adults seem to feel an irresistible urge to pick up the infant and jiggle it, or even toss it in the air. As a toddler, the same child may be shaken vigorously by the shoulders when his parents are angry with him. These common practices can be quite dangerous, a Pittsburgh pediatrician cautions: in fact, shaking a baby younger than 2 years old may cause severe brain damage—or even death.

A young child's head, explains Dr. John Caffey, is relatively heavy, and his neck muscles are weak. Under the stress of being tossed in play or shaken in anger, the baby's head flops about freely, creating a high risk of massive bleeding from the blood vessels that supply the brain. Such bleeding can result in a subdural hematoma, a condition in which membranes form around the brain and prevent it from growing. With early

Tony Rollo—Newsweek

Child's play: Handle with care

death, and autopsies of the infants showed that they had indeed died of brain hemorrhaging. Dozens of other babies cared for by the same woman grew

mmune kids differed from nd Bernsie in their remarka- ducation. With the exception , the strict therapeutic com- orthern California, the com- kids free to learn or not learn. the latter. The children were red "not to get into college. d," says Rothchild. Even so. hat the "children of rural vere not basket cases. Intel- vas nonexistent there, but for ure other ways to live." Still. Rothchild wonder whether en will ever be able to enter ream of American life—if in- ver want to.

Their travels made the authors exam- ine their goals as parents. "I'm much tougher," says Rothchild. Wolf, im- pressed by the self-reliance of many of the commune kids, says she "learned to ask more from my children than I thought I could have." Yet the couple decided that tribal living was not for them. "Commune parents wanted a kind of emotional goodness for their children which they gave them at the cost of the self-centered drive that leads to personal achievement," they concluded. "We couldn't see famous writers or scientists coming out of that generation of ragamuf- fins. We still had that self-centered drive, that urge for private fantasy and mental exercise." Liberation, in short, can be a very confining experience.

—MARY ALICE KELLOGG

K. March 29, 1976
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With the advent of scientific thinking came several experts to theorize about child development. Dr. John B Watson, a behavioral psychologist, believed that children could be trained like animals by "conditioned reflex," and thus behave in certain obedient ways. Many parents used Watson's techniques to toilet train, feed, and teach chores to their children. A minimum of open affection went along with this philosophy.

In the mid-1930's, the rigidity of Watson's thinking was replaced by more democratic beliefs. Publications, parent associations, and pediatricians were prolific — most embracing a more permissive attitude.

The most important child care manual to come out of this century was Dr. Benjamin Spock's *Baby and Child Care* — the parents' bible since its publication in 1946. Dr. Spock outlined methods for the physical, emotional, and social upbringing of the modern child. This famous baby expert suggested a gentle but firm hand, rather than total permissiveness, to instill responsibility.

The second half of this century fostered many new child care theories from psychologists, sociologists, child care laboratories, and even the government. But tho... children today have many more rights and comforts, they still share some of the same gripes and problems faced by their colonial ancestors.—P.C.

**A History of Child Rearing in America;* Charles Scribner's Sons, New York, 1975.

Photographs courtesy of the New York Public Library

Man's Problem: Learning to Be A Better Parent

By Thomas Grubisich
Washington Post Staff Writer

EQUIPPED WITH a bigger brain, man has frequently outsmarted creatures beneath him on the evolutionary scale. But not always

Take, for example, being a parent Compared with his inferiors in the animal world, say, the monkey, chimpanzee or elephant, man makes a poor parent. And not just contemporary man, the befuddled target of lecturing grandparents and patronizing how-to-be-a-better-parent books.

According to Dr. Dan Leviton, profes-

DeMause also mentions the frequent practice of terrorizing children with stories, many legitimized into classics, where their peers were eaten raw, torn to pieces, held over the pit of hell and had the blood sucked from the marrow of their bones, presumably to make them "less rash and ungovernable" (quoting the ancient writer Dio Chrysostom).

Why has man so often been a poor parent"

Leviton thinks so because man, while frequently the master of his environ-

But Leviton said he chose the words peace and love deliberately because he feels that while there has been voluminous study into aggression and abuse, there has been little research into the positive aspects of child rearing.

The course would emphasize the importance of body contact between parent and child because "skin contact transmits love, it tells the child he's worthwhile."

Leviton sees potential problems in the increasing reliance on day-care center when both parents work. Too often, he said, chilren are kept busy with crayons and paper and other activities that don't involve contact between the child and teacher who is the substitute parent.

Unabashedly stressing peace and love, Leviton said he doesn't doubt his course "will be viewed as grandiose

TREATMENT (II.20)
30, 1975

UNIT III

The Episode of Child Maltreatment

ERIC

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective for Unit III

THE STUDENT WILL BE ABLE TO DESCRIBE THE COMPONENTS IN AN EPISODE OF CHILD MALTREATMENT.

Generalizations for Unit III

A. The episode of child maltreatment is attributed to a potentially abusive or neglectful caretaker, to a potentially vulnerable child, and to stress as the "triggering" mechanism.

B. The episode of child maltreatment may also include a passive partner and/or sibling on-looker(s).

C. The potentially abusive or neglectful caretaker is representative of a cross-section of any community in terms of race and/or social or economic status.

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7. IDENTIFY the potentially abusive or neglectful caretaker.

8. STATE the characteristics of the potentially abusive or neglectful caretaker.

9. IDENTIFY the potentially vulnerable child.

10. STATE the characteristics of the potentially vulnerable child.

11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.

12. STATE the meaning of the term "stress" in relation to time (duration).

13. LIST the characteristics of stress.

14. CLASSIFY the kinds of stress.

15. DESCRIBE the origins of stress.

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UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization A and B

1. LIST the components in the episode of child maltreatment.
2. EXPLAIN the role of the caretaker.
3. EXPLAIN the role of the child.
4. EXPLAIN the role of stress.
5. EXPLAIN the role of the passive partner.
6. EXPLAIN the role of sibling on-looker(s)

2. The role of the potentially vulnerable child

   a) All children are potentially vulnerable. (See I B Sample Content 1, 2, and 3)

   b) Some children are more vulnerable than others. (See I C; II B)

3. The role of stress as the "triggering" mechanism

   a) Stress may "trigger" action or inaction; i.e., abuse or neglect. (See II A and C)

   b) Individuals differ in their ability to cope with stress. (See I C)

4. The role of the passive partner

   a) Intervention by the partner may be possible. (See Unit II Case Histories.)

   b) Absence of intervention by the partner will:

Suggested Classroom Activities and Procedures for Performance Objectives 1 through 6

1. Review II. The Nature of Child Maltreatment.
2. Introduce Generalization III A and B and write on board for students.
3. Use a variety of techniques to clarify student understanding of the Definition of Terms (III.1a) 1 through 6 as appropriate.
4. Utilize the following to develop student understanding of the role of the potentially abusive or neglectful caretaker:

   Identity of the Caretaker, Transparency 6

   I B Sample Content 4

   Questions and Answers (I.4)

   Dysfunctions of Society, the Family, and the Individual (I.6)
5. Write III A Sample Content 1 on the board for students.
6. Utilize the following to develop student understanding of the role of the potentially vulnerable child:

   Typical Manifestations of Physical Abuse and Neglect (II.8) or Transparency 11a and b

   Typical Manifestations of Psychological Abuse and Neglect (II.9) or Transparency 12a and b

   I B Sample Content 1, 2, 3; I C; II B
7. Write III A Sample Content 2 on the board for students.
8. Discuss the negative aspects of stress in society, the family, and the individual.
9. Utilize the following to develop student understanding of the role of stress as the "triggering" mechanism:

   Unit II Generalizations A and C

   Unit I Generalization C
10. Have students read and discuss "How a Baby Learns to Love" (III.8) in relation to III A Sample Content 1 through 3 and Interpretations of

the Nurturing Experience (III.1b) Clarify student understanding of the term "nurturing." See Definition of Terms (III.1b)

11. Have students read and discuss "How To Conquer Stress" (III.10) and "Holiday Season Filled With Child Abuse" (III.13) in relation to III A Sample Content 1 through 3.

12. Refer students to Typical Manifestations of Psychological Abuse and Neglect (II.9) and discuss the possible role of the child as the stress factor.

13. Focus class attention on Generalization III B.

14. Write III B Sample Content 4 on board.

15. Utilize selected case histories from Unit II for class discussion of the role of the passive partner in relation to III B Sample Content 4.

16. Discuss the alternatives for the passive partner. (See VI A.)

17. Utilize the following to develop student understanding of the role of sibling on-looker(s):

    II C Sample Content 1 and 2

    IV D

18. Summarize utilizing Transparency 13 The Episode of Child Maltreatment and Transparency 10 Characteristics of Child Maltreatment

19. Conclude with assessment measures for Performance Objectives 1 through 6.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization C

7. IDENTIFY the potentially abusive or neglectful caretaker.

8. DESCRIBE the characteristics of the potentially abusive or neglectful caretaker.

Generalization C

THE POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER IS REPRESENTATIVE OF A CROSS-SECTION OF ANY COMMUNITY IN TERMS OF RACE AND/OR SOCIAL OR ECONOMIC STATUS.

Sample Content

1. The Potentially Abusive or Neglectful Caretaker
   a) Frequently (90%)
      1) The emotionally immature
      2) The punitive and authoritarian
      3) The psychoneurotic

b) Less frequently (10%)

1) The psychopathic

2) The mentally impaired

2. Characteristics of the Potentially Abusive or Neglectful Caretaker may be:

a) Abused or neglected in infancy or childhood

1) Deprived of a nurturing experience in infancy or childhood

2) Conditioned toward violence in human behavior

b) Isolated by choice or circumstance

c) Lacking self-esteem

d) Lacking understanding of the normal physical and psychological stages of child development

e) Unable to cope with stress

Suggested Classroom Activities and Procedures for Performance Objectives 7 and 8

1. Review the following:

Appropriate definition of terms (III.1a)

Identity of the caretaker (II.3)

Role of the caretaker

2. Introduce Generalization III C and write on board for students.

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3. Develop student understanding of III C through utilization of:

   Review of Unit I B Sample Content 4

   Questions and Answers About Child Maltreatment (I.4)

   Dysfunctions of Society, the Family, and the Individual (I.6)

4. Show Transparency 14a

   Emphasize "NOTE" on transparency and generality of terms.

   Clarify student understanding of terms.

   Emphasize the 90% in relation to III C.

5. Conduct class discussion of the 90% in relation to <u>The Criteria for Emotional Maturity</u> (III.4).

6. Conduct class discussion of the 90% in relation to Interpretations of the Nurturing Experience (III.1b).

7. Conduct class discussion of the 90% in relation to the role of stress as the "triggering" mechanism. See III A Sample Content 3.

8. Conduct class discussion of the 90% in relation to the child as the stress factor. See II.9.

9. Conduct class discussion of the 90% in relation to The Phenomenon of Child Maltreatment (I.6).

10. Repeat activities 5 through 9 using the 10%.

11. Write III C Sample Content 1 on board for students.

12. Show Transparency 14b.

    Clarify student understanding of terms.

    Emphasize "NOTE" on transparency.

    Point out that the characteristics noted may be found also in the caretaker who is neither abusive nor neglectful.

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13. Develop student understanding of the characteristics of the potentially abusive or neglectful caretaker as follows:

For Sample Content 2 a) see IV D and I C:

a) The caretaker deprived of a nurturing experience in infancy or childhood may experience difficulty in the adult nurturing role.

b) The caretaker conditioned in childhood toward violence in human behavior may adopt a behavior pattern of violence in later life. (See also the role of the sibling on-looker.)

For Sample Content 2 b) see II Case Histories and I C:

a) The caretaker may be isolated by choice; i.e., the social isolate.

b) The caretaker may be isolated by circumstances; e.g., absence of supportive person(s), friends, the extended family, pastor.

For Sample Content 2 c) see II Case Histories; I C; and the role of stress as the "triggering" mechanism.

a) Stress is ever present; i.e., a fact of life, both positive and negative.

b) Stress may trigger action or inaction; i.e., abuse or neglect.

c) Individuals differ in ability to cope with stress (II.4, 5, and 6).

d) The child as the stress factor (II.9)

For Sample Content 2 d) see I C and II C:

a) Lack of understanding as a dysfunction of society, the family, or the individual

b) Lack of understanding resulting from custom or oral tradition in child-rearing practices (I A)

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For Sample Content 2 e) develop student understanding of:

a) Origins of self-esteem

b) Self-esteem in relation to ability to cope with stress

c) Self-esteem in relation to dysfunctions of society, the family, and the individual

14. Students may:

- . Invite a resource speaker (child psychiatrist) to address aspects of Sample Content 2 e) in relation to the infant nurturing experience and/or the after effects of maltreatment in infancy or early childhood
- . Carry out independent research on the development of self-esteem in the individual
- . Read and discuss (or write a brief review) "Working with Abusive Parents -- A Social Worker's View/A Psychiatrist's View" (VI.11)
- . Review and discuss VI C Sample Content 1 and 2
- . Read and discuss "Child Care by Adolescent Parents" (III.11) in relation to characteristics of the potentially abusive or neglectful caretaker
- . Research resources for the caretaker in Montgomery County
- . Read and discuss "How A Baby Learns to Love" (III.8) and 'Battered' Babies, Birth Without Violence (III.9) in relation to a) Interpretations of the Nurturing Experience (III.1b) and b) the development of self-esteem

15. Conclude with assessment measures for Performance Objectives 7 and 8.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization D

9. IDENTIFY the potentially vulnerable child.
10. DESCRIBE characteristics of the potentially vulnerable child.
11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.

Generalization D

THE POTENTIALLY VULNERABLE CHILD MAY BE AN EXCEPTIONAL OR DEMANDING CHILD OR A NORMAL CHILD.

Sample Content

1. The potentially vulnerable child
   a) The exceptional or demanding child
   b) The normal child
2. Characteristics of the potentially vulnerable child
   a) The exceptional or demanding child may be:
      1) Precocious or gifted
      2) Physically or mentally impaired
      3) Premature
      4) Emotionally disturbed
      5) Others

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b) The normal child may be:

1) Stepchild
2) Foster child
3) Adopted child
4) Illegitimate
5) Undesired sex
6) Conceived prior to marriage
7) Sibling position (oldest; youngest, etc)
8) Unwanted pregnancy
9) One of twins or triplets
10) Others

3. Characteristics of the potentially vulnerable child from the viewpoint of the caretaker:

"too dumb"

"too smart"

"too slow"

"too burdensome"

"too independent"

"too dependent"

"too hard-to-comfort"

"needs too much comforting"

"poor eater"

"finicky"

"willful"

"stubborn"

"bad"

"spoiled"

"disobedient"

"whiney"

"fussy, irritable"

"smart aleck"

Suggested Classroom Activities and Procedures for Performance Objectives 9, 10, and 11

1. Review the role of the potentially vulnerable child:

    III A Sample Content 2

    I B Sample Content 1, 2, and 3

    I C

    II B

2. Introduce Generalization III D, and write on board for students.

3. Clarify student understanding of the terms.

4. Show Transparency 15a.

    Discuss selected case histories from Unit II in terms of the exceptional or demanding child.

    Discuss the exceptional or demanding child in relation to the Identity of the Caretaker (II.3)

    Discuss care of the exceptional or demanding child in relation to The Criteria of Emotional Maturity (III.4) and III.1b.

    Discuss the exceptional or demanding child in relation to the role of stress as the "triggering" mechanism.

    Discuss the exceptional or demanding child in relation to the role of the potentially vulnerable child as the stress factor.

    Emphasize NOTE on the transparency.

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5. Write III D Sample Content 1 a) and b) on board for students.

6. Show Transparency 15b.

   Discuss selected case histories from Unit II in terms of the normal child.

   Discuss the normal child in relation to the Identity of the Caretaker (II.3)

   Discuss care of the normal child in relation to <u>The Criteria of Emotional Maturity</u> (III.4)

   Discuss care of the normal child in relation to the role of stress as the "triggering" mechanism (III A Sample Content 3).

   Discuss care of the normal child in relation to the role of the potentially vulnerable child as the stress factor.

   Emphasize NOTE on transparency.

7. Write III D Sample Content 2 on board for students.

8. Distribute copies of III D Sample Content 3 and have students try to identify whether an a) exceptional, b) demanding, or c) normal child is being described.

9. Discuss the exceptional, demanding, or normal child in relation to characteristics of the potentially abusive or neglectful caretaker.

10. Students may:

   - Invite a speaker to talk about resources for the maltreated child in Montgomery County

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- Research resources for the maltreated child (See VI B Sample Content 1 and 2)
- Write a paper on dysfunctions in society, the family, or the individual in relation to the potentially vulnerable child
- Review and discuss Characteristics of Child Maltreatment Today (II.7)
- Review and discuss Typical Manifestations of Psychological Abuse and Neglect in the Child in relation to the exceptional or demanding child and the normal child (See II.9.)
- Roundtable discuss the potentially vulnerable child in relation to custom or oral tradition in child-rearing practices
- Invite a resource speaker (e.g., Child Development teacher) to discuss parenting skills for the normal child versus those for the exceptional or demanding child
- Research educational opportunities in Montgomery County for the development of parenting skills
- Invite a resource speaker (e.g., Special Education teacher) to discuss parenting skills for the exceptional child or demanding child versus those for the normal child.
- Invite a resource speaker (e.g., pediatrician, child psychiatrist) to discuss parenting skills for both the exceptional or demanding and the normal child.

.1. Conclude with assessment measures for Performance Objectives 9, 10, and 11

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UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization E

12. STATE the meaning of the term "stress."
13. LIST the characteristics of stress in relation to time (duration).
14. CLASSIFY the kinds of stress.
15. DESCRIBE the origins of stress.

Generalization E

STRESS, THE "TRIGGERING" MECHANISM, MAY ORIGINATE WITHIN SOCIETY, THE FAMILY, OR THE INDIVIDUAL.

Sample Content

1. Definitions of stress:
   a) Physical, mental, or emotional strain or tension within the individual
   b) Any condition or situation which produces strain or tension within the individual
2. Characterization of stress in relation to length of time (duration)
   a) Minutes, hours
   b) Days, months
   c) Years, indefinitely

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3. Kinds of stress:

    a) An influence or influences

    b) An event or events

    c) A person or persons

4. Origins of stress:

    a) Within society (I C Sample Content 1)

    b) Within the family (I C Sample Content 2)

    c) Within the individual (I C Sample Content 3)

<u>Suggested Classroom Activities and Procedures for Performance Objectives 12 through 15</u>

1. Discuss briefly the positive and negative effects of stress, using general examples unrelated to maltreatment.

2. Review the role of stress as the "triggering" mechanism in the episode of child maltreatment. (III A Sample Content 3)

   Have students read and discuss III.10 and III.11.

3. Introduce Generalization III E, and write on board for students.

4. Clarify student understanding of the term <u>stress,</u> using III E Sample Content 1 a) and b).

5. Have students list examples of stress in relation to duration, using III E Sample Content 2 a) Minutes, hours; b) Days, months; c) Years, indefinitely.

   Write student examples on board according to the three categories above.

6. Emphasize the importance of an in-depth understanding of all aspects of stress, since stress is identified as one of the controlling factors in both child abuse and child neglect, physical as well as psychological or emotional.

7. Develop student understanding of the possible kinds of stress, using examples of III E Sample Content 3:a) An influence or influences; b) An event or events; c) A person or persons.

8. Have students use stress examples which they have listed according to duration (see #5 above) and regroup these examples into categories according to kinds of stress.

9. Refer students to III.3 and discuss examples of stress according to duration and kind in relation to the potentially abusive or neglectful caretaker.

10. Restate III E Sample Content 4, and refer students to Dysfunctions in Society, the Family, and the Individual (I.6) to develop student understanding of the origins of stress in relation to duration and kind.

15. Students may:

- Make a collage of stress examples according to duration, kind, or origin
- Discuss case histories from Unit II in relation to stress factors
- Make a chart similar to Transparency 17c, using many examples
- Invite a resource speaker (e.g., psychologist) to talk about the positive and negative aspects of stress upon the individual
- Invite a resource speaker (e.g., psychiatrist) to talk about individual coping mechanisms for stress
- Research offerings of the Montgomery County Mental Health Association for coping with stress
- Research possible areas of dysfunction in Montgomery County such as a) economic conditions; b) environmental conditions; c) social values; and d) institutions in relation to stress as the "triggering" mechanism
- List and discuss some of the controlling factors in individual ability to cope with stress
- Invite a member of the Montgomery County Child Protection Team to

EVALUATION

for

III. The Episode of Child Maltreatment

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2, AND 3 --
UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization A, B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. LIST the components in an episode of child maltreatment.	Fill in blanks: The components in an episode of child maltreatment include ________, ________, ________, and often ________ and ________.	The student will give correct information by utilizing the resources listed below: III Generalization A and B III.1a Transparency 13
2. EXPLAIN the role of the caretaker in an episode of child maltreatment.	Explain the role of the caretaker in two ways.	III A Sample Content 1 III.1a and 1b I B Sample Content 4 I.4 and I.6 Transparency 6 (10,13)
3. EXPLAIN the role of the child in an episode of child maltreatment.	Explain the role of the child in two ways.	III A Sample Content 2 III.1a and 1b I C I B Sample Content 1 - 3 II B

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 4, 5, AND 6 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization A, B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 4. EXPLAIN the role of stress as the "triggering" mechanism in an episode of child maltreatment.	Explain the role of stress as the "triggering" mechanism in two ways.	The student will give correct information by utilizing the resources listed below: III A Sample Content 3 III.1a and 1b III.10 III.11 I C II A II C II.9 Transparency 10 Transparency 13
5. EXPLAIN the role of the passive partner in an episode of child maltreatment.	Explain the role of the passive partner in: a) abusive acts b) neglectful acts	III B Sample Content 4 III.1a II Selected Case Histories VI A Transparency 10 Transparency 13

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 7 AND 8 --
UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 7. IDENTIFY the potentially abusive or neglectful caretaker.	a) Ninety percent of the potentially abusive or neglectful caretakers may be identified as: (1) (2) (3) a) Ten percent of the potentially abusive or neglectful caretakers may be identified as: (1) (2)	The student will give correct information by utilizing the resources listed below: III C Sample Content 1 a) and b) III.1a III A Sample Content 1 I B Sample Content 4 I.4 I.6 II.3
8. DESCRIBE the characteristics of the potentially abusive or neglectful caretaker.	The potentially abusive or neglectful caretaker is characteristically described as: a) b) c)	III C Sample Content 2 III.1a and 1b III.4 III.8 III.9 III A Sample Content 3 I.6 I A I C II.4 II.5 II.9

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 9, 10, AND 11 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization D Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 9. IDENTIFY the potentially vulnerable child.	The potentially vulnerable child may be identified as: a) b) c)	The student will give correct information by utilizing the resources listed below: III D Sample Content 1 III A Sample Content 2 III.1a III.5 I B Sample Content 1 - 3 I C II B II.3 Transparency 15 a
10. DESCRIBE characteristics of the potentially vulnerable child.	Give _____ examples of each of the above.	III D Sample Content 2 III.5 III A Sample Content 3 II Selected Case Histories II.3 Transparency 15 b
11. DESCRIBE the poten-	Give examples of	III D Sample Content 3

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 12 THROUGH 15 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization E Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 12. STATE the meaning of the term "stress."	Define the term stress.	The student will give correct information by utilizing the resources listed below: III E Sample Content 1 III A Sample Content 3 III.1a III.10 III.13
13. LIST the characteristics of stress in relation to time (duration).	TRUE/FALSE In an episode of child maltreatment, stress is usually only a few minutes in duration.	III E Sample Content 2 III A Sample Content 3 III.1a III.3 III.10 III.13 I.7 I.C II Slides or Film II Case Histories Transparency 16 a, b, c Transparency 17 a, b, c

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 12 THROUGH 15 --
UNIT III, THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization E Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 14. CLASSIFY the kinds of stress.	COMPLETION: In an episode of child maltreatment, the stress factor could be any one of the following kinds: b) c)	The student will give correct information by utilizing the resources listed below: III E Sample Content 3 III A Sample Content 3 III.1a III.3 III.10 III.13 I.7 I C II Slides or Film II Case Histories Transparency 16 a, b, c Transparency 17 a, b, c
15. DESCRIBE the origins of stress.	Give t o examples of stress in relation to each of the following: a) Dysfunctions of society b) Dysfunctions of the family c) Dysfunctions of the	III E Sample Content 4 III.1a III.3 III.10 III.13 I.7 I C II Case Histories II Slides or Film

CLASS RECORD FORM

S = SATISFACTORY

U = UNSATISFACTORY

UNIT III: THE EPISODE OF CHILD MALTREATMENT

CLASS ______________________________ PERIOD ________________

INSTRUCTIONAL OBJECTIVE: The student will be able to describe the components in an episode of child maltreatment.

	PERFORMANCE OBJECTIVE															AVERAGE %	
NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	S	U

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GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

COURSE ______

r COURSE ______

INDIVIDUAL STUDENT RECORD

PERFORMANCE OBJECTIVES																AVERAGE Instructional Objectives S	U
4	5		6	7	8												
4	5	6	7	8		9	10										
5	6		7	8		9	10	11		12	13	14	15				
4	5	6	7	8		9	10	11	12	13		14	15	16	17		
5		6	7	8	9	10		11	12	13	14	15					
5																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

III. The Episode of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (III.1a)
2. Interpretations of the Nurturing Experience (III.1b)
3. The Components (III.2)
4. The Potentially Abusive or Neglectful Caretaker (III.3)
5. The Criteria of Emotional Maturity (III.4)
6. Characteristics of the Potentially Vulnerable Child (III.5)
7. Typical On-Going Stress Factors (III.6)
8. Typical Stress Factor Immediately Prior to Maltreatment (III.7)
9. "How A Baby Learns to Love" (III.8)
10. "'Battered' Babies, Birth Without Violence" (III.9)
11. "How To Conquer Stress" (III.10)
12. "Child Care by Adolescent Parents" (III.11)
13. "Mom and Dad" (III.12)
14. "Holiday season filled with child abuse" (III.13)

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AUDIOVISUAL MATERIALS

Overhead Transparencies

13. The Episode of Child Maltreatment, The Components

14. The Potentially Abusive or Neglectful Caretaker (a and b)

15. Characteristics of the Potentially Vulnerable Child (a and b)

16. Typical On-Going Stress Factors (a, b, c)

17. Typical Stress Factors Immediately Prior to Maltreatment (a and b)

17c World of Abnormal Rearing

Films

Birth Without Violence. A film depicting the birth delivery techniques of Dr. Frederick Leboyer, who has himself delivered more than 10,000 babies. Though considered radical by some, his supremely simple technique seemingly eases the birth trauma and helps the new human being to start life without pain, confusion and fear. Recommended for classroom use, where available.

Second Chance. The treatment of maternal deprivation syndrome is described in this film. A deprived 22-month-old child is seen through the period of hospitalization at the Chicago Children's

THE EPISODE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (III.1a)

	Term		Definition
1.	Potential	adj.	- 1: existing in possibility: capable of development into actuality
2.	Vulnerable	adj.	- 1: capable of being physically wounded 2: open to attack or damage
3.	Stress	n.	- 1: constraining force or influence: as c: a physical, chemical, or emotional factor that causes bodily or mental tension d: a state resulting from stress
4.	Positive	adj.	- 6a: marked by or indicating acceptance, approval, or affirmation b: affirming the present of that sought or suspected to be present
5.	Negative	adj.	- 1a: marked by denial, prohibition, or refusal 2b: marked by features (as hostility or withdrawal) opposing constructive treatment or development
6.	Passive	adj.	- 3a: receiving or enduring without resistance: SUBMISSIVE
7.	Punitive	adj.	- 1: inflicting, involving, or aiming at punishment
8.	Authoritarian	adj.	- 1: relating to or favoring blind submission to authority
9.	Psychopathic personality	n.	- 1: an emotionally and behaviorally disordered state characterized by clear perception of reality except for the individual's social and moral

THE EPISODE OF CHILD MALTREATMENT

INTERPRETATIONS OF THE NURTURING EXPERIENCE (III.1b)

".....the process in which an adult takes care of an infant; that is, a theoretically mature capable, self-sufficient person caring for a helpless, needy, dependent, immature individual...Mothering consists of feeding, holding, clothing, and cleaning the infant...along with the more subtle ingredients of tenderness, of awareness and consideration of the needs and desires of the infant and of appropriate emotional interaction with it."

".....the deep, sensitive, intuitive awareness of and response to the infant's condition and needs, as well as consideration of the infant's capacity to perform according to his age."

From "A Psychiatric Study of Parents Who Abuse Infants and Small Children" by Brandt F. Steele and Carl B. Pollock in The Battered Child, edited by Ray E. Helfer and C. Henry Kempe. Chicago: The University of Chicago Press (1974).

".....intimacy, empathy, trust and 'mothering', used in the generic sense of mother-father parenting. Intimacy as the positive outgrowth of a willingness to risk a sharing of oneself with another is seen as an expression of a bond of affection and closeness between 'parent and child'--Intimacy is the emotional touching that leads to affectional fulfillment in an interpersonal relationship. It is the foundation stone to family harmony."

From "Parent Surrogate Roles: A Dynamic Concept in Understanding and Treating Abusive Parents" by Morri J. Paulson and Anne Chaleff in Journal of Clinical Child Psychology, Vol. II (3) Fall 1973.

(Transparency 13)

THE EPISODE OF CHILD MALTREATMENT

THE COMPONENTS (III.2)

1. The Potentially Abusive or Neglectful Caretaker

2 The Potentially Vulnerable Child

3. Stress, the "triggering" mechanism

4. The Passive Partner

5. The Sibling On-looker(s)

ERIC

(Transparency 14)

THE EPISODE OF CHILD MALTREATMENT

*THE POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER (III.3)

THE POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER IS REPRESENTATIVE OF A CROSS-SECTION OF ANY COMMUNITY IN TERMS OF RACE AND/OR SOCIAL OR ECONOMIC STATUS.

1. The Potentially Abusive or Neglectful Caretaker
   a) Frequently (90%)
      1) The emotionally immature
      2) The punitive and authoritarian
      3) The psychoneurotic
   b) Less frequently (10%)
      1) The psychopathic
      2) The mentally impaired
2. Characteristics of the Potentially Abusive or Neglectful Caretaker may be
   a) Abused or neglected in infancy or childhood
      1) Deprived of a nurturing experience in infancy or childhood
      2) Conditioned toward violence in human behavior
   b) Isolated by choice or circumstance
   c) Lacking understanding of the normal physical and psychological stages of child development
   d) Lacking in self-esteem
   e) Unable to cope with stress

*NOTE: There is continuing research in terms of prevention to determine the characteristics of the potentially abusive or neglectful caretaker.

THE CRITERIA OF EMOTIONAL MATURITY (III.4)

HAVING the ability to deal constructively with reality

HAVING the capacity to adapt to change

HAVING a relative freedom from symptoms that are produced by tensions and anxieties

HAVING the capacity to find more satisfaction in giving than receiving

HAVING the capacity to relate to other people in a consistent manner with mutual satisfaction and helpfulness

HAVING the capacity to sublimate, to direct one's instinctive hostile energy into creative and constructive outlets

HAVING the capacity to love

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(Transparency 15 a and b)

THE EPISODE OF CHILD MALTREATMENT

*CHARACTERISTICS OF THE POTENTIALLY VULNERABLE CHILD (III.5)

THE POTENTIALLY VULNERABLE CHILD MAY BE AN EXCEPTIONAL OR DEMANDING CHILD OR A NORMAL CHILD. All children may be vulnerable. Some children may be more vulnerable than others.

1. The exceptional or demanding child may be
   a) Precocious or gifted
   b) Physically or mentally impaired
   c) Premature
   d) Emotionally disturbed
   e) Others

2. The normal child may be:
   a) Stepchild
   b) Foster child
   c) Adopted child
   d) Illegitimate
   e) Undesired sex
   f) Conceived prior to marriage
   g) Sibling position (oldest, youngest)
   h) Unwanted pregnancy
   i) One of multiple birth
   j) Age
   k) Others

*NOTE: There is continuing research in terms of prevention to determine the characteristics of the potentially vulnerable child.

(Transparency 16 a, b and c)

THE EPISODE OF CHILD MALTREATMENT

*TYPICAL ON-GOING STRESS FACTORS (III.6)

Insufficient income

Heavy financial debt

Misuse of adequate income

Unemployment

Poor work stability

Physical illness or injury

Alcohol addiction

Other drug addiction

Mental retardation

Currently receiving treatments at mental health facility

Marital

Religious differences

Work related

New baby in the home

Pregnancy

Heavy and continuous child care responsibility

Absence of essential family member

Physical abuse of spouse

Police/court record (excluding traffic)

Newcomer to household

Recent relocation

History of abuse as a child

Repetition of family style

Normal method of discipline

Other

None apparent

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(Transparency 17 a and b)

THE EPISODE OF CHILD MALTREATMENT

*TYPICAL STRESS FACTORS IMMEDIATELY PRIOR TO MALTREATMENT (III.7)

Family breakup

Job related difficulties

Health problems

Argument

Physical fight

Under the influence of alcohol

Other drugs

Child's incessant crying

Child's disobedience/loss of control during discipline

Child's hostility or provocation

Child's resistance to perpetrator's sexual advances

Other immediate stress

None apparent

*National Standard Form--[illegible]
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Redbook Magazine, May 1971
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HOW A BABY LEARNS TO LOVE

by Selma Fraiberg

The author of *The Magic Years* describes a mysterious current that flows from baby to mother and back to baby again, creating the bond of love that proves to be the basis of life itself

During the past two decades a number of child-development specialists have started a new trend in the scientific study of babies. They began to sneak off one by one from their consulting rooms and their laboratories and camped out in homes where new babies had just arrived. I was one of them. We took along pencils and paper, cameras and tape recorders, and said to baffled mothers, "Don't mind us. Just do everything you ordinarily do in the course of the day. We want the baby to teach *us* a few things."

The mothers quite frankly thought we had lost our minds. But if the doctors wanted to learn how to diaper an infant or how to get a spoonful of mashed peas into a baby with a mind of his own, the mothers felt, Well, just go ahead. Actually there were no benefits to the parents but sometimes if a mother needed an hour of emergency baby sitting, it was a comfort to know that a Harvard professor was

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Mrs. Selma Fraiberg, professor of child psychoanalysis, University of Michigan Medical School, and director of the Child Development Project, University of Michigan Medical Center, has taken part in numerous investigations dealing with the absence or rupture of human ties in infancy. Her perceptive and entertaining book "The Magic Years" tells how a child views his world.

rtain the baby with the
.ept in his kit.

we scientists wanted to
one very elusive question:
to love? Since no
y to his mother, "I love
to attach the problem
signs of love and attach-
een months of life?

ny of the scientists found
signs. If we follow the
attachments from the
end of his first year, we
mother, and his father
And
love all other
because the mother
first year of life, he
engaged in the work

the baby has the
Continued on page 180

there is the language of the smile, the language of vocal sound-making, the language of the embrace. It's the essential vocabulary of love before we can yet speak of love. (In 18 years, when the baby is grown and "falls in love" for the first time, he will woo his partner through the language of the smile, through the utterance of endearments and the joy of the embrace.)

How does the smile become part of the vocabulary of love? The smile is innate, the universal greeting sign of our species. Already in the early weeks of life it appears in deep sleep; then gradually it is elicited more and more frequently by external stimuli. At three months of age the one stimulus that will automatically produce a smile is the human face. At this age *any* human face will elicit a smile, which seems a poor reward for maternal devotion, but between three months and six months the smile becomes a smile of preference—for the mother.

The baby smiles more frequently for his mother than for others and his smiles for her are bigger and more joyful. During the same period he "talks" more, jabbers more fluently, with his mother than with a stranger. And if he is frightened or has taken a bad bump, he cannot be comforted by "just anyone" any longer; he seeks the comfort of his mother's arms. His mother's arms and her lap, the closeness of her body, have a magical quality in soothing him and creating the feeling that all is well.

At this stage, then, the baby has discriminated his mother from others, shows preference for her and associates her with the satisfaction of his hunger and body needs. But, we ask ourselves doubtfully, is this "love"? Not yet, perhaps. But these are signs of selection, of intimate exchange and partnership, that will lead him to love.

Between six and 12 months something new begins to emerge. The baby now begins to show us another way in which he places special value upon his mother. While he has always been sociable and smiled for the uncle who wiggled his ears or for the lady in the red dress, he now begins to become downright unsociable. In place of a smile they may get a look of cold scrutiny, or a frown, or—regrettably—a howl of indignation.

The infant's parents are quick to offer apologies. "I don't know what's got into him! He used to be so friendly." What's-got-into-him is something the baby specialists call *stranger reaction*, perfectly normal behavior between six and 15 months. It means, very simply, that his mother for the time being is the center of his world and the "stranger" is somehow an intruder, someone who unsettles the intimacy and safety of the private world. Typically, after the baby produces a negative reaction to the stranger his eyes will begin to search the room for his mother, and when he finds her face he bestows a big smile upon her and then may make overtures to be picked up.

Odd as it may sound, this behavior toward strangers is one of the signs of the baby's increasing affection for his mother. All love, even in later life, begins with a feeling of exclusiveness. "You are the one who matters—only you." It's the magic circle of love that in infancy includes the father and a few other choice people but not yet the stranger. In a few months, by the way, the baby will receive strangers quite hospitably again, but that's because he is secure enough to feel that the magic circle is no longer threatened by outsiders.

At around the same time, about eight months of age, the baby shows his growing love for his mother in still another way. He complains when he is separated from her. He may not object if she leaves him to go to the kitchen, but his face is very likely now to pucker up when he sees her in her hat and coat. And his baby sitters may report that he complains loudly for a time after she leaves.

"Do you think he's spoiled?" some mothers and fathers will ask. But he's not spoiled. At this time his mother is still the most important person in his world. And he behaves the way all of us behave when a loved person is absent for a while: "I can't bear to be without you. I am lost. . . . I am not myself when you're gone. . . . You are my world, and without you the world is empty."

If all this seems too extravagant to put into the minds of babies, we need only watch an infant of this age whose mother has been called away on an emergency for several days or a baby who has been isolated from his mother in a hospital. The face of grief is no different at eight months from that at 30 years of age. Loss of appetite, sleeplessness, refusal of comfort from someone else—for both ages the symptoms are the same.

From this short sketch we can see that by the end of the first year the baby has gone through a sequence of phases in his human attachments—from simple recognition of the mother to recognition of her as a special person to the discovery that she is the source of joy, the satisfier of body hungers, the comforter, the protector, the indispensable person of his world. In short, he has learned to love.

This is what we learned from scientific camping out in the homes of babies.

Another group of scientists chose to study babies who had been reared from birth in institutions as well as babies reared in their own families. And they emerged with a different story.

In the institutions—even the best ones—no baby has a mother or a mother substitute. There may be 12 to 30 babies in a ward with two to four nurses or aides for each of three shifts. No one person, no matter how much she loves babies, can serve as mother substitute under these circumstances. The infant is fed, bathed and changed by a rotating staff. In many institutions it saves staff time to feed the baby by means of a propped-up bottle. A good part of his time is spent in a crib during the first year of life.

At three months of age, when our homegrown babies smiled in response to the human face, the babies in institutions smiled too. The smiles were not as frequent, some of the scientists noted, but they were there. The babbling sounds that babies make at three months were made by the institutional babies also—but their vocalizations were less frequent than those of family-reared babies and seemed to have a more limited range of sounds.

Then between three months and 12 months of age something that should happen to the smile and something that should happen to vocalizations did not appear in the institutional babies. At a time when the home-reared baby showed preference with huge smiles for mother and father, the institutional baby smiled indifferently at everyone he saw. And around six to 12 months, the time when the family baby reserved his smile for the members of the magic circle and showed negative reac[illegible]s toward strangers, the institutional baby behaved no differently toward the daily nurses and attendants and casual visitors to the nursery whom he had never seen before.

Everyone had equal value in his eyes because no one had special value. Anyone who created a diversion in the monotony of the nursery day could get a smile.

During a period when the family-reared infant began to carry on "conversations" in gibberish with his mother and father and when he began to imitate sounds (around eight months of age), the institutional baby h[illegible]d a restricted range of sounds. He was not imitating sounds; and the melodies of speech, which emerge at this time like an absurd parody of English, were not present at all.

How odd! we think. These institutional babies were exposed to all the ordinary conversational exchanges of nurses and aides; they were not being reared in isolation. But findings such as these are very common among institutional babies. From this we learn that while the brain is "programed" so that a full range of articulations are available to every normal infant, the organization of these sounds into patterns and the use of these sounds for communication is entirely dependent upon the existence of human partners.

We can confirm this very simply as adults. It is possible to live in a foreign country for months, exposed to the native language day after day, and not acquire even the rudiments of discourse in that language if there is no relationship with a native who speaks the language, someone who provides the conditions for dialogue.

The institutional babies had heard the sounds of English all around them, but because there were no partners to provide the intimate exchange that is vital to the acquisition of language, they were slow to acquire the sounds and the cadences of that language. And if they remained in the institution for the early years of life, speech became one of the areas of severe retardation in their development.

How did the institutional i[illegible]nts react to separation from the nurses and aides who were the only representatives of a human world? We know that babies reared in their own homes show distress at a mother's absence, and if absence is prolonged, there is terrible grief. We understand that pain at separation is another measure of the child's love for his mother. But the institutional baby showed no signs that the absence of one or another of the people who cared for him had any meaning to him. If the red-haired nurse took a two-week vacation, there were five other nurses who performed identical duties and were interchangeable parts in the human machine that fed, bathed and changed him.

In many of the institutions, babies were placed in foster homes in the second and third years, and the possibilities of human bonds were opened up to them. But some of the babies spent their early years in the institution without human partners, without intimacy. And these children offered science the most chilling testimony for the power of love.

At the age of three and four they were already different from other children. They continued to show by their behavior that one adult was interchangeable with any other adult, and they were measurably retarded in speech and abstract thinking.

In follow-up studies in later childhood and in adult life the scientists found many of them in social agencies, in clinics and in courts. Their life problems were in all cases different, of course, but they all suffered from the most extreme effects of a love-starved infancy. They had one thing in common—they were unable to form stable human bonds, unable to love. They were rootless and unbound, without partners—or, often, with casual and shifting partners, since no one partner was valued.

Of the children who had spent their early years in institutions, some managed to become relatively well adjusted adults, able to make meaningful, if limited, human associations. But many of the children who had never known physical closeness or the certainty of satisfaction of body hungers became men and women who seemed to have no pleasure in body intimacy and whose sexual appetites were impoverished or bizarre. Aggression, which is normally modified in the early years through the agency of love, appeared in these loveless men and women in erratic forms, sometimes fused with eccentric sexual practices. The human capacity for empathy, for feeling oneself into another personality, was simply absent. And because there can be no conscience without the capacity to feel for another, there was a vacant space in personality where conscience should have been.

Once again the scientific question led back to the first years of life. What was it, we asked ourselves, that transpired between an ordinary baby and his parents that usually guaranteed the capacity for love in later life? Surely since the dawn of mankind and in every society the human family has produced and nurtured babies who grew into men and women capable of experiencing enduring love and physical joy. In contemporary "primitive" societies, simple and illiterate parents achieve this miracle by simply doing what their ancestors have been doing for thousands of years.

It appears that the "program" for infant-mother attachment was laid down in our biological ancestry. It has much in common with the infant-rearing practices of all mammals and has close resemblance to infant rearing among the higher primates.

In the biological pro[illegible]am we inherit, an infant leaves intrauterine life and comes into a radically changed environment. He is cushioned against the shock of the journey—from the water world to the land world, from enclosed space to unclosed space—but he brings little instinctive baggage into the world to ensure his adaptation or his survival. As a specimen of our genus, he is unfinished by comparison with the newborn of other spec[illegible]s.

At the end of his journey there are [illegible]ovisions in the program that the woman who sheltered and nourished him in intrauterine life should be the woman to shelter and nourish him outside the womb. Body intimacy, the shelter of enclosing arms and nourishment are all marvelously contrived in the program to center around the mother's breast.

In breast feeding, the infant is cradled in the mother's arms. Pleasure in sucking, the satisfaction of hunger, intimacy with the mother's body, are united with his recognition of her face. The baby learns to asso[illegible] *this* face, his mother's face, with an enjoyable and co[illegible] experience. As we watch

this intimacy give the baby the body closeness and sensual pleasure that are the first requirements of love. Many mothers who feed by means of the bottle choose to take over all or most of the feedings themselves. There is probably no reason why Father or Grandma cannot take over an occasional feeding. But when Mother is the main person who feeds him, the baby will *recognize* her earlier and begin to respond to her as a very special person, another requirement of love.

Thus most mothers have maintained the traditions while substituting the bottle for the breast. But today in many thousands of families, as well as in institutions for the care of infants, the old traditions have been lost. In many busy households or nurseries the baby is fed by means of a propped-up bottle and is deprived of one of the vital nutriments for love. Alone with his bottle in his crib, he will not learn to associate feeding with body intimacy and the face of his mother. And in cases when a baby is fed during his bottle feeding by someone other than his mother he may not associate feeding with pleasure and intimacy in relation to a central person—which disturbs the conditions for the love bonds.

The bottle gives a mother far more mobility than the breast, which is one of the reasons for its growing popularity during the past two decades. And a baby today experiences many more separations from his mother than the baby in the traditional breast-feeding societies. How does this affect the stability of the bonds to his mother?

At this point none of us can know for certain how changes in baby rearing have affected the development of children in our society during the past 20 years. I have cited the evidence from extreme cases, the babies in institutions who received no mothering. What we have learned from these tragic life stories is sobering, but the lesson also should be read as a testimony for love. It means that something goes on between an ordinary baby and ordinary mothers and fathers that creates and ensures the capacity for love in infancy and in later life. It tells us that love and pleasure in the body begin in infancy and progress through childhood and adolescence to a culminating experience, "falling in love," the finding of the permanent partner, the achievement of sexual fulfillment.

In every act of love in mature life there is a prologue that originated in the first year of life. There are two people who arouse in each other sensual joy, feelings of longing and the conviction that they are absolutely indispensable to each other—that life without the other is meaningless. Separation from each other is intolerable. In the wooing phase and in the prelude to the act of love the mouth is rediscovered as an organ of pleasure and the entire skin surface is suffused with sensual joy. Longing seeks its oldest posture, the embrace.

In the first falling in love, every pair of lovers has the conviction that "nothing like this has ever happened to me before. I never knew what love could be." And this is true, but only in a certain sense. The discovery of the partner, the one person in the world who is the source of joy and bliss, has its origin in the discovery of the first human partner in infancy. What is new is the *new* partner and the experience of genital arousal with longing for sexual union. Yet the pathway to full arousal in mature life was laid down in infancy, long before the genitals could play a dominant role in experience. It was the infant's joy in his own body, the fullness of infant sensuality, that opened the pathways to fulfillment in maturity.

Freud said all this 65 years ago and there were few who believed him. THE END

THE WASHINGTON POST
B 6 Thursday, May 8, 1975 — LEISURE —

Book World

'Battered' Babies

BIRTH WITHOUT VIOLENCE. By Frederick Leboyer. (Knopf, 114 pp. $7.95)

Reviewed by
Mavourneen McCarthy

The reviewer is a registered nurse with experience in obstetrics.

Thanks to such sources as newspapers, magazines and congressional committee reports, the public has been learning the details about child abuse. Battered children can be victimized in the homes of the wealthy as well as the poor. Parents who brutalize their young were often physically abused in their own childhood. In general, what we have been learning is that child abuse is more widespread than we had thought, if we thought about it at all. In "Birth Without Violence," Frederick Leboyer, a French obstetrician, takes us even further, raising a number of unsettling questions about the pain that parents, doctors, nurses and the medical community unthinkingly inflict on babies at birth.

The world *unthinkingly* is important. Doubtless all those involved in the birth process see themselves as being careful or tender, the infant's fragility being obvious to everyone. Leboyer, who has assisted at 10,000 births, makes a forceful case for the need to understand why infants suffer so much at birth. "What makes being born so frightful is the intensity," he writes, "the boundless scope and variety of the experience, its suffocating richness.

"People say—and believe—that a newborn baby feels nothing. He feels everything.

"Everything — utterly, without choice or filter or discrimination.

"Birth is a tidal wave of sensation, surpassing anything we can imagine. A sensory experience so vast we can barely conceive of it."

Leboyer's purpose is one of advocacy on behalf of the newborn. He suggests, for example, that lights be dimmed in the delivery room at the time of birth. With lamps and floodlights aimed at the new arrival, "the infant howls aloud. And why should this surprise us? Its eyes have just been burned.

"They say a newborn child is blind." No, it is *blinded*."

It is much the same for the other delicate sense, hearing. "Who bothers to lower his voice in the delivery room?" Leboyer asks. "There is more shouting than speaking.

"'Come on! Push, push! Again, again!'"

As for the method of catching the baby, when the physician seizes him and handholds him upside down, Leboyer says that such a grip is "convenient. Convenient for *us*.

"And for the infant?

"What does it feel, finding itself suddenly upside down?"

"Indescribable vertigo."

Much of Leboyer's thinking is scarcely new to those working in the nation's delivery rooms. His sensitive portrayal of the beginnings of life, and our contributions of pain to those beginnings, reveal an original mind pondering the oldest of subjects.

After saying that, though, there is an incompleteness to his thoughts. He gives us new knowledge but fails to suggest how to use it. Does he think for a minute that those who run hospital delivery rooms are going to put the lights low or that doctors at 3 a.m. are going to heed his advice: "to protect newborn children from fear, we must unveil the world to them infinitely slowly, in an endless sequence of severely limited revelations"? Hardly. For whatever reasons—routine, efficiency, financial costs—hospitals treat a delivery as a medical procedure, not an emotional event.

Leboyer had an ideal opportunity to take the discussion further along so that we could learn from him how some changes might be made. They assuredly won't be made, say, when a woman is wheeled into the delivery room and requests that the lights be dimmed and everyone talk in whispers. Leboyer neglected also to suggest that medical schools begin teaching future obstetricians about the tumult of birth, so that at least there is a chance for enlightenment among the younger doctors not yet set in their medical ways. Instead of discussing how hospitals have put technology between mother and child, and suggesting that women begin thinking about the logical alternative of home birth—where the mother can indeed ask that the lights be dimmed, talk be restrained and other kindnesses be shown the infant—Leboyer concludes by issuing a call that makes him [illegible] like the Rod McKuen [illegible] "At [illegible] of our tale, I can [illegible] one thing: 'Try.'

"Everything that has been said here is simple. So simple that one feels ashamed to be so insistent about it.

"Perhaps we have lost our taste for [illegible]."

Or maybe we have lost our taste for [illegible] the [illegible] of [illegible] the [illegible] of [illegible] which is what Leboyer appears to have done.

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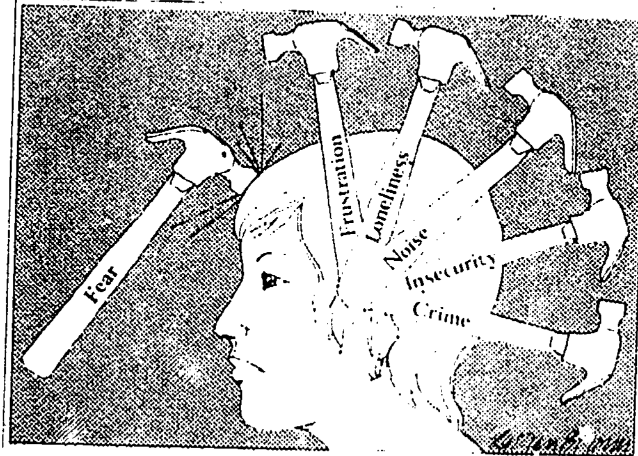
HOW TO CONQUER STRESS

Must we pay with our health for the tensions of our modern world? Not if we learn what causes emotional wear and tear and how to minimize it in our daily lives

By JOHN PRUTTING, M.D., with PATRICIA CURTIS



"THAT REALLY makes my blood boil!" said a man in my office recently, referring to something that angered him. Another patient used a familiar expression when she described a relative who lived with her as "a pain in the neck." These are not merely picturesque sayings—they are recognitions of the cause-and-effect connections between emotions and physical reactions. Our language is full of such idioms. Suppose you were faced with a tense situation. "My stomach is tied up in knots," you might say—and you would not be far from wrong. The accelerated heartbeat and rise in blood pressure (which prompts an expression like "blood boiling"), the neck pain, the stomach spasm are all symptoms of the same thing: stress.

People tend to think of stress as synonymous with nervous tension or pressure or emotional upset. These are not themselves stress, but if prolonged or severe, they can produce stress. Medically and biologically, stress is a state in which a chain of glandular and hormonal reactions takes place to help the body adapt to its physical and emotional environment. Not all of these reactions are necessarily destructive. They make it possible for you to accomplish difficult tasks, withstand physical and emotional shock, cope with trying situations, combat disease, heal damaged body tissue; they enable you to perform a superhuman feat in a crisis, or to do something as simple as adjust to extreme changes in weather. But when these adjustment demands on the body are extreme, or continual, the body's adaptive mechanisms may break down, and you can become ill—even die.

While the world has known for centuries that emotions can cause physical symptoms, it is only comparatively recently that doctors and medical researchers investigating hormones and body chemistry have begun to understand how destructive stress can be. Colitis, asthma, heart diseases, ulcers, gout, high blood pressure, headaches, rashes, constipation, infections—an alarming list of illnesses can be directly or indirectly traced to stress. Muscle spasms are typical indications of stress—they show up as stomach cramps, pains at the back of the neck, a feeling of fullness in the throat due to spasm of the throat muscle (*globus hystericus*). Severe premenstrual tension and menopausal symptoms can be due to stress. Sex drive and ability to perform are destroyed by stress.

Let's look at some hypothetical case histories of people who could be any of us.

• Mary C., a legal secretary and young newlywed, moved with her husband to a city 1,000 miles from the small town where she had lived all her life. She settled into her tiny apartment and went about finding a job. The lawyer who hired her was pleasant and considerate, but she soon discovered that his senior partner was a driving, disagreeable tyrant who continually interfered with everyone and everything in the office. One day he wrongfully accused Mary of making a mistake and told her boss that if it happened again, her boss would have to fire her.

Mary's husband was sympathetic enough, but she missed her family, especially her sisters, with whom she had always been able to share her troubles. Because she was naturally shy, she had not yet made any close friends in the city.

Meanwhile, she began to notice that her husband had started to drink excessively. He explained that his job as a salesman involved a great deal of socializing at lunch and after work, but Mary privately worried because he often kept right on drinking when he came home in the evening.

Mary became more and more frustrated and unhappy, both at work and at home. She began to suffer from headaches, a feeling of pressure in the back of her head. She had frequent abdominal cramps and diarrhea. Shortly after a letter from home told her that

DR. JOHN PRUTTING *is a practicing internist in New York City and president of the Foundation for the Advancement of Medical Knowledge. Last March, he and staff writer Patricia Curtis brought* FAMILY CIRCLE *readers the important news about magnesium in the article, "The Miracle Mineral That Keeps You Fit."*

Reprinted from January 1972 issue of Family Circle Magazine.

her mother was ill, Mary broke out in a severe rash, especially prominent on her legs and ankles. She consulted a doctor.

On examining Mary, the doctor found she had an elevated blood pressure and extreme neck muscle spasm, and tests he ordered showed a spastic colon and changes in her body chemistry. The rash turned out to be caused by a deficiency of Vitamin C—even though Mary drank orange juice and took vitamin pills every day. Mary's symptoms were due to that great destroyer of health, stress. The adaptive mechanisms of her body had broken down under prolonged frustration, loneliness and worry and were causing the potentially dangerous physical reactions.

• Joe M., an engineer, had always been a self confident man bursting with good health and blessed with a calm disposition. He was content in his work; liked and trusted by the people in his department. At home, he was a steady, loving husband and father.

About a year ago it became apparent that the increasing air traffic at the huge airport near Joe's home was making life unbearable. The noise overhead bombarded the neighborhood day and night. Joe and his wife wanted to buy a new home elsewhere, but the engineering firm Joe worked for was suffering a recession. Many of Joe's associates had lost their jobs. he never knew when he might be next.

Gradually this robust man began to lose weight and tire easily. He was often unable to fall asleep, or was awakened by nightmares. His formerly happy sex life was affected. His wife was considerate and uncomplaining for, although she didn't realize how precarious Joe's job actually was she suspected he was worried. But Joe in turn worried further about her disappointment in him.

Then one Saturday Joe was working with a flammable fluid in his garage. Probably because he was overtired, he failed to observe the normal safety measures, and some of the fluid exploded. Joe suffered some painful burns.

Joe's doctor, in treating the burns, found that they healed very slowly, became infected easily, and that Joe's general body resistance was extremely low. While he was still being treated for the burns, Joe developed an ulcer and cardiac irregularities. Tests showed Joe's glandular reactions were abnormal and his cholesterol was high. The glands that produce tissue-healing hormones were not functioning as they should to mend his burns. Like Mary, Joe was in a state *To page 100*

of stress, brought on by a breakdown of his body's ability to defend itself and adjust to such destructive forces as noise, anxiety, trauma and pain.

• Sarah D., a 46-year-old nursing supervisor, had been distressed for over a year about her only son, who had dropped out of college and moved to California. She had only a vague idea of where and how he was living, for he rarely communicated with her. Her best friend became ill with what Sarah learned was cancer. Sarah had just been hit with a staggering rent increase. Muggings and robberies in her part of town were increasing, too.

One day Sarah noticed she had developed periorbital edema (swelling around her eyes) and painful swelling of her breasts. When she consulted her doctor, he noted that her ankles were somewhat swollen also, and that she had gained weight.

Water retention is a symptom of stress that could have its roots deep in our primitive origins. When early man felt fear or anxiety, he was usually threatened with some kind of encounter in which he would have to run or fight for his life. His body would perspire (perspiring is the body's cooling mechanism, needed during heavy activity), drawing from its reservoir of fluids. But in the case of human beings today, anxiety is rarely resolved in flight or battle, so there is no excessive perspiration to use up the stored water. The usual result is water retention, such as Sarah's.

SOMETIMES STRESS can affect a whole population. A dramatic illustration of this was the phenomenally high rate of hyperthyroidism, a disease of the thyroid gland, in Denmark during the German occupation. Hyperthyroidism, in fact, reached epidemic proportions. It could not be traced to any cause other than the occupation; the rate went down when the Germans left.

Much of our understanding of stress comes from the work of Dr. Hans Selye, Professor and Director of the Institute of Experimental Medicine and Surgery at the University of Montreal. Dr. Selye's experiments revealed some crucial facts about the hormonal and glandular changes that take place in living beings when they are in stressful situations. In one series of experiments, he subjected large numbers of laboratory animals to such conditions as fear, frustration, noise, hunger, cold, overcrowding—and discovered that whatever the type of stress factor, after a sufficient length of time, the animals all showed approximately the same internal damage: Abnormal changes of the adrenal cortex and of the thymicolymphatic system, and gastrointestinal disorders. Dr. Selye named three quite distinct stages of stress: the initial alarm reaction, the resistance stage and finally exhaustion.

Largely from his work, researchers

have learned that under combinations of stressful conditions, certain changes take place in the bodies of human beings, largely in the nerve and hormone mechanisms. These changes involve the hypothalamus (the area of the brain most involved with emotions) and the pituitary, adrenal and other glands, and may affect most tissues of the body. Also, certain hormones are released that affect the blood pressure. It has been recently shown that cholesterol and uric acid will become elevated during severe stress. And further recent evidence indicates that we have a greater need for Vitamin C when we're under stress.

While initially the secretion of hormones and other changes in the body prepare you to meet the stress of a disturbing situation, during what Selye calls the alarm reaction, these factors become destructive if the stress is continued overlong. The examples of Mary, Joe, Sarah and the Danes suggest some of the events and conditions of life that can bring a person's internal adaptive reactions through the stages of alarm and resistance to exhaustion.

ANIMALS OTHER than those in Dr. Selye's laboratory also give some evidence of the effects of stress. We all know how most wild creatures die in captivity. Even when they are uninjured and are offered food, water, warmth and comfortable cages, few wild rabbits, birds, foxes or deer, for example, can live with the fear and frustration of confinement. And many animals who *can* survive in zoos cannot or will not reproduce.

Heavy attacks on the sensory organs —flickering or glaring lights, say, and loud noise—lead us to believe that too much TV and loud amplification of music can bring on more than visual disturbances or impaired hearing—they can be damaging stress factors. (So can the content of much of television.) Some studies have shown that highly stimulating movies cause a marked elevation in a person's output of adrenalin and other hormones. Some of my patients with low frustration tolerances can't take a terrifying or depressing movie or even read the

periods are followed by rest and repair. Many experiments, including Hans Selye's, show that small doses of stress factors, or short periods of severe stress, with sufficient recuperative time in between, can even help build up a resistance to future damage from stress. Dr. Selye's laboratory rats that were subjected to small shocks early in life were able to withstand more stress factors when fully grown than rats that had no alarm situations in infancy. Some parents attempt the impossible and try to provide their children with totally stress-free lives, and then feel guilty when they fail. There is good evidence that if a well-loved child is exposed early to some harsh realities, within reason, they can have a toughening and conditioning effect that equips the child to better cope with life as an adult.

We are living in a very turbulent environment. Besides the national anxiety we all share because of the Vietnam War, inflation, unemployment, civil disturbances, crime, noise, air pollution, water pollution and overcrowding, each person has his own individual stress factors to contend with. Frustration, lack of realization of ideals, and insecurity can be insidious. Just simple loneliness can be harmful; how often has it happened that an older person died within months or a few years of losing a mate? Soldiers in combat suffer terribly from stress; "combat fatigue" is merely a military word for stress. Studies made following World War II indicate that, in many cases, soldiers and prisoners of war suffered from effects of stress for many years after the war—even for the rest of their lives.

WE CANNOT CONTROL all the factors in our lives that cause stress. But if we know what they are, we can avoid some of them—or help someone in our family. Sum up the stress factors in your life—sit down and make a list of them. Separate those over which you have some direct control and balance them against those about which you are relatively powerless. You cannot help your worry over your brother's illness, say, but while

cise is an excellent stress reliever: It helps the body use the hormones and chemicals that have accumulated during periods of tension. Hobbies, vacations and sufficient rest help, too. Having someone to talk to—a clergyman, psychologist, family doctor, even a wise friend—will diminish harmful stress.

It is especially important to recognize and limit your stress factors when your body is already fighting an illness. I believe that almost every disease is aggravated by stress. I once had a diabetic patient whose diabetes went out of control for no apparent reason, until I learned she was in the midst of some deep family trouble. Sir William Osler once said that it is more important to know what sort of patient has a disease than what sort of disease a patient has.

I have had some patients who had to change their jobs to save their lives. Others have helped themselves by changing their life-styles. In a world where we are continually exhorted to buy, spend, go, do, eat, drink and turn on in one way or another, it might be our salvation to learn to simplify, to seek out serenity and to cultivate moderation. To put it simply, cool it.

I think in some ways the current fashion among young people to drop out of what they consider to be the rat race of life and seek simpler ways of living may be a healthy attempt to find a better life-style. Their interest in Eastern religions with the something from what they are attempting to say.

On your list of stress factors are probably a number of situations that would seem to be out of your hands—war, crime, noise, pollution, overcrowding. I believe that unless mankind comes to vastly better terms with his ecology—his social ecology as well as his physical environment—stress may reach epidemic proportions, particularly in our country. Sincere and informed efforts to solve our national problems should be a matter of self-preservation for all of us.

It may seem odd to hear a medical physician speak about such things as love and courage, but in terms of stress, these are two of the most protective qualities to cultivate. While it's true that the ability to love and to be brave are formed early in life, it is also true that sometimes simply by acting, the appropriate emotion will follow. If we are generous and kind toward others, we usually find that we begin to *feel* good toward them. If we behave with courage, even when we are inwardly afraid, we often feel braver for having acted that way. This is not altruism—this is medical advice. ■

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Child Care by Adolescent Parents

by VLADIMIR DE LISSOVOY

Although the results of research in the field of adolescent marriage—including the high risk factor in such marriages—have been given considerable attention recently, surprisingly little information has been published concerning the adolescent parents' expectations of and attitudes toward their children. This article, based on the results of a larger longitudinal study of adolescent marital adjustment over a 3-year period, focuses on the childrearing attitudes and practices of mothers and fathers who married while they were still enrolled in high school. The findings, in terms of the young parents' expectations and attitudes, are disturbing.

Forty-eight couples, all natives of semi-rural areas or small towns in central Pennsylvania, agreed to participate in this study. Of these couples, 46 were expecting a child at the time of their marriage. Forty-one of the wives and 35 of the husbands withdrew from school prior to their graduation.

The girls ranged in age from 15 to 18, with an average age of 16½, while the boys, who were between the ages of 14½ and 19, had an average age of just over 17. According to the last group I.Q. tests administered to them, their scores clustered just above 100.

The families of the couples can be best described as belonging to the rural working class. The fathers were mostly farm owners or tenants and skilled or unskilled laborers. Most of the mothers were homemakers. Although detailed information regarding their parents' education was not obtained, most of the mothers had reached a higher grade in school than their husbands, and more of the mothers were high school graduates.

The young married couples came from families with an average of three children; the girls had two to nine brothers and sisters, with an average of four, while the boys had two to six siblings with an average of three. At the beginning of this study, 12 of the couples lived in a private apartment or house, 21 lived with the wife's family and 15 with the families of the husband.

During the course of the study, each of the couples was visited at least five times. The first visit, to obtain background information and demographic data, was followed by a second about a month later, when the husband and wife were asked to rate themselves according to a marriage adjustment scale. During the third visit—six to nine months later—a brief test of the parents' knowledge of child development was administered. At the fourth visit, made when the first child was between 18 and 30 months old, a childrearing practices schedule, designed to measure only the dimensions of the mothers' acceptance and control of their children, was administered. The final visit was held at the end of the 3-year period.

Because the sample was an atypical one, the results presented here must be noted with caution. Nevertheless, the findings merit the attention of those who work with adolescents in schools or in com-

Only five mothers, for example, expressed enjoyment of their children in the sense that they spontaneously cuddled or played with them just for the sheer joy of it. It was also surprising to learn that in this primarily rural area only three mothers had attempted to breastfeed their children.

There is little question that these young parents were undergoing severe frustrations. Their lack of knowledge and experience, their unrealistic expectations of child development, their general disappointment in their lives and their lack of economic resources served to raise their irritability and lower their threshold of tolerance.

It is evident that the young parents were not familiar with developmental norms . .

The following results are based upon the data gathered specifically in regard to the children by means of interviews, self-rating scales, objective tests and clinical notes taken during and immediately after each visit.

Because developmental norms are often suggested as guidelines

children between six and nine months of age.

The questions required an answer stating only the age, in weeks, months or years, at which the parents expected their child to demonstrate certain behavior. One question, for example, asked, "How old do you think most babies are when they can sit alone without any support?" In this way answers were elicited for the parents' expectations of the ages at which babies might smile, take their first step, speak their first word, and achieve other selected patterns of behavior. The questions and the parents' responses for each area of development are shown in the table below.

It is evident that the young parents were not familiar with developmental norms. Only in their expectations of the first appearance of the social smile did three mothers and four fathers mention a realistic norm.

When, for purposes of comparison, the same questions were posed to a group of unmarried seniors attending a rural high school, the response scores of the boys and girls in this group, who were approximately the same age as the young parents, were almost identical.

To note the parents' ideas concerning how often their babies could be expected to cry, we posed the question: "Let's say the baby is fed and dry. How much crying can you expect from him or her for almost no reason?" The parents were given four choices of answers:

Should not cry at all;

Very little crying, but then only if he wants anything;

AGES AT WHICH PARENTS EXPECTED BABIES TO ACHIEVE SELECTED PATTERNS OF BEHAVIOR

Area of development and approximate norm in weeks		Parents' Estimates in Weeks	
		Mothers	Fathers
Social Smile	(6)	3	3
Sit alone	(28)	12	6
Pull up to standing	(44)	24	20
First step alone	(60)	40	40
Toilet training (wetting)		24	24

Maybe it depends on the baby—some cry more than others;

You can expect a lot of crying.

While 67.4 percent of the mothers recognized the fact that some babies cry more than others, or realized that one can expect a lot of crying, only 39.7 percent of the fathers selected these answers. What is important to note here is that almost one-third of the mothers' responses and almost two-thirds of the fathers' suggested an attitude of low tolerance toward their baby's crying. This low tolerance, combined with unrealistic expectations of development, contributed to their impatience with their children—and to their sometimes cruel treatment of them. In fact, during a number of visits parents freely discussed how they spanked their babies for crying or for other "misdeeds" and on several occasions I witnessed such punishment by different couples.

MEASURING ATTITUDES

Thirty-one mothers were interviewed to assess their acceptance of their children and the control they exercised in dealing with them. At this time 17 of the mothers had one child and eight of these were expecting another. The other 14 mothers already had two children and three were again pregnant.

Of the questions used for this part of the study, 22 were rated to determine the acceptance dimension and 16 the control dimension. The mothers' answers, set down verbatim Danny's food likes and dislikes? How do you get him to eat the things that are good for him but which he does not like?"

Her answers were rated on a 5-point scale with three points on the scale defined as follows:

☐ Evidence of tension and irritability in the handling of feeding problems. Appears unresponsive to the needs of the child.

☐ Conscientious desire to make certain that the child gets the right food. Mild pressure, such as talking to the child, telling stories while feeding him, disguising food and otherwise making certain that he gets enough of the right food.

☐ Easy going and child-centered in her manner. Understands individual differences in appetite and recognizes the child's right to food preferences. Methods of feeding reflect warmth of attitude.

Only five of the mothers spontaneously cuddled or played with their children just for the sheer joy of it . . .

The mothers' acceptance scores on the series of questions clustered around the lower end of the 5-point rating scale—the mean rating was 2.47—while their control scores averaged 3.29, just over mid-point toward the high end of the scale helpful in many ways—primarily in helping the couples achieve marital stability—they were not very effective in helping them cope with their children. The couples' parents apparently believed that raising children is "doing what comes naturally," and frequently told the young parents, "You'll find out soon enough" when they were asked specific questions. Their "advice" stressed the importance of success in early toilet training, being strict to insure that the child would "mind," and letting the baby "cry it out" so it would not be spoiled.

While collecting this data I was asked a variety of questions by the young parents. In order to minimize personal involvement, these questions were parried by saying a discussion would be forthcoming at a later session. However, in the light of some of the cruel acts toward children I witnessed, this was an especially difficult thing to do and in two cases all semblance of objectivity was abandoned in the interest of protecting the child from harsh punishment.

During one visit, for instance, a 6-month-old infant had been crying very hard for some time and, at my suggestion, the mother brought the child into the living room. The baby screamed and thrashed furiously as the mother held it on her lap. Then the baby arched and appeared to hit the back of its head against the mother. When these actions were repeated and the mother had twice slapped the baby

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damage could result from such actions.

During another visit, a young father spanked a 7-month-old baby who had apparently pulled the nipple from his bottle and spilled the contents in his crib. Here again I intervened, stressing the possible damage which could result from physically punishing the infant. Although I pointed out that the bottle was probably spilled because the nipple was not put in correctly, the father said, "He has been asking for this all day." In this particular case the mother worked afternoons and did not return home until early in the evening. Obviously, coping with the baby's daily demands was a difficult task for this young father.

According to the parents' statements, such physical punishment as spanking and slapping a child's wrist, hand or face were common practices after the child started to crawl. When asked what type of discipline they used to prevent children's marking on walls, jumping on furniture, hurting bric-a-brac and climbing out of the crib, 80 percent of the mothers mentioned physical punishment as a means of control.

To the question, "How often do you spank?," the mothers' replies included, "When he deserves it," "It depends on what he has done," and "When I can't take it any longer." Virtually all of the mothers gave an answer that could be interpreted that their children were so punished, and all but two mothers said their husbands also spanked the children.

We must conclude that experience with younger brothers or sisters—and occasional baby-sitting jobs—had not helped these parents understand how a child develops or that

Neither was much help offered by their physicians. What advice was given usually came in the form of mimeographed directions indicating formulas for feeding, the times to introduce certain foods and food supplements, and the schedules for future visits to the physician. These items were usually distributed by the doctor's nurse.

Caring for their children proved to be a trying experience for the majority of the couples . . .

In measuring maternal attitudes, I used a questionnaire based upon questions utilized in an earlier study conducted by R. R. Sears, E. E. Maccoby and H. Levin.[2] Their investigation of childrearing practices among a younger group of mothers led them to similar conclusions in regard to the young mothers' impatience and irritability with their children.

Obviously, a realistic approach to helping young people become effective parents is necessary. One major national step in this direction is the Education for Parenthood program described in the special March-April 1973 issue of this journal. A joint Office of Education-Office of Child Development effort, it is designed to

Another major effort on the national level is being undertaken by the Consortium on Early Childbearing and Childrearing, Child Welfare League of America, Inc. The Consortium's activities to help communities throughout the United States develop and improve services for school-age pregnant girls, the young fathers and their children, also are described in that issue (see "School-Age Parents" by Shirley A. Nelson).

However, the restrictive and sometimes punitive behavior of the young parents described here was due not only to ignorance or lack of experience. The parents' personal, social and economic frustrations, which contributed to disenchantment in their marriage relationships, also affected their behavior toward their children. Personal counseling, through community social service agencies or through adult education classes, could help them resolve many of these frustrations and, as another result, improve their childrearing practices. Such resources should be made available to adolescents. Public health nurses also should be encouraged to visit periodically the young families in their community.

It is my conclusion that the children of many adolescent marriages have a high risk of joining the number of battered and abused babies; any measures to help prevent this deserve serious consideration. ■

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[1] Statistical information can be obtained by writing Dr. Vladimir de Lissovoy, Professor of Child Development and Family Relationships, College of Human Development, The

The National Observer, October 18, 1975
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Mom and Dad

By August Gribbin

AMERICANS make lousy parents. It shows in the way their lousy kids are wrecking society. A lot of ordinary citizens and some experts on the American family would agree with this sweeping generalization. Some extremists even recommend that couples should get permits before they are allowed to have children.

Many middle-class Americans read books and take courses to improve as parents. Yet few give much thought to how they will rear youngsters *before* they start having them. They rarely consider the adverse impact that child rearing frequently has on marriages, and they commonly produce offspring for inappropriate reasons.

Bored Malcontents

The behaviorists who level the above allegations add that Americans typically are bewildered and exasperated by "parenting," which they find tedious to say the least. That's important, these critics say, because unsure parents can confuse their children and engender the kind of maladjustment that's partly responsible for the huge bunch of bored malcontents who seem bent on venting their spleens on their parents and on society.

This summer a group of psychiatrists, psychologists, pediatricians, educators, social workers, sociologists, and others met in Philadelphia to talk about all this. Formally they were to discuss whether the family as we've known it can survive. They came to no conclusion on that

ments, The Observer turned to more than 60 parents, single persons, and expectant parents from such diverse places as Baltimore; Boston; Columbia, S.C.; Denver; Ephrata, Wash.; Hillandale, Md.; Los Angeles; Minneapolis; New York City; Port Isabel, Texas; Schenectady, N.Y.; and Washington, D.C.

Underrated Demands

These interviewees generally agreed with the accusers, as did other authorities interviewed. They noted, for instance, that parents-to-be tend to underrate the physical and psychic energy that child rearing demands. They said that although being a parent is one of the most significant things people can do, they tend to devote less time preparing for it than to obtaining a driver's license. They agreed that typically even young parents have lost contact with youngsters and have forgotten what children are like by the time they have their own offspring.

Listen to what some interviewees said—

About confusion:

"They used to warn, 'Spare the rod and spoil the child.' Then they urged: 'Spare the rod! Spoil the child!' Now? Zillions of theories. What do you do?"

"The kid arrives like a new bike, and parents just have to sit down and figure out how to put it together."

"Society doesn't prepare young people for child rearing. It's overromanticized."

els; there weren't any 15 years ago. You had Doris Day and the lady who cleaned her floor on TV. You *always, always* felt inadequate."

"Being a mother has lost prestige; sometimes I feel even my husband doesn't think I'm as worth-while any more."

"I resent this baby and the changes it's bringing to my marriage. Yet I love her; I planned for her."

"The other day my husband said he never wanted four kids. He'd grown up in a big family and despised it. Now he's got four teen-agers. He says they crowd him; he hates it."

A Discouraging Picture

Then there's the 30-year-old Boston businesswoman who recalls that her parents seemed frustrated by child rearing. She remarks: "One of my fondest memories—now—is of my mother saying, 'Be happy, dammit, or I'll beat the hell out of you!'"

Urie Bronfenbrenner, professor of human development and family studies at Cornell University, declares that when child-rearing problems impact unfavorably on the child, the first symptoms are "emotional and motivational: disaffection, indifference, irresponsibility, and inability to follow through in activities requiring application and persistence [followed by] antisocial acts injurious to the child and society."

Translate the generalities to specifics and multiply them, and, as Bronfenbrenner points out, you get this sort of picture:

There's a birth in the nation every 10 seconds; a serious crime every 4. Overall, juveniles commit 30 per cent of those grave crimes. In suburbia they commit 35.2 per cent.

Nearly a million predominantly middle-class youth run away from home each year. About the same number of young people drop out of high school; that's a fourth of all who start.

Parents' Attitudes Important

Drug and especially alcohol abuse among the young is increasing again. Vandalism is at a new high. The number of suicides by youths aged 15 to 24 years old has gone from 2.7 per 100,000 in 1950 to 10.9 per 100,000 in

chiatrists and other clinicians say, for women to become resentful of status loss after forfeiting careers and having children. It's also typical for married career women's childlessness to prompt snide remarks.

A municipal employe living in suburbia says: "I finally started lying. Told neighbors and others that I couldn't have kids. Then they started pitying my 'handicap,' which was almost as insufferable as their needling me about the 'selfishness' of not being a mother."

Yet stay-at-home mothers feel criticism too. A 31-year-old divorcee and mother of three says: "At parties people ask me what I *do.* When I say I keep house for my children, they act like *I do nothing* and that I am nothing. It's embarrassing; sometimes I lie too."

Partly because of this quandary, Boocock concludes that no transition "in our society today [is] as stressful as the transition to motherhood." But there's another big cause of stress: *fathers.*

Many argue that because mothers lack the aid they formerly got from others in their homes, fathers nowadays must help significantly with the children. In fact, many have assumed that there's a trend toward dads helping with the kids because so many young women stridently proclaim they shouldn't—or won't—be solely responsible for day-to-day child care, and because so many men at least pay lip service to the notion.

Not so, says Boocock. "The father role is not being filled in many families by the biological father or any other male." (Mothers questioned by The Observer generally agreed—and vigorously.) Bronfenbrenner quotes reports revealing that although middle-class fathers asserted in interviews that they spent "an average of 12 to 20 minutes a day playing with their 1-year-old infants," actual observation showed they spent an average of 37.7 *seconds* per day "interacting" with their babies in any way.

Scale of Dissatisfaction

On another matter Observer interviewees typically declared that rearing

dissatisfaction increases with the number of children they have.

Students of family life now are questioning people's motives for becoming parents, Boocock says. Frequently they find the motives "not conducive to the welfare of children."

If it's best for children that parents opt to have them out of love and a conviction that they can rear happy, achieving offspring, it's also the rarest reason given, behaviorists say. The Observer's admittedly small and unscientific sampling backs the conclusion.

Reasons for Children

For while minimizing child rearing's unpleasantries, interviewees commonly said they wanted--or had wanted--"the joy of children" or wished to "perpetuate themselves," "carry on the family name," or "fulfill themselves." Some said they "feared missing out on something," "felt having children was expected," or "just did it without much thought." One collegian said he wanted children "because living for someone else is what makes life complete"; several mothers said they "liked children."

And then there s the confusion that child rearing purportedly causes. Mrs. George Rivera of Port Isabel, Texas, has this typical view: "Methods our parents and grandparents used to cope and raise children, we're told, are no longer valid; yet the new methods of experts aren't working. . . . [Parents] are lied to, cheated, made fun of on TV, exposed to so many conflicting theories . . . that we're confused, we've lost self-respect, and we even listen to the kids' advice--we don't trust our own instincts."

In an interview, psychologist John Girdner, associate professor at Union College, Schenectady, N.Y., traces the confusion to many things, including the loss of the religious base that once largely influenced people's relationships with children. But the social sciences have complicated the problem, he says, because so-called experts "have been ladling out information, and one doesn't know if it's much damn good."

Parents Look for Help

Nonetheless, parents look to books and courses for help. The current volume of *Books in Print* lists some 150

More than 200,000 parents have paid $50 to $65 each to attend the relatively new Parent Effectiveness Training courses created by clinical psychologist Tom Gordon of Solana Beach, Calif. The courses, given by some 7,000 trained instructors across the country, attempt to help parents apply in child rearing such venerable therapeutic

skills as "active listening," handling confrontations, problem solving, and the like. Gordon's $4.95 course text, *Parent Effectiveness Training*, has sold 500,000 copies.

A Lack of Programs

There are private associations such as the Child Study Association of America Well-Met Inc., which, among other things, publishes and disseminates books and pamphlets about parenting and child problems. Still, authorities say there's no effective educational program for people to understand parenthood's demands before becoming parents.

To try to fill the need, the U.S. Office of Child Development has produced, as part of a comparatively small, $4.2-million effort, a one-year high school curriculum on parenting. It's also being offered as an optional course to schools, the Boy Scouts, 4-H clubs, and the like. Currently 648 public and private schools, 102 colleges and universities, and 134 social agencies and hospitals utilize the course and its materials.

There are suggestions for other action. Among them, says Bettye Caldwell, professor of education at the University of Arkansas, are proposals for mandatory "preparenting training" and for requiring "parenting licenses" before a couple could have a child legally. If a parenting license smacks of Orwell's *1984*, well, it's also a sign of the depth of some people's concern.

Common but Perhaps Wrong

Baltimore's National Organization for Non-Parents (NON) is one group suggesting parent licenses. Carol Goldman, its executive director, says NON has done so mainly to publicize the idea that having children can be irresponsible. Parenting is so important that would-be parents should have to justify their decision to have children, she says, and nonparents shouldn't have to justify their decision not to.

"praise, punish, and posture at the right time with proper enthusiasm like the conducting of a major symphony." That's wrong, says Kagan, professor of social relations at Harvard.

Parents do not have the definitive role in child rearing, and the child's character is not immutably formed in its early years, says Kagan. Friends and teachers also mold him. A child's requirements change, he asserts, and the parent-programed "tapes" of the child's character aren't "nonerasable." "Experiences during later childhood [are perhaps] even more influential than the maternal treatments experienced during the first three years."

A Need for Standards

Children do have psychological needs, Kagan notes. He says one is the need for consistent standards. The standards themselves are "less critical than the fact of knowing that what is wrong and what is right remain constant . . . [for] a child is made uncertain by . . . being punished for fighting on Monday but jokingly teased for the same violation on Wednesday."

How should parents go about rearing children who will have what Kagan terms the qualities that our society demands of well-adjusted children: a sense of worth; autonomy in personal decision-making; the ability to decide conflicts for himself; heterosexual success; and personal competence?

Kagan has no magic formula--and in fact few behaviorists are willing to give general advice on child rearing. But Girdner, the Union College psychologist, says: "The No. 1 principle is for parents to know where they are--to know themselves. It's hard. It's hard for young parents at 18 or 21 years old to understand themselves when they're in misery from a bad home situation or when they're feeling like superbeings with the world at their feet."

Girdner has another thought for prospective parents: "Remember that you probably aren't going to get much satisfaction or self-fulfilment or joy with parenting. So be realistic."

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The Home News NEW BRUNSWICK, N.J., THURSDAY, DEC. 18, 1975

lay season filled with child abuse

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as opposed to 420
ll of November.

They say the increase in child abuse as the holidays approach is a national trend.

"There has always been a big increase of child abuse around holidays," said Dr. Irwin Redlener, a pediatrician.

Redlenen attributed the increase to emotional stress during the holidays coupled with the current economic problems.

Alberta Murphy, a state welfare worker, agreed that the economy plays a large role.

"There's not enough money and there's a little too much holiday cheer — alcohol," she said, adding that emotional prolems are compounded during Christmas.

"People have unhappy memories of things that happened in the past during the holidays," she said.

Redlener suggested that parents recognize outside pressures, remember that unchecked physical punishment can result in serious injuries to children and seek help if they fear "things are getting out of control."

ERIC

IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

--- Why Do They Do It?

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UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

The student will develop understanding of the psychodynamic dimension of child maltreatment.

Performance Objectives for Generalization D

14. EXPLAIN the relationship of nurturing experiences in infancy or childhood to the ability to nurture in later life.

15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.

16. RECOMMEND ways to break the recurring cycle of child maltreatment within society.

17. RECOMMEND ways to break the recurring cycle of child maltreatment within the family and the individual.

Generalization D

THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT MAY BE MEASURED IN THE RECURRING PATTERN OR CYCLE OF ABUSE AND NEGLECT WITHIN THE SAME FAMILY FROM ONE GENERATION TO THE NEXT.

Sample Content

1. The potentially abusive or neglectful caretaker is often one who was abused or neglected in infancy or childhood:
   a) Deprived of a mothering or nurturing experience
   b) Conditioned toward violence in human behavior
2. The abused or neglected infant or child will frequently in adult life:
   a) Experience difficulty in the adult nurturing role
   b) Adopt violence as a way of life

Suggested Classroom Activities and Procedures for Performance Objectives 14 through 16

1. Prepare students for an understanding of Generalization IV D through a complete review of Unit III, focussing upon III C Sample Content 1 and 2.
2. Review briefly IV A and Definition of Terms (IV.1).
3. Introduce Generalization IV D, and write on board for students.
4. Show Transparency 7, 8, and 9 for examples of the recurring pattern or cycle of abuse and neglect within a given family.
5. Write IV D Sample Content 1 and 2 on board for students.
6. Review II C Sample Content 1 and 2.
7. Show Transparency 10 and have students discuss characteristics of child maltreatment in terms of child-rearing practices as custom or tradition:
   a) How child-rearing practices may differ from family to family
   b) How child-rearing practices originate
   c) The role of the passive partner in child-rearing practices (III B)
   d) The role of the sibling on-looker(s) in relation to child-rearing practices as custom or tradition (III B)
8. Have students read and discuss III.1b and III.8 in terms of child-rearing practices as custom or tradition.
9. Write IV D Sample Content 1 and 2 on board for students.
10. Review the definition for the child maltreatment syndrome (I.1) and III D, the potentially vulnerable child.

11. Point out the recurring pattern or cycle in IV D Sample Content 1 and 2.

12. Have students read and discuss:

    a) "The Abused Parent of the Abused Child" by Wasserman (VI.20)

    b) "Violence in Our Society" by Steele (IV.10)

13. Review and discuss I A Sample Content 1 and 2.

14. Have students read and discuss "Our Forebears Made Childhood a Nightmare" (I.2) in relation to the recurring cycle of violence in society, the family, and the individual.

15. Have students suggest and list on board ways to break the recurring cycle of violence in society, the family, and the individual. (For in-depth study, see Unit VI Child Maltreatment: Help and Hope.)

16. Students may:

    . Write a brief review of IV.6; IV.9; or IV.10.

    . Write a brief paragraph on violence in society, the family, or the individual (which could result in a physically or psychologically damaged child).

    . Research and bring to class current newspaper examples of violence in society, the family, or the individual (which could result in a physically or psychologically damaged child).

    . Invite a speaker from the Mental Health Society to discuss the prevention of mental illness through awareness and understanding of child maltreatment.

    . Roundtable discuss selected articles from "Violence Against Children" Journal of Clinical Child Psychology, Fall 1973.

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- Research and write a brief paper on the lives of Charles Manson, Sirhan Sirhan, Arthur Bremer, or Marilyn Monroe in relation to the recurring cycle of violence in human behavior.
- Invite a resource speaker to discuss the importance of the nurturing experience in infancy and early childhood in relation to emotional maturity in adulthood.
- Roundtable discuss the use of violence as a form of entertainment in relation to the recurring cycle of violence in human behavior.

7. Conclude with assessment measures for Performance Objectives 14 through 16.

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EVALUATION

for

IV. The Psychodynamics of Child Maltreatment

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2 AND 3 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. STATE the meaning of the term psychodynamics.	Define the term psychodynamics in relation to child maltreatment.	The student will give correct information by utilizing the resources listed below: IV A Sample Content 1 IV.1 I B Sample Content 1 - 4 I C Sample Content 3 III A Sample Content 1 - 3 III.3
2. STATE the meaning of the term interaction.	Define the term interaction in relation to child maltreat treatment.	IV A Sample Content 1 and 2 IV.1 I B Sample Content 1 - 4 I C Sample Content 3 III A III.3
3. EXPLAIN psychodynamic interaction in relation to stress factors: a) within society b) within the family c) within the individual	Define the term psychodynamic interaction in relation to stress, using examples from: a) society b) the family c) the individual	IV A Sample Content 4 IV.1 I B Sample Content 1 - 4 I C Sample Content 3 II.9 III A III.3 III E III.5

Key Word[1] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

EXPLAIN - to describe the relationship between things and/or /to/ present the reasons for an occurrence or relationship

[1] Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 4, 5, AND 6 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 4. STATE the meaning of the term conscious (re)actions in relation to the caretaker.	Define and give ____ examples of conscious (re)-actions of the caretaker in an episode of child maltreatment.	The student will give correct information by utilizing the resources listed below: IV B Sample Content 1, 2, and 3 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 III E III.6 III.7 Film War of the Eggs
5. STATE the meaning of the term unconscious (re)actions in relation to the caretaker.	Define and give ____ examples of unconscious (re)actions of the caretaker in an episode of child maltreatment.	IV B Sample Content 1, 2, and 3 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 III E III.6 III.7 Film War of the Eggs
6. DESCRIBE typical (re)actions of the caretaker to the child.	Describe ____ typical (re)-actions of the caretaker to the child which illustrate psychodynamic interaction.	IV B Sample Content 4 IV A Sample Content 1 - 4 IV.1 II.4 II.5 II.6 II.9 III D III E III.5 III.6 III.7 Film War of the Eggs Transparency 19

Key Word[2] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

2 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 7 AND 8 --
UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 7. DISCRIMINATE conscious and unconscious (re)actions of the caretaker to the child.	Identify the following as a = conscious (re)action b = unconscious (re)action 1. 2. 3. 4. 5. 6. 7. (See itemized resources)	The student will give correct information by utilizing the resources listed below: IV B Sample Content 1 through 4 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 II.9 III D III E III.5 III.6 III.7 Film War of the Eggs Transparency 19
8. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the caretaker to the child.	Explain and give examples of the caretaker's (re)actions to the child which illustrate stress as a psychodynamic factor in an episode of child maltreatment.	IV B Sample Content 1 through 4 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 II.9 III D III E III.5 III.6 III.7 Film War of the Eggs Transparency 19

Key Word[3] (See Appendix A.)

DISCRIMINATE - to be able to differentiate one type from another -- similar to "classify"

EXPLAIN - to describe the relationship between things and/or /to/ present the reasons for an occurrence or relationship

3 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 9, 10, AND 11 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 9. STATE the meaning of the term conscious (re)actions in relation to the child.	Define and give ________ examples of conscious (re)-actions of the child mal-treatment.	The student will give correct information by utilizing the resources listed below: IV C Sample Content 1 - 3 IV A Sample Content 1 - 4 IV.1 II.7 II.8 II.9 III A Sample Content 1 - 3 III C III D III E III.3 Transparency 17 c Transparency 20 a, b, c
10. STATE the meaning of the term unconscious (re)actions in relation to the child.	Define and give ________ examples of unconscious (re)actions of the child in an episode of child maltreatment.	IV C Sample Content 1 - 3 See above.
11. DESCRIBE typical reactions of the child to the caretaker.	Describe ________ typical (re)actions of the child to the caretaker; i.e., to mal-treatment which illustrate psychodynamic interaction.	IV C Sample Content 1 - 3 See above.

Key Word[4] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

4 Evaul.

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 12 AND 13 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 12. DISCRIMINATE conscious and unconscious reactions of the child to the caretaker.	Identify the following as a) conscious reaction or b) unconscious reaction of the child to the caretaker.	The student will give correct information by utilizing the resources listed below: IV C Sample Content 1 - 4 IV A Sample Content 1 - 4 IV.1 II.7 II.8 II.9 III A Sample Content 1 - 3 III C III D III E III.3 Transparency 17 c Transparency 20 a, b, c
13. EXPLAIN the relationship of stress to the conscious and unconscious reactions of the child to the caretaker (i.e., to maltreatment).	Explain and give ________ examples of the child's (re)actions to the caretaker; i.e., to maltreatment which illustrate stress as a psychodynamic factor in an episode of child maltreatment.	IV C Sample Content 1 - 4 See above.

Key Word[5] (See Appendix A.)

DISCRIMINATE - to be able to differentiate one type from another -- similar to "classify"

EXPLAIN - to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship

5 Evaul.

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 14 AND 15 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization D Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 14. EXPLAIN the relationship of nurturing experiences in infancy and childhood to the ability to nurture in later life.	Write a paragraph or paper in which you explain the relationship of nurturing in infancy and childhood to ability to nurture in later life (adolescence or adulthood).	The student will give correct information by utilizing the resources listed below: IV D Sample Content 1 and 2 IV A IV.1 IV.6 IV.9 IV.10 I A Sample Content 1 & 2 I.1 I.2 II C Sample Content 1 & 2 III A III B III C III.1b III.8 VI.20 Transparency 7, 8, 9, 10
15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.	Write a paragraph or paper in which you explain the relationship of infant or childhood conditioning toward violence to violent behavior in later life (adolescence or adulthood). Name ______ ways in which infant or childhood conditioning toward violence is expressed through violence in later life (adolescence or adulthood).	IV D Sample Content 1 and 2 See above.

Key Word[6] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship

6 Evaul.

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 14 AND 15 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization D Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 16. RECOMMEND ways to break the recurring cycle of child maltreatment within soc society.	Write a paragraph or paper in which you recommend ways to break the recurring cycle of child maltreatment within society. Name ______ ways to break the recurring cycle of child maltreatment within society.	The student will give correct information by utilizing the resources listed below: IV D Sample Content 1 and 2 IV A IV.1 IV.6 IV.9 IV.10 I A Sample Content 1 & 2 I.1 I.2 II C Sample Content 1 & 2 III A III B III C III.1b III.8 VI.20 Transparency 7, 8 9, 10
17. RECOMMEND ways to break the recurring cycle of child maltreatment within the family and the individual.	Write a paragraph or paper in which you recommend ways to break the recurring cycle of child maltreatment within the family. Write a paragraph or paper in which you recommend ways to break the recurring cycle of child maltreatment within the individual. Name _____ ways to break the recurring cycle of child maltreatment within the family/ the individual.	IV D Sample Content 1 and 2 See above.

Key Word[7] (See Appendix A.)
RECOMMEND - to present something as worthy of acceptance

7 Evaul.

CLASS RECORD FORM

S = SATISFACTORY

U = UNSATISFACTORY

UNIT IV: THE PSYCHODYNAMICS OF CHILD MALTREATMENT

CLASS ______________________________ PERIOD _______________

INSTRUCTIONAL OBJECTIVE: The student will be able to explain the psychodynamic dimension of child maltreatment.

	PERFORMANCE OBJECTIVE																	AVERAGE %	
NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	S	U
AVERAGE % S																			
AVERAGE % U																			

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE.

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE ______

TOTAL % UNSATISFACTORY for COURSE ______

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES	AVERAGE % Instructional Objectives S	U
UNIT I Instructional Objective	1 2 3 4 5 6 7 8		
UNIT II Instructional Objective	1 2 3 4 5 6 7 8 9 10		
UNIT III Instructional Objective	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		
UNIT IV Instructional Objective	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17		
UNIT V Instructional Objective One	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		
UNIT V Instructional Objective Two	1 2 3 4 5		
UNIT VI Instructional Objective One	1 2 3 4		
UNIT VI Instructional Objective Two	1 2		

CLASSROOM INSTRUCTIONAL MATERIALS

for

IV. The Psychodynamics of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (IV.1)
2. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series (IV.2)
3. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (IV.3)

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Films

War of the Eggs. A heart-rending incisive story of a young couple who quarrel and as a result, their young son begins to cry hysterically. The enraged young wife roughly pushes him down the stairs, badly injuring him. At the hospital a psychiatrist gently tries to help them. Painfully, husband and wife open to each other, accept responsibility for what they have done, and turn for help. Written by Michael Crichton, author of Andromeda Strain.

Paulist Productions 1974 16mm color 26½ min. MCPS Film Library

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

*Definition of Terms (IV.1)

	Term		Definition
1.	Physical	adj.	- 3a: of or relating to the body b: concerned or preoccupied with the body and its needs
2.	Psychological	adj.	- 2: directed toward the will or toward the mind
**3.	Dynamics	n.	- 2: the driving physical, moral, or intellectual forces of any area or the laws relating to them
4.	Psychodynamics	n. adj.	- the psychology of mental or emotional forces or processes developing esp.

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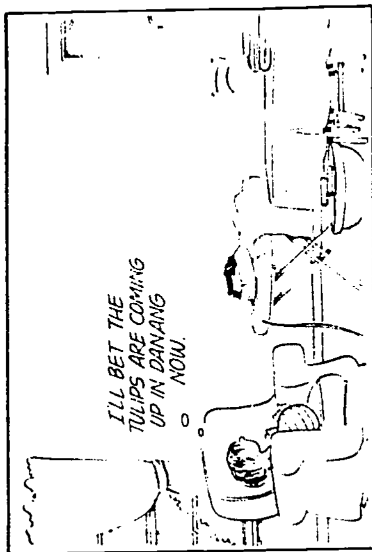
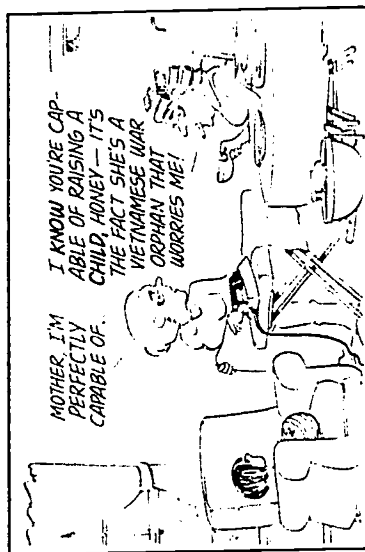
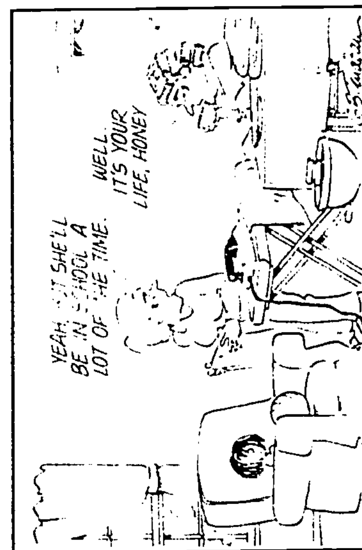
(Transparency 18)

IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT (IV.2)







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(Transparency 19 a, b, c)

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

TYPICAL CONSCIOUS AND UNCONSCIOUS (RE)ACTIONS OF THE CARETAKER TO THE CHILD (IV.3)

- Expects (demands) the child to perform above his/her physical, emotional, or intellectual capacity
- Uses the child as an object of aggression in order to discharge hostility directed toward another; i.e., as a "pawn"
- Depends upon the child to fulfill the emotional or physical needs

(Transparency 20 a, b, c)

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

*TYPICAL CONSCIOUS AND UNCONSCIOUS (RE)ACTIONS OF THE CHILD TO THE CARETAKER; i.e., TO MALTREATMENT (IV.4)

Disturbed eating habits; i.e., irregular, too much, too little

Nightmares

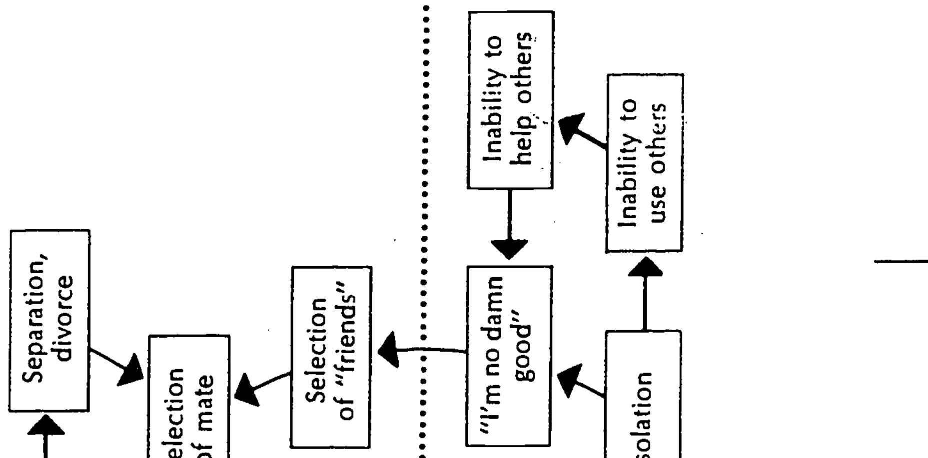
Bedwetting, soiling

Extreme passivity

Extreme aggressiveness

IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT (IV.5)

DHEW Publication No. (OHD) 75-69



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IN THIS ISSUE

The Center Quarterly Focus Spring, 1975. Reprinted by permission.

The **Center Quarterly Focus** is on a review of the literature concerning early child abuse and its relation to adolescence.

Colleen Baumtrog[1] came to the Center for Youth Development and Research to explore the effects of early child abuse on adolescence as a means of illuminating her work with a thirteen year old girl in a residential treatment center for disturbed children. Her questioning led to an examination of the literature on early child abuse — definition, history, incidence, demography, etiology — and its relation to adolescence. She undertook this literature review as an independent study project at the Center for Youth Development and Research. It has been edited for publication and reflects, in its publication, the Center's commitment to including young persons in every aspect of its work.

This review underscores the need to pursue at least two additional issues: *The first* is "adolescent abuse" per se, though it seems likely that most young people suffering abuse as adolescents also experienced such treatment as children.

> "Abuse of adolescents and youth is being reported more frequently in some communities. They may provoke adults into assaulting them ('conflict of values') or the abuse may represent an extension of the phenomenon of the abuse of infants and small children."[2]

The definition of "child abuse" Ms. Baumtrog uses clearly encompasses persons in adolescence. Yet despite increasing concern and comment about adolescent abuse, it has not generated a critical mass of research and documentation with implications for practice. This is changing.

EARLY CHILD ABUSE AND ADOLESCENCE-

A Literature Review by
Colleen Baumtrog

"...the child is psychologically the father of the man and the events of his first years are of paramount importance for his whole subsequent life."

Sigmund Freud, 1940
An Outline of Psychoanalysis

FOCUS OF CONCERN

Increasing concern over child abuse has produced research, legislation, and education of individuals whose jobs bring them into contact with possible victims of child abuse, as well as attempts to understand and help abusive parents. Efforts to reduce child abuse and deal with it when it arises are commendable, but child abuse is more than a medical and legal problem. Its effects linger long after the abuse is reported and stopped and the physical damage is repaired.

The focus of this paper is on a neglected but significant area of concern: *the psychological and emotional effects of abuse in early childhood on the functioning of adolescents.* Adolescence is seen as a unique stage of development characterized by rapid

obvious clinical signs of abuse receive attention and thus are better off (provided they survive, of course) than those who go undetected.

HISTORY

Child abuse has been practiced since the beginning of recorded time. Reasons for its existence are varied. Among them are religious appeasement, reactions to prophecies of doom, cultural tradition, population control, and mere discipline. Theo Soloman (1973) states that infanticide has been responsible for more children's deaths than any other cause in history except perhaps the bubonic plague. Infanticide was reported as a regular feature of many cultures including Eskimo, Polynesian, Egyptian, African, American Indian, and Australian aborigine. As late as 1837 fe-

not reported, much less investigated. The amount of abuse can be likened to an iceberg, its tip analagous to the *reported* cases. Fontana (1973) notes that 956 cases were reported from New York City alone in 1968. Each year since then the number has almost doubled, rising to over 5,200 in 1972. Data from California and Colorado, when extrapolated, yield an estimate of 200,000 to 250,000 children abused annually in the United States. Kempe (1972) estimated the number to be 60,000. In Congressional testimony (1973) it was estimated that 6,000 children die each year as a result of abuse. Reported abuse unquestionably is increasing. Whether this reflects improved reporting rates or an actual increase in incidence, or both, the data are startling. It should also be noted that even less is known about the incidence of emotional and psychological abuse of children. The lack of an accepted operational definition of such

In summary, indications are that the causes of child abuse are more subtle than can be detected from investigating demographics such as region, sex, age, race, or socioeconomics. Even when the investigations conclude that one of these factors is differentially involved, such as age, the findings only lead to more questions.

ETIOLOGY

Parent abusers are not a homogeneous group. On the surface they represent a random cross section of the general population. They emerge from all socioeconomic strata; they live in large metropolitan areas as well as small towns; their housing varies from substandard to high class suburban; their educational achievement ranges from partial grade school to post-graduate degrees; their religious affiliations include Catholic, Jewish and Protestant. The psychopathology

the typicality of youthful marriages. unwanted pregnancies, illegitimacies, and forced marriages (Merrill, 1962; Elmer, 1967; Zalba, 1971).

Merrill (1962) notes three distinct clusters of personality characteristics in the parents he studied. The first group shows traits of hostility and aggressiveness with the appearance of being continually angry. This anger was described as stemming from conflicts within the mothers themselves. Flynn (1970) also cites parental anger in the form of defective defense structures of the ego, which causes the parent to project anger onto their children while denying and repressing it in themselves. The second group Merrill describes is identified by personality characteristics of rigidity, compulsiveness, and lack of warmth. Many mothers in this group exhibited marked rejection attitudes toward their children. The third group of parents showed strong feelings of pas-

preventing the infliction of prolonged mental and physical suffering on children should be the core of preventive psychiatry.

Though evidence that today's abusive parents have a disturbed history seems clear enough, it is noted by several investigators (Spinetta et al. 1972; Kempe, 1971; Steele, 1968; Morse et al. 1970) that this factor by itself is not sufficient to result in child abuse.

Inappropriate expectations

A third quality abusive parents have in common is that they project inappropriate expectations onto their children. These demands and expectations are unrealistic because they are often beyond the ability of the children to comprehend. Kaufman (1962) describes this practice as parental distortion and misperception. He states "the child is not perceived as a child, but some symbolic or delusional figure" and may be perceived as the psychotic

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cal or developmental deprivation *prior* to the reporting of injury. Elmer (1960) in her hospital survey judged 71 percent of her subjects to be mentally retarded and 30 percent emotionally disturbed.

The abused child may also have qualities which have negative associational effects for the abusing parent. He may remind the parent by looks, time of birth, or mannerisms of an event or a person the parent would rather not remember. Research involving "high risk" groups of children reflecting a variety of intellectual, physical and emotional problems needs to be done.

Precipitating crisis

A second factor associated with child abuse but not directly related to the qualities of the parent is some type of precipitating crisis. Kempe (1972) says, "in the early stages of dealing with parents, it is always safe for the worker to assume that some sort of crisis has occurred in the family." One

EFFECTS OF EARLY CHILD ABUSE ON ADOLESCENCE

Adolescence at best is fraught with problems and potential dangers. Prior abuse increases the hazards and the severity of the problems. For example, an adolescent whose first four years were filled with traumatic batterings, perhaps disguised as severe discipline, certainly has had a pathological relationship with his parents. This developmental stage, described by Erickson (1968) as trust versus mistrust, probably remains unresolved. Taipale et al (1972) conclude that a seven-year-old who was grossly mishandled at age two is less adversely affected by his slight brain damage than by the basic weakness of his sense of trust, thus impairing his ability to relate to new foster parents.

Many adolescents today are drawn to the attention of juvenile authorities and are placed in detention centers, residential treatment centers, or foster homes as a direct result of their inap-

most fundamental motivators of behavior (along with the sex drive). Watson, on the other hand, limited his innate motivators to hunger, thirst, sex, and a few specific fears (loud sounds, for example). He left the explanation of aggression exclusively to learning. Aggression, for the purposes of this paper, is viewed as having characteristics of both. It has its basis in an instinctual drive system that has enabled men to survive, yet the expression of aggression and the qualitative and quantitative forms it takes in an individual's life are left largely to experience.

An experience shown to lead to aggression is frustration. Dollard et al (1939) who were the first to study aggression systematically were influenced by Freud's concepts of aggressive impulses, but they rejected Freud's instinct theory in favor of their own hypothesis that aggression is always a response to some form of frustration. Several studies have demonstrated that frustration does lead to aggression. Block and Martin (1955) and Mallick and McCandles (1966) demonstrated that children become

boys increased size, physical maturity and independence — it became more like a crisis.

Eron, Walder, and Lefkowitz (1971) also found physical punishment, rejection, lack of nurturance, marital discord, and aggressiveness by parents to be positively related to aggression in children. In addition they found that the children who identified strongly with their parents grew less aggressive the more they were punished for aggression, while among boys who did not identify with their fathers, punishment increased aggression. Since most did not identify strongly with their parents, the general effect of severe punishment was to

increase aggression. Kempe (1971) presents an explication of the diagnosis and treatment of abused children based on the concept that child abuse is caused by a disturbance in mothering. It is that early frustration as a result of abuse, together with an inadequate parent-child relationship, can lead to inappropriate aggression as the child becomes an adolescent.

In summary, although this is by no means an all-inclusive presentation of

Conclusion

Specific problems manifested during adolescence are a result of the physical and cognitive changes of the period, together with the effects of a disturbed early development characterized by a pathological parent-child relationship and physical or emotional abuse or both. It is unfortunate that pity and disbelief prevail in dealing with abused infants and children while fear and misunderstanding characterize the handling of these children when they become adolescents. In both cases society mishandles the situation.

The practice of focusing solely on the medical aspects of abuse and the possible removal of the child from the home is inadequate. Treatment of adolescents should include efforts to deal with the etiology of their maladjustment. These adolescents should be treated as disturbed human beings who need and often want help, not as delinquents or criminals needing incarceration.

A considerable amount of knowledge exists about the when, where, why and how of abuse, but this is not enough. The psychological and emotional effects of child abuse are far more severe than the medical effects, if for no other reason than because we do not know how to deal with them. Therefore it is long overdue that society deals with child abuse realistically; treatment of these children once abuse has occurred should include psychological as well as medical treatment.

Finally, adolescents with histories of abuse, especially when the parent-child relationship is disturbed, should receive help, not punishment and socially deroga-

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Home Called More Violent Than Street

By Edward Schumacher
Special to The Washington Post

BOSTON, Feb. 24—From a slap in the face to murder, violence is more likely to occur between members of the family than anyone else.

And yet the laws protecting wives and children, the principal victims, are weak and poorly enforced, a panel of criminologists reported to a meeting here this week of the American Association for the Advancement of Science.

No thorough national studies have been done, they said, but according to accumulated scraps of data and a number of limited studies, the problem is worse than crime on the streets.

"If you're going to be killed in America, if you're going to be beaten up in America, it's more likely to happen by someone in your own family," University of Rhode Island Professor Richard J. Gelles said.

Gelles said in a study of 86 families in a small New Hampshire town, 56 per cent of the parents said that they intentionally tried at least once to physically harm their spouse. One beats the other at least monthly in 25 per cent of the families involve parents and children, according to studies cited by University of New Hampshire Professor Murray S. Straus.

Gelles estimates that the level of family violence has remained about the same in recent years. He said the sharp rise in police reports is probably due to a growing willingness to report family members.

The growing independence of women has helped take the problem "out of the closet," he said. Now, however, it is unclear if that independence will increase or decrease wife beatings—or husband beating.

Reasons for family violence presented by experts here include emotional intensities and physical proximities of living in a family, age and sex discrepencies, and alcohol usage. It is unclear whether violence is higher in economically poorer homes, they said.

Another primary factor in family violence is the use of physical punishment — "spanking" — to discipline a child. Straus, Gelles and Steinmetz report that 84 to 97 per cent of American families use physical punishment at some point in a to pass and enforce laws that intrude on the family. In many states, for instance, wives are not allowed to sue their husbands for rape or assault and battery.

"We're talking about a couple of million wives getting beat up regularly and don't know what to do about it," Gelles said.

America Said to Face 'Female Crime Wave'

BOSTON, Feb. 24 (UPI)—America is facing a "female crime wave" and there may be more behind it than just the women's liberation movement that often is cited as the cause, a New York sociologist said today.

Dr. Florence L. Denmark said the reasons responsible for the sharp rise in female crime rates during the past decade probably go far deeper than the increasing awareness of women's options in society.

"The female offender, whether acting by herself or with others, is not typically the emancipated intellectual striving for civil liberties." Denmark told a final session of the annual meeting of the American Association for the Advancement of Science male crimes of shoplifting and prostitution," Denmark said. "Kitchen knives have given way to pistols and sawed-off shotguns.

"We seem to be witnessing a female crime wave," she told a special symposium on violence in America.

The reasons, she said, probably involve an interaction of psychological, social, economic, political and even religious factors.

Denmark said the rise in female crime cannot be fully seperated psychologically from inner conflict and stress. And she said the fact that more women than men are reported to be suffering from some sort of mental illness suggests "a powerful link between what women are experiencing and what they are doing."

The Washington Post, February 25, 1976
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Ann Landers

THE WASHINGTON POST *Thursday, March 2-, 19-6*

Dear Ann Landers:

Is there relief of kind for a person with my problems? How do other people deal with it? I can't be the only one.

I am nearly 60 years old and I still cry, brawl, sob walk the floors and wring my hands because of my miserable childhood.

Never a hug or a kiss, a compliment or a kind word. It was always an order, a crack on the side of the head, a shove or a kick. We weren't spanked. We were beaten. We weren't slapped, we were pummeled.

Why can't I forget? Why do parents do such things? No sweet memories. It's torture. Am I crazy?

Dear Haunted:

No, you aren't crazy, but you do need professional help to overcome the anger and resentment that has hung on much too long.

You were an unloved, battered child. Most unloved and battered children had parents who were also unloved and battered. When

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Psychological Bulletin
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THE CHILD-ABUSING PARENT: A PSYCHOLOGICAL REVIEW

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Review of professional opinions in the literature reveals that (*a*) the abusing parent was himself raised with some degree of deprivation; (*b*) the abusing parent brings to his role as parent mistaken notions of child rearing; (*c*) there is present in the parent a general defect in character structure allowing aggressive impulses to be expressed too freely; and (*d*) while socioeconomic factors might sometimes place added stresses on basic personality weakness, these stresses are not of themselves sufficient or necessary causes of abuse. A critique is made of a recent demographic survey in light of the foregoing data.

Why does a parent physically abuse his or her own child? During the past 10 years, many attempts have been made to answer this question. An extensive literature has emerged on the medical and legal aspects of the problem of child abuse since the publication of an article by Kempe, Silverman, Steele, Droegemueller, and Silver (1962) and the pursuit of child-protective laws in California by Boardman (1962, 1963). Sociologists and social workers have contributed their share of insights, and a few psychiatrists have published their findings, but surprisingly little attention has been devoted to the problem of child abuse by the psychologist. One seeks with little success for well-designed studies of personality characteristics of abusing parents. What appears is a literature composed of professional opinions on

DEFINITION

What is child abuse? Kempe et al. (1962) limited their study to children who had received serious physical injury, in circumstances which indicated that the injury was caused willfully rather than by accident. They coined the term "battered child" to encompass their definition. Zalba (1966), after a brief review of definitions, likewise addressed himself primarily to those cases in which physical injury was willfully inflicted on a child by a parent or parent substitute.

Because of the difficulty of pinpointing what is emotional or psychological or social neglect and abuse, and because of the extent of the literature on physical abuse alone, this review, following Kempe's and Zalba's lead, limits the term "child abuse" to the

terns, problems, and accomplishments of the child-abuse reporting laws. A thorough bibliography on child abuse was published by the United States Department of Health, Education and Welfare (1969).

This review is not concerned with the medical and legal aspects of the problem and refers only to those articles that gave more than a passing mention to the psychological and social determinants of parental abuse of children.

Review of the Literature

Most of the studies of child abuse are subject to the same general criticism. First, the studies that set out to test specific hypotheses are few. Many start and end as broad studies with relatively untested common-sense assumptions. Second, in most studies in this area, the researchers used samples easily available from ready-at-hand local populations, and thus the samples were not truly representative. We shall have to rely on the convergence of conclusions from various types of sampling to establish generalizations. Third, practically all of the research in child abuse is ex post facto. What is left unanswered and still to be tested is whether one can determine prior to the onset of abuse which parents are most likely to abuse their children, or whether high-risk groups can only be defined after at least one incident of abuse has occurred.

In spite of these criticisms, the studies of families, children were born in very close succession. Often one child would be singled out for injury, the child that was the victim of an unwanted pregnancy.

Various other studies enter figures from their own samples, generally repeating Kempe's findings (Birrell & Birrell, 1968; Cameron, Johnson, & Camps, 1966; Ebbin, Gollub, Stein, & Wilson, 1969; Elmer & Gregg, 1967; Gregg & Elmer, 1969; Helfer & Pollock, 1967; Johnson & Morse, 1968; Nurse, 1964; Schloesser, 1964; Skinner & Castle, 1969).

Elmer (1967) and Young (1964) add to Kempe's findings the factors of social and economic stress, lack of family roots in the community, lack of immediate support from extended families, social isolation, high mobility, and unemployment.

While pointing to the role that economic and social stresses play in bringing out underlying personality weaknesses, the majority of the foregoing authors caution that economic and social stresses alone are neither sufficient nor necessary causes for child abuse. They point out that, although in the socially and economically deprived segments of the population there is generally a higher degree of the kinds of stress factors found in abusing families, the great majority of deprived families do not abuse their children. Why is it that most deprived families do not engage in child abuse, though subject to the same economic and social stresses as those families who do abuse their children?

Allowing that child abuse in many cases may well be the expression of family stress, Adelson (1961), Allen, Ten Bensel, and Raile (1969), Fontana (1968), Holter and Friedman (1968), and Kempe et al. (1962) considered psychological factors as of prime importance in the etiology of child abuse. There is a defect in character structure which, in the presence of added stresses, gives way to uncontrolled physical expression.

Paulson and Blake (1969) referred to the deceptiveness of upper- and middle-class abusers, and cautioned against viewing abuse and neglect as completely a function of educationally, occupationally, economically, or socially disadvantaged parents, or as due to physical or health impoverishment within a family.

If it is true that the majority of parents in the socially and economically deprived segments of the population do not batter their children, while some well-to-do parents engage in child abuse, then one must look for the causes of child abuse beyond socioeconomic stresses. One of the factors to which one may look is parental history.

Parental History

One basic factor in the etiology of child abuse draws unanimity: Abusing parents were themselves abused or neglected, physically or emotionally, as children. Steele and Pollock (1968) have shown a history of parents having been raised in the same style that they [illegible] was rejection, indifference, and hostility in their own childhood that produced the cruel parents.

Ten years later, Tuteur and Glotzer (1966) studied 10 m[illegible]rs who were hospitalized for murdering t[illegible]r children and found that all had grown up in an emotionally cold and often overtly rejecting family environment, in which parental figures were either absent or offered little opportunity for wholesome identification when present.

Komisaruk (1966) found as the most striking statistic in his study of abusing families the emotional loss of a significant parental figure in the early life of the abusive parent.

Perhaps the most systematic and well-controlled study in the area of child abuse, that of Melnick and Hurley (1969), compared two small, socioeconomically and racially matched groups on 18 personality variables. Melnick and Hurley found, among other things, a probable history of emotional deprivation in the mothers' own upbringing.

Further support for the hypothesis th[illegible] the abusing parent was once an abused [illegible] neglected child is found in Bleiberg (1965[illegible] Blue (1965), Corbett (1964), Curtis (196[illegible] Easson and Steinhilber (1961), Fairburn a[illegible] Hunt (1964), Fleming (1967), Green (1965[illegible] Harper (1963), Kempe et al. (1962), M[illegible] Henry, Girdany, and Elmer (1963), Morr[illegible] Gould, and Matthews (1964), Nurse (196[illegible] Paulson and Blake (1969), Silver, Dubl[illegible] and Lourie (1969b), and Wasserman (196[illegible]

In a summary statement, Gluckman (196[illegible]

the nature of child rearing, and look to the child for satisfaction of their own parental emotional needs.

Steele and Pollock (1968) found that the parents in their study group expected and demanded a great deal from their infants and children, and did so prematurely. The parents dealt with their children as if older than they really were. The parents felt insecure and unsure of being loved, and looked to their children as sources of reassurance, comfort, and loving response, as if the children were adults capable of providing grown-up comfort and love.

Melnick and Hurley (1969), in their well-controlled study of personality variables, also found in the mothers severely frustrated dependency needs, and an inability to empathize with their children.

Galdston (1965) concurred that abusing parents treated their children as adults, and he added that the parents were incapable of understanding the particular stages of development of their children.

Bain (1963), Gregg (1968), Helfer and Pollock (1967), Hiller (1969), Johnson and Morse (1968), Korsch, Christian, Gozzi, and Carlson (1965), and Morris and Gould (1963) also reported that abusing parents have a high expectation and demand for the infant's or child's performance, and a corresponding disregard for the infant's or child's own needs, limited abilities, and helplessness. Wasserman (1967) found that the parents not only considered punishment a proper disciplinary ing children with an exaggerated intensity and at an inappropriately early age.

Presence of Severe Personality Disorders

There has been an evolution in thinking regarding the presence of a frank psychosis in the abusing parent. Woolley and Evans (1955) and Miller (1959) posited a high incidence of neurotic or psychotic behavior as a strong etiological factor in child abuse. Cochrane (1965), Greengard (1964), Platou, Lennox, and Beasley (1964) and Simpson (1967, 1968) concurred. Adelson (1961) and Kaufman (1962) considered only the most violent and abusive parents as having schizophrenic personalities. Kempe et al. (1962), allowing that direct murder of children betrayed a frank psychosis on the part of the parent, found that most of the abusing parents, though lacking in impulse control, were not severely psychotic. By the end of the decade, the literature seemed to support the view that only a few of the abusing parents showed severe psychotic tendencies (Fleming, 1967; Laupus, 1966; Steele & Pollock, 1968; Wasserman, 1967).

Motivational and Personality Variables: A Typology

A review of opinions on parental personality and motivational variables leads to a conglomerate picture. While the authors generally agree that there is a defect in the abusing parent's personality that allows aggressive impulses to be expressed too freely (Kempe

(Cochrane, 1965; Delaney, 1966; Jacobziner, 1964; Ten Bensel, 1963).

Some authors consider a role reversal between the spouses as a prime factor in the etiology of child abuse. A home in which the father is unemployed and the mother has taken over the financial responsibility of the family is considered a breeding ground for abuse (Galdston, 1965; Greengard, 1964; Nathan, 1965; Nurse, 1964).

Finally, there are those authors who considered low intelligence as a prime factor in the etiology of child abuse (Fisher, 1958; Simpson, 1967, 1968), although this point is disputed in the findings of Cameron et al. (1966), Holter and Friedman (1968), Kempe et al. (1962), and Ounsted (1968).

Is there a common motivational factor behind child abuse? Is there only one "type" of abusing parent? Realization that each of the above described characteristics was found to exist at least in some individual circumstances has led some authors to group together certain characteristics in clusters, and to evolve a psychodynamic within each cluster. The first major attempt at a typology was made by Merrill (1962). Because Merrill's typology is the most often quoted, it is summarized in some detail.

Merrill identified three distinct clusters of personality characteristics that he found to be true both of abusing mothers and fathers, and a fourth that he found true of the abusing fathers alone. The first group of parents seemed to Merrill to be beset with a continual and pervasive hostility and aggressiveness, sometimes focused, sometimes directed

concern with their own pleasures, inability to feel love and protectiveness toward their children, and in feelings that the children were responsible for much of the trouble being experienced by themselves as parents. These fathers and mothers were extremely compulsive in their behavior, demanding excessive cleanliness of their children. Many of these parents had great difficulty in relaxing, in expressing themselves verbally, and in exhibiting warmth and friendliness.

Merrill's third group of parents showed strong feelings of passivity and dependence. Many of these parents were people who were unassuming, reticent about expressing their feelings and desires, and very unaggressive. They were individuals who manifested strong needs to depend on others for decisions. These mothers and fathers often competed with their own children for the love and attention of their spouses. Generally depressed, moody, unresponsive, and unhappy, many of these parents showed considerable immaturity.

Merrill's fourth grouping or cluster of personality characteristics included a significant number of abusing fathers. These fathers were generally young, intelligent men with acquired skills who, because of some physical disability, were now fully or partially unable to support their families. In most of these situations, the mothers were working and the fathers stayed at home, caring for the children. Their frustrations led to swift and severe punishment, to angry, rigid discipline.

Two further attempts at classification, Delsordo (1963) and Zalba (1967), with slight modifications, can be reduced to Merrill's

whatever source is present in the abusing parent allowing aggressive impulses to be expressed too freely. During times of additional stress and tension, the impulses express themselves on the helpless child.

Critique of a Survey

Of the studies surveying the demographic characteristics of families in which child abuse has occurred, the most extensive in scope was the national survey undertaken by Gil (1968a, 1968b, 1969).[3] In 1969, Gil reported that the phenomenon of child abuse was highly concentrated among the socioeconomically deprived segments of the population. Concluding that "physical abuse is by and large not very serious as reflected by the data on the extent and types of injury suffered by the children in the study cohort [p. [illegible]]," Gil placed [illegible] intervention strategy in the general betterment of society. For Gil, the cultural attitude permitting the use of physical force in child rearing is the common core of all physical abuse of children in American society. Since he found the socioeconomically deprived relying more heavily on physical force in rearing children, he recommended systematic educational efforts aimed at gradually changing this cultural attitude, and the establishment of clear-cut cultural prohibitions against the use of physical force as a means of rearing children. He viewed this educational effort as likely to produce the strongest possible reduction in the incidence and prevalence of physical abuse of children.

For Gil, child abuse is ultimately the re-

the availability in every community of resources aimed at the prevention and alleviation of deviance and pathology; (*c*) the availability of comprehensive family planning programs and liberalized legislation concerning medical abortions, to reduce the number of unwanted children; (*d*) family-life education and counseling programs for adolescents and adults in preparation for and after marriage, to be offered within the public school system; (*e*) a comprehensive, high-quality, neighborhood-based national health service, to promote and assure maximum feasible physical and mental health for every citizen; (*f*) a range of social services geared to the reduction of environmental stresses on family life; and (*g*) a community-based system of social services geared to assisting families and children who cannot live together because of severe relationship [illegible]. Gil's ultimate objective is "the reduction of the general level of violence, and the raising of the general level of human well-being throughout our entire society [p. 863]."

While one must praise the efforts of the Gil study in data collection, and the ultimate objective of reducing the general level of violence and raising the general level of human well-being in our entire society, one cannot help but feel that Gil did not address himself to the question of child abuse. If there really does exist as strong a link as Gil suggests between poverty and physical abuse of children, why is it that all poor parents do not batter their children, while some well-to-do parents engage in child abuse? Eliminat-

[illegible]

the lessening of the prevalence of child abuse is generally agreed upon, and finds support throughout the literature. However, most of the authors explicitly caution against considering abuse, as does Gil, as a function solely of educational, occupational, economic, or social stresses. This point is made by Adelson (1961), Allen et al. (1969), Elmer (1967), Fontana (1968), Helfer and Pollock (1967), Holter and Friedman (1968), Kempe (1968), Kempe et al. (1962), Paulson and Blake (1967), Silver et al. (1969a, 1969b), and Steele and Pollock (1968).

The great majority of the authors cited in this review have pointed to psychological factors within the parents themselves as of prime importance in the etiology of child abuse. They see abuse as stemming from a defect in character leading to a lack of inhibition in expressing frustration and other impulsive behavior. Socioeconomic factors sometimes place added stress on the basic weakness in personality structure, but these factors are not of themselves sufficient or necessary causes of abuse.

Conclusions

The purpose of this review has been to bring together the published professional opinions on the psychological characteristics of the abusing parent, in order to determine from the most commonly held opinions what generalizations can be induced, and thus to lay the groundwork for more systematic testing of hypotheses.

The psychologist, both as a specialist in the functioning of the human as an individual and as a scientist trained in research determine after the fact of abuse which families must receive the most attention to assure the further safety of their child.

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VIOLENCE IN OUR SOCIETY

VIOLENCE IS THE NAME we give to the more extreme forms of aggression that we consider destructive and wrong. There is much of it in our society. There is much of it all over the world, and we deplore it. But rather than just deploring it further, repeating the common phrase, "We've got to stop it," I would like to describe a few of my ideas, shared by some others, about why violence persists in our culture, why it is expressed the way it is, and when it is.

At the outset, I should say that I am one of those who believes that there is such a thing as an instinctive drive or urge toward aggression. All of us human beings share an urge toward action that can become either constructive or destructive. Aggression is part of our biological heritage. In the relatively short time of our evolution as homo sapiens, we have not had time to mutate free of the aggressive drive that is so characteristic of all subhuman primates and lower animals. It is doubtful if we could survive without aggression. Even if we did, we would lose much of our ability to be creative and progressive.

During my own childhood in those quiet, post-Victorian years of the early part of this century, many cautionary tales and poems were used for the admonition of children. One of these little poems that my Quaker grandmother and my maiden aunts often quoted to my brothers and me went as follows: "Let dogs delight to bark and bite, for 'tis their nature to; let lions and tigers growl and fight, for God hath made them so. But children, you should never let your angry [illegible]

ways do we have permission to discharge our aggressive drives?

In recent years we have been quite disturbed by the assassination of John Kennedy, Robert Kennedy, and Martin Luther King. Since the United States began, not quite two centuries ago, four presidents have been killed and three others shot at but not killed. We are all very much distressed by this evidence of violence. Let us look for a minute at a corresponding number of years in the history of Rome, covering the period from Julius Caesar through the reign of the Emperor Hadrian. In our period, we have had 37 presidents. In the corresponding period in Rome, 21 men assumed the leadership of government. Of those 21, 8 were murdered, 4 committed suicide, 8 died a natural death. One man, Cassius, does not quite fit into this classification because, after his defeat by Marc Antony, he ordered his own [illegible]

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Confederacy. He killed Lincoln to avenge himself and the South against the evil he believed Lincoln had done against their rights.[1] Why did Guiteau kill Garfield? He was a disappointed office-seeker to be sure. He was also a member of a political group called "the stalwarts," who were very much against Garfield, and who felt that he had not recognized their rights and their privileges. Therefore, Garfield personified the evil that Guiteau thought existed, so he killed him.[2] Leon Czolgosz assassinated McKinley. Czolgosz was a member of a group of anarchists whose ideals and sense of duty led them to assassinate rulers.[3]

Theodore Roosevelt, Franklin Roosevelt, and Harry Truman were shot at by people whom we called "fanatics." We disagree completely with their behavior and are horrified by it, yet we must realize that from their standpoint they were following the highest of ideals and duty.

It is this pattern of the discharge of aggression in violent forms with a sense of rightness or even righteousness that I want to accent. This pattern has a long and very frightening history in our culture. Let me cite a few examples. Late in the 10th century, King Olaf Tryggvesson converted the Norwegians to Christianity. How did he do it? He took his army out through the country and offered the villagers two choices: either to become Christians or have their heads chopped off. Is this much different from the present groups in our society who say, "You must either follow our ideals and demands--what we believe is right or we will riot, pillage, and destroy?" Somewhat later the Crusaders, carrying the banner of God and the Church with the noble purpose of liberating the Holy Land, killed thousands of infidels and Saracens. In the name of holiness and righteousness, the Spanish Inquisition tortured and burned the heretics. In the name of goodness and their own purity, our New England Puritans burned witches at Salem. The Ku Klux Klan, absolutely sure of its white Protestant superiority, lynched Negroes and attacked Catholics. The Nazis, convinced of their own nobility, purity, and our righteousness in following these old patterns of killing in the name of goodness. Only recently has the righteousness of the law, and the right of the law to put people to death in gas chambers, in electric chairs, and on the gallows—only recently has this become questioned and out of style. But there are still many of us who believe that these types of behavior are very right and very good and very necessary.

Margaret Mead, the anthropologist, wrote clearly in this area. She says, "We know of no human society that does not distinguish between permissible and unpermissible killing. To kill a human being in forbidden ways is *murder;* to kill the trespasser, the enemy, is approved, or even enjoined."

It seems obvious that individuals as well as various cultural and social groups tend to use aggression and violence that they consider good or right to enforce their good and right standards. Even nominally peaceful people use this mechanism. Let me turn again to the Quakers for an example. A Quaker woman named Hannah Whitall Smith was a devout, peace-loving woman brought up near Philadelphia, where she married and raised her children, and later moved to England where she lived the rest of her life. She often gave talks on religious subjects and was a very active member of the British Women's Temperance Union. Like many other Quakers she was very much interested and active in improving the status of women. Not quite 100 years ago she wrote in a letter to a friend: "Girls have a right to a college education. They should be made to get it, even at the point of a bayonet." Several months ago, a newspaper item under a San Francisco dateline quoted Governor Ronald Reagan to the effect that he would keep San Francisco State College open, even if it required the use of bayonets. In these statements of Hannah Smith's and Governor Reagan's, we see clearly demonstrated the tendency to use force to implement a perfectly good ideal. Not openly expressed but certainly implied is a lack of consideration or

Instructional Objective Two

The student will be able to state the provisions of federal, state, and local child maltreatment law.

Performance Objectives for Generalization D

1. DESCRIBE briefly the chronology and extent of child maltreatment law in the U. S.
2. STATE the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.
3. STATE the provisions of the state laws for a) abuse and b) neglect.
4. COMPARE the state law with the local law for a) abuse and b) neglect.
5. DESCRIBE in detail the local reporting process a) for abuse, b) for neglect.

Generalization D

CHILD MALTREATMENT -- WHETHER CIRCUMSTANTIAL, INCIDENTAL, OR INTENTIONAL -- IS DEFINED BY LAW.

Sample Content

1. Child maltreatment legislation
2. Current child maltreatment laws
   a) State law
   b) Local
3. The local process for reporting child abuse
   a) Mandatory by law
   b) Identity not required
   c) Provision for immunity
   d) Authorized agencies
   e) Methods of investigation
   f) Registration of case
      1) Local
      2) Central
4. The local process for reporting child neglect

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Suggested Classroom Activities and Procedures for Performance Objectives

1 through 5

1. Prepare students through a review of Unit I Generalization B Sample Content 1 through 4. Include also Suggested Classroom Procedures and Activities for Performance Objectives.

   Utilize Transparencies 7 through 12 for discussion where appropriate.

2. Introduce Generalization V D, and write on board for students.

3. Clarify student understanding of terms through a brief review of Generalizations V A, V B, and V C.

4. Have students read and discuss in class:

   a) "Child Abuse in the United States" (V.2)

   b) "Child Abuse Legislation in the 1970's" (V.3)

   c) "Child Abuse: Attempts to Solve the Problem by Reporting Laws" (V.4)

5. Develop student understanding of the federal Child Abuse Prevention and Treatment Act of 1974 (V.5).

6. Show and discuss Transparency 5 and Transparency 6.

7. Develop student understanding of the Maryland State child maltreatment laws (V.6 and V.7).

   a) Child Abuse

      1) Physical injury

      * 2) Sexual abuse

      3) Protection for children up to age 18

      4) Must be inflicted by a caretaker responsible for the child's welfare

* See Appendix F.

b) Child Neglect

1) Under age of 18

2) "Child in need of assistance"

8. Develop student understanding of the Montgomery County child maltreatment law.

a) Montgomery County abuse law is part of the Maryland State criminal code.

b) Montgomery County neglect law is part of the Maryland State civil code.

c) Montgomery County has adopted the State Department of Human Resources guidelines for neglect. (See "A Policy Statement on Child Abuse and Neglect" (VI.3)

9. Develop student understanding of the reporting process in terms of:

a) The state reporting process (may differ in each locality) for abuse and for neglect

b) The local reporting process for abuse and for neglect

10. Students may:

- Invite a member of the local Child Protection Team to discuss the local reporting process
- Group discuss the definition of emotional neglect (V.8)
- Write a review of The Problem of the Battered Child (V.10)
- Make a list of important steps in preparing a neglect proceeding (V.9)
- Write a condensation of Child Abuse Syndrome: A Review (V.11)
- View selected films on child maltreatment

11. Refer to student options for Performance Objectives 1 and 2 for II A.

12. Conclude with assessment measures for Performance Objectives 1 through 5.

EVALUATION

for

V. The Problem of Child Maltreatment

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 THROUGH 3 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
1. STATE the meaning of the term circumstantial child maltreatment.	Define the term circumstantial in relation to child maltreatment.	V A Sample Conte . 1 V.1 Unit I Unit II
2. DESCRIBE ci m-stantial child maltreatment in relation to dysfunctions within society.	Give ______ examples of circumstantial child maltreatment resulting from dysfunctions within society.	V A Sample Content 2 V.1 Unit I Unit II
3. DESCRIBE cumstantial child maltreatment in relation to dysfunctions within the family.	Give ______ examples of circumstantial child maltreatment resulting from dysfunctions within the family.	V A Sample Content 3 V.1 Unit I Unit II

Key Word[1] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture of /to/list the characteristics of a person, place, thing, or event

1 Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 THROUGH 3 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 4. EXPLAIN the relationship of circumstantial child maltreatment to dysfunctions in the individual.	In a brief paragraph, explain the possible relationship of circumstantial child maltreatment to dysfunctions in the caretaker. In a brief paragraph, explain the possible relationship of circumstantial child maltreatment to dysfunctions in the child.	The student will give correct information by utilizing the resources listed below: V A Sample Content 4 V.1 Unit I Unit II Unit III Unit IV
5. PREDICT the probability of circumstantial child maltreatment in relation to individual ability to cope with stress.	In a brief paragraph, explain the importance of the caretaker's ability to cope with stress relative to circumstantial child maltreatment. In a brief paragraph, explain the importance of the child's ability to cope with stress relative to circumstantial child maltreatment.	V A Sample Content 5 V.1 Unit I Unit II Unit III Unit IV

Key Word[2] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to /present the reasons for an occurrence or relationship

PREDICT - to state a possible conclusion before it occurs

2 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 6, 7, AND 8 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 6. STATE the meaning of the term incidental child maltreatment.	Define the term incidental in relation to child maltreatment.	The student will give correct information by utilizing the resources listed below: V B Sample Content 1 V.1 Unit I Unit II
7. DESCRIBE incidental child maltreatment in relation to dysfunctions within society.	Give _____ examples of incidental child maltreatment resulting from dysfunctions within society.	V B Sample Content 2 V.1 Unit I Unit II
8. DESCRIBE incidental child maltreatment in relation to dysfunctions within the family.	Give _____ examples of incidental child maltreatment resulting from dysfunctions within the family.	V B Sample Content 3 V.1 Unit I Unit II

Key Word[3] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something.

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

3 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 9 AND 10 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
9. EXPLAIN the relationship of incidental child maltreatment to dysfunctions within the individual.	In a brief paragraph, explain the possible relationship of incidental child maltreatment to dysfunctions in the care-taker. In a brief paragraph, explain the possible relationship of incidental child maltreatment to dysfunctions in the child.	V B Sample Content 4 V.1 Unit I Unit II Unit III Unit IV
10. PREDICT the probability of incidental child maltreatment in relation to individual ability to cope with stress.	In a brief paragraph, explain the importance of the care-taker'a ability to cope with stress relative to incidental child maltreatment. In a brief paragraph, explain the importance of the child's ability to cope with stress relative to incidental child maltreatment.	V B Sample Content 5 V.1 Unit I Unit II Unit III Unit IV

Key Word[4] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship

PREDICT - to state a possible conclusion before it occurs

4 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 11, 12, AND 13 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 11. STATE the meaning of the term intentional child maltreatment.	Define the term intentional in relation to child maltreatment.	The student will give correct information by utilizing the resources listed below: V C Sample Content 1 V.1 Unit I Unit II
12. DESCRIBE intentional child maltreatment in relation to dysfunctions within society.	Give _____ examples of intentional child maltreatment resulting from dysfunctions of society.	V C Sample Content 2 V.1 Unit I Unit II
13. DESCRIBE intentional child maltreatment in relation to dysfunctions within the family.	Give _____ examples of intentional child maltreatment resulting from dysfunctions of the family.	V C Sample Content 3 V.1 Unit I Unit II

Key Word[5] (See Appendix A.)

- STATE - to make a declarative word phrase setting forth something
- DESCRIBE - to state a verbal picture or /to/list the characteristics of a person, place, thing, or event

5 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 14 AND 15 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 14. EXPLAIN the relationship of intentional child maltreatment to dysfunctions within the individual.	In a brief paragraph, explain the possible relationship of intentional child maltreatment to dysfunctions in the caretaker. In a brief paragraph, explain the possible relationship of intentional child maltreatment to dysfunctions in the child.	The student will give correct information by utilizing the resources listed below: V C Sample Content 4 V.1 Unit I Unit II Unit III Unit IV
15. PREDICT the probability of intentional child maltreatment in relation to individual ability to cope with stress.	In a brief paragraph, explain the importance of the caretaker's ability to cope with stress relative to intentional child maltreatment. In a brief paragraph, explain the importance of the child's ability to cope with stress relative to intentional child maltreatment.	V C Sample Content 5 V.1 Unit I Unit II Unit III Unit IV

Key Word[6] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship

PREDICT - to state a possible conclusion before it occurs

6 Evaul.

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2, AND 3 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective Two: The student will be able to state the provisions of federal, state, and local child maltreatment law.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. DESCRIBE briefly the chronology and extent of child abuse and neglect law in the U.S.	In a brief paragraph, describe the chronology and extent of child abuse and neglect law in the U.S.	The student will give correct information by utilizing the resources listed below: V B Sample Content 1 V.2 V.8 V.3 V.9 V.4 V.10 V.11 Transparencies 7 - 12
2. STATE the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.	In outline form, state the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.	V B Sample Content 1 V.5 V.10 V.8 V.11 V.9 Transparency 5 Transparency 6
3. STATE the provisions of the state law for a) abuse b) neglect	In outline form, state the provisions of the state law for a) abuse b) neglect	V B Sample Content 2 V.6 V.9 V.7 V.10 V.8 V.11 Transparencies 7 - 12

Key Word[7] (See Appendix A.)

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

STATE - to make a declarative word phrase setting forth something

[7] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 4 AND 5 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective Two: The student will be able to state the provisions of federal, state, and local child maltreatment law.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 4. COMPARE the state law with the local (Montgomery County) law for a) abuse b) neglect	In outline form, compare the state law with the local (Montgomery County) law for a) abuse b) neglect	The student will give correct information by utilizing the resources listed below: V B Sample Content 2 V.1 V.9 V.6 V.10 V.7 V.11 V.8 Transparencies 7 - 12
5. DESCRIBE in detail the local reporting process for a) abuse b) neglect	In outline form, describe in detail the local reporting process for a) abuse b) neglect	V B Sample Content 3 and 4 V.1 V.9 V.6 V.10 V.7 V.11 V.8 VI.3 Transparencies 7 - 12

Key Word[8] (See Appendix A.)

COMPARE - to list the similarities and differences of things

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

8 Evaul.

CLASS RECORD FORM

S = SATISFACTORY

U = UNSATISFACTORY

UNIT V: THE PROBLEM OF CHILD MALTREATMENT

CLASS ______________________________ PERIOD ________________

INSTRUCTIONAL OBJECTIVE ONE: The student will be able to identify the individual and societal problem of child maltreatment.

NAME		PERFORMANCE OBJECTIVE														AVERAGE %	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	S	U
AVERAGE % S																	
AVERAGE % U																	

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE ______

TOTAL % UNSATISFACTORY for COURSE ______

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

V. The Problem of Child Maltreatment

1. Definition of Terms (V.1)
2. "Child Abuse in the United States" (V.2)
3. "Child Abuse Legislation in the 1970's" (V.3)
4. "Child Abuse: Attempts to Solve the Problem by Reporting Laws" (V.4)
5. "The Child Abuse Prevention and Treatment Act of 1974" (V.5)
6. Child Abuse: Maryland State Child Maltreatment Law (V.6)
7. Child Neglect: Maryland State Child Maltreatment Law (V.7)
8. "Defining Emotional Neglect" (V.8)
9. "Preparing for a Neglect Proceeding: A Guide for the Social Worker" (V.9)
10. "The Problem of the Battered Child" (V.10)
11. "Child Abuse Syndrome: A Review" (V.11)
12. Instructional Materials for Units I, II, III, and IV
13. Classroom learning center for child maltreatment

*DEFINITION OF TERMS (V.1)

Circumstantial	adj.	- 1: belonging to, consisting in, or dependent upon circumstances
Incidental	adj.	- occurring merely by chance or without intention or calculation.
Intentional	adj.	- 1: done by intention or design

* Webster's New Collegiate Dictionary, 1974.

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(Exerpt from CHILD ABUSE by Jean Yavis Jones, Education and Public Welfare Division, Congressional Research Service, Library of Congress 75-97-ED)

I. CHILD ABUSE IN THE UNITED STATES

Ironically, it may very well be the abhorrence of child abuse which has made it such a slow-moving area of both Federal and State legislation. The very idea that a parent, who is supposed to love and protect his offspring, could be responsible for his or her child's physical injury, or even death, is so repulsive that many are reluctant to believe it. Our courts and legislatures have also been reluctant to get involved in internal family government, preferring to let the families determine their own laws and punishments. The implied "hands-off" policy followed by the government owes much to our close association with English Common Law. Under this Common Law, the right of the father to custody and control of his children was considered virtually absolute, even where this was at odds with the welfare of the child. This has carried over to some extent in our own legal system.

Early History of Child Abuse in the U.S.

In colonial America, the father ruled both his wife and his children. Parental discipline was severe, and parents, teachers and ministers found justification for stern disciplinary measures in the Bible.

Legally speaking, the early American child was, in fact, little more than the property of his parents. It was not unusual for a child to be bound out to other households as an indentured servant or apprentice. The shortage of labor in colonial America, as well as the strongly pervasive Puritan work ethic, was reflected in early laws. In 1642 a Massachusetts statute required parents and masters to provide for the "calling and imployment [sic] of their children."1/

Early laws made a distinction between apprenticeship and servitude (the former requiring training in a trade) but this was not always followed. Eventually, two forms of apprenticeship evolved. Under a voluntary apprenticeship, the child and his parents entered into an agreement on their own initiative. The other form,

1/ Order of the General Court of Massachusetts, 1642, Massachusetts Records, II (1853): 8-10.

compulsory apprenticeship, resulted from the practice of binding out dependent children, who had little or no say in the choice of their master or trade. As time went on laws were passed prohibiting the binding out of infants, but the practice of binding out children beyond infancy continued.

The earliest recorded trial case of child abuse involved a master and his apprentice.2/ In Salem, Massachusetts, in 1639, a man by the name of Marmaduke Perry was arraigned for the death of his apprentice. The evidence given stated that the boy had been ill-treated and subject to "unreasonable correction" by his master. However, the boy's own charge that his master had been responsible for the fracture of his skull (which ultimately resulted in his death) was called to question by testimony that he had told someone else that the injury was the result of falling from a tree. The defendant was acquitted.

In 1643, a master was executed for causing the death of his servant boy,3/ and in 1655 in Plymouth a master was tried and "was subsequently found guilty of manslaughter and ordered 'burned in the hand' and all his goods confiscated."4/ Other early recorded cases show the masters of servant children being admonished for abuse and in some cases the children being freed from indenture because of ill-treatment. In 1700, Virginia issued specific laws for the protection of servants against mistreatment.

As can be seen, most of the early recorded cases of child abuse were specifically related to offenses committed by masters upon servants and did not reflect any movement toward protecting children from abusive treatment by their own parents.

2/ Winthrop, John. The History of New England from 1630-1649. J. Savage, ed. Boston, v. 1, 1853: 318-319.

3/ Rev. John Eliot's Records of the First Church in Roxbury, Massachusetts. Sixth Report of Boston Record Commissioners, Boston, 1881: 187.

4/ Children and Youth in America: a Documentary History 1600-1865. R. Bremner, ed. Cambridge, Massachusetts, Harvard University Press, v. 1, 1970: 123.

Whatever court action there was involving family matters was limited to the removal of children from "unsuitable" home environments. "Unsuitable" usually referred to the parents not providing their children with a good religious upbringing, or refusing to instill in them the value of the work ethic. There were two cases in Massachusetts in 1675 and 1678 in which children were removed because of "unsuitable" homes."5/ In the first case, the children were removed because the father refused to see that they were "put forth to service as the law directs."6/ The second case gave similar justification for the removal of the children, with that offense being compounded by the refusal of the father to attend church services.

The removal of children from such "unsuitable" home environments did not reflect any concern about the physical abuse of children and, in fact, may have been responsible for putting them into a more potentially dangerous environment. It was a common practice for children who were dependent upon public support to be bound out. These children would be auctioned off to the lowest bidder, who would then accept his payment from public funds and take the child as a servant or apprentice.

In the larger cities where the problem of poverty was greater, dependent children were put into almshouses. Conditions in these public poorhouses were bad enough for adult paupers, let alone young children. It was not until the beginning of the nineteenth century that major efforts were made to provide separate residences for children, and it was not until then that public recognition of the abuse of these children in institutions was noted.

The dearth of recorded family child abuse cases in early American history suggests the general tendency of the courts to allow parents their own discretion in determining the kind and degree of home discipline. Parents were considered immune

5/ Ibid, p. 41-42.
6/ Ibid, p. 41.

from prosecution unless the punishment was beyond the bound of "reasonableness" in relation to the offense, or excessive, or the child injured permanently.7/

In 1840, there was a criminal case in Tennessee which involved parental prosecution for excessive punishment. "The evidence showed that the mother struck the child with her fists, and had pushed her head against a wall and that the parents had whipped her with a cowskin, tied her to a bedpost with a rope for two hours, and switched her. The court reversed the parents conviction holding that whether punishment was excessive was a question of fact for the jury to decide rather than a question of law."8/

Early Reform Movements -- Children as Animals

It was not until the second decade of the nineteenth century that public authorities began to intervene in cases of parental neglect. Most of the reform movements were directed toward children in institutions, however, and were aimed at preventing a neglected child from entering a life of crime.

Probably the most significant and helpful of all reform campaigns for child protection was that launched by the American Society for the Prevention of Cruelty to Animals (ASPCA). In 1874, a church worker sought the help of the President of the ASPCA on behalf of an abused child. The case concerned a ten-year-old foster child named Mary Ellen Wilson who was the victim of child abuse. At that time there were laws which protected animals but no local, State or Federal laws to protect children. The case was presented to the court on the theory that the child was a member of the animal kingdom, and therefore entitled to the same protection which the law gave to animals.9/

7/ Thomas. Mason P. Child Abuse and Neglect. Part I: Historical Overview, Legal Matrix and Social Perspectives. North Carolina Law Review, v. 50: 305.
8/ Ibid. p. 305.
9/ New York Times, April 10, 11, 1874, and December 27, 1875.

In the aftermath of public indignation over the case, Elbridge T. Gerry, the lawyer who represented the ASCPA, founded the New York Society for the Prevention of Cruelty to Children. It was originally organized as a private group and later incorporated. Legislation was soon passed in New York and cruelty societies were authorized to file complaints for the violation of any laws relating to children, and law enforcement and court officials were required to aid the societies.

Similar societies were soon organized in other cities throughout the country and by 1922 there were 57 Societies for the Prevention of Cruelty to Children, and 307 humane societies concerned with the welfare of children. With the advent of government intervention into child welfare the number of these societies has declined.

Recent Developments

One of the main reasons for the lack of prosecution in child abuse cases has always been the difficulty in determining whether the physical injury was, in fact, a case of deliberate assault or an accident. In recent years, however, doctors in the area of pediatric radiology have been able to determine the incidence of repeated child abuse through more sophisticated developments in x-ray technology. These advances have allowed radiologists to see more clearly such things as subdural hematomas (blood clots around the brain resulting from blows to the head) and abnormal fractures. This has brought about more recognition of the widespread incidence of child abuse and public reaction has been on the rise.

State Legislation

The discovery of the bruised and weighted down body of three-year old Roxanne Felumero in the East River in 1969 set off particular furor when it was discovered that just two months prior to her death her parents had been brought before the New

York Family Court for alleged neglect and abuse, and the judge had released the child back to their custody. The inability of the courts to conclusively prove the criminal act of child abuse can lead to just this kind of tragic situation.

The problem of protecting a child from abuse is a particularly difficult one, for it involves a victim who often will not, or cannot testify against his or her attacker; it is usually committed in the privacy of the home, and even when it is reported, it is difficult to prove in the absence of eyewitnesses.

All fifty States have some form of child abuse laws. These are basically concerned with reporting laws which encourage or require the reporting of suspected child abuse (usually by doctors and other professional persons); criminal law provisions to punish those who abuse children; juvenile court acts, and State legislation to establish or authorize protective services for children.

Between 1963 and 1969, all fifty State legislatures passed some kind of child abuse reporting statute, and all but four had mandatory requirements for reporting. (See Part III-B --The Laws for Reporting Child Abuse.) It is estimated that there are thousands of cases of child abuse which remain unreported every year. The problem is difficult to solve through legislation. The reluctance of people to get involved, and the possibility of civil suits against them if they do, seems to remain a deterrent, despite the fact that all but one of the States have passed some form of immunity legislation. Part of the problem may also lie in the lack of information about the subject. The first studies which appeared in the early 1960's were often more sensational than informative. Since that time more substantive studies have been conducted.

The degree of immunity given and laws making the reporting of child abuse mandatory vary from State to State. In many States there are penal sanctions for failure to report. Most of these involve financial penalties, but there are a few States which have criminal penalties. Because of the variance of reporting laws,

legislative models have recently been proposed by such groups as the United States Children's Bureau, the Council of State Governments, the American Humane Association and the American Medical Association.

Federal Legislation

The Federal Government did not get involved in child welfare until 1912, when after considerable debate, Congress passed a bill to create the United States Children's Bureau. This bill was signed into law by President Taft on April 9, 1912, and authorized the creation of a special bureau to do research and provide information about children. In 1935, with the passage of the Social Security Act, the Federal Government became more directly involved in child welfare services. The grants were to be used for "...the protection and care of homeless, dependent and neglected children and children in danger of becoming delinquent." (Now Title IV-B)

The 1962 Social Security Amendments required each State to make child welfare services available throughout the State to all children and provide coordination between current child welfare services (Title IV-B) and the social services under the Aid to Famililies With Dependent Children (IV-A) program. This latter requirement was to be accomplished by making maximum use of child welfare staff in providing consultation and services for children in families receiving public assistance. The 1962 amendment also revised the definition of "child welfare services" to specifically include reference to the prevention or remedying of child abuse.[10]

Since 1962, most of the funds for services for child protection have been spent under Title IV-A (new Title XX, effective October 1, 1975) which provides services primarily for families on welfare, with the major portion of funds under

10/ U.S. Congress. Senate. Committee on Finance. Report on H.R. 10606 - Public Welfare Amendments of 1962. 87th Congress, 2nd Session, Washington, D.C., U.S. Govt. Print. Off., 1962: 15.

Child Welfare Services (Title VI-B) being spent on foster care. For example, of fiscal year 1972 Federal and non-Federal expenditures, it is estimated that $99.4 million was spent under Title IV-A Social Services Program for child protection services, as compared to $8.4 million for child protection services under Title IV-B.[11] Under Title IV-B Federal funding has been fixed by appropriations acts at between $46-$50 million each of the last several years, whereas under Title IV-A there is 75% Federal matching and, up until 1973, there was completely open-ended funding. (With the enactment of P.L. 92-512 a $2.5 billion limit was placed on Federal funding of Social Services.)

Services for child protection (under Title IV-A & B) end as soon as the child is removed from the home, but may be continued indirectly through foster care services for children removed from a home because of abusive treatement.

Funds have also been granted under Title V (Maternal and Child Health) for research studies on the subject of child abuse and neglect.

Thus, Federal legislative activity in the area of child abuse (with the exception of legislation for the District of Columbia) has been concentrated on financial assistance to the States for child welfare and social services and in research grants. Traditionally, the Federal government has stayed away from specific legislation regarding child abuse, considering it under the jurisdiction of the States. In the last few years, however, perhaps because of increasing awareness of the incidence of child abuse, and the resulting public outcry, a number of bills were introduced in Congress concerning mandatory reporting requirements and the creation of a National Center on Child Abuse and Neglect.

On January 31, 1974, one of these bills (S. 1191), entitled The Child Abuse Prevention and Treatment Act was enacted (P.L. 93-247).

11/ U.S. Congress. Senate. Committee on Finance. Staff Data and Materials on Social Service Regulations. 93rd Congress, 1st Session, Washington, D.C., U.S. Govt. Print. Off., 1973: Table A.

CHILD ABUSE LEGISLATION

IN THE 1970's

Revised Edition

By
Vincent De Francis, J.D.
and
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The American Humane Association, Children's Division
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CHILD ABUSE LEGISLATION IN THE 1970's

SECTION I

THE LAWS FOR REPORTING CHILD ABUSE

Few recent social causes have aroused public sensibility, or created as much concern, as has our present awareness that child abuse is a shocking reality and a problem which knows no bounds in relation to economic or educational levels of parents.

While the current wave of public concern is of comparatively recent origin, the problem itself is old to protective service workers. The first recorded child protective case – The Mary Ellen Case, New York City, 1874 – involved a grossly abused child whose plight became a "cause celebre" when laws to protect animals had to be invoked in her behalf because no laws to protect children had as yet been enacted.

Public indignation at parental disregard of the rights of children and for their traditional protective role is frequently turned toward punitive action against parents who transgress ideals about family responsibility for children. All too frequently, however, the need for constructive planning and the need for services on behalf of the abused child are given only secondary consideration because of the hostility engendered in the process of pursuing sanctions against offending parents.

SIZE OF THE PROBLEM

There are no accurate national statistics on the incidence of child abuse. Several studies serve to index the size of the problem.

Of particular significance is a 1962 study by the Children's Division of The American Humane Association. That study reviewed cases of child abuse reported in United States newspapers. The study amassed information on 662 incidents culled from newspapers in 48 states. The cases represented the grossest types of child abuse - situations which were reported to law enforcement authorities and which were deemed "newsworthy" by the local press. The severity of abuse reported may be judged from the fact that in 178 of the cases, almost one-fourth of the total, the child died from the injuries.

The 662 cases studied represent only that portion of child abuse incidence which was identified and reported by the press. For each such case making the headlines there may well be a hundred or more, unseen, unreported and unidentified.

Educated estimates place the probable national incidence of *serious* child

abuse at more than 10,000 cases a year. There are, no doubt, many additional thousands of cases in which the mistreatment is of less dangerous proportions. David Gil's nationwide study at Brandeis University produced a finding of 9,300 cases of reported child abuse for the nation in 1967 with "approximately 6,000 cases of confirmed abuse." Cases were reported to that study by central registries in the states and territories.

The Children's Division of The American Humane Association, through a grant from the United States Children's Bureau and the Office of Child Development, is in the initial stages of establishing a national information center on child abuse and neglect. It will serve as a national clearinghouse to collect information on abuse and neglect on a systematic, on-going basis. It is hoped that through the operation of the center the magnitude of the abuse problem in the United States can be more accurately documented. The Clearinghouse should be operational early in 1974.

But even with a means of obtaining an accurate count of reported child abuse cases, the essential question remains: How to find and identify the vast number of child abuse cases which are hidden from public view and thus not reported. Not only did this question pose the problem which promoted the move for mandatory reporting statutes, but it continues to be the principal subject of amendatory legislation.

WHY A REPORTING LAW?

The need to discover and identify child victims of abuse is the compelling reason for devising a casefinding tool such as the reporting law. Medical personnel came to be selected as the principal target group of the law's mandate as a result of ferment within medical circles where research and study was producing irrefutable evidence that some cases of child abuse can be determined by medical diagnosis.

Numerous articles in medical journals implore practitioners to exercise great care when examining children brought to them for treatment of injuries. All too frequently, they are told, doctors accept glib stories about such injuries resulting from accidental cause. The use of X-rays and a study of all symptoms may reveal findings inconsistent with the history given, and may provide the doctor with reasonable cause to suspect inflicted, rather than accidental, injury. Failure to recognize the "Battered Child Syndrome" could subject the child to additional or repeated injury or even death.

The logic and force of medical concern as expressed in the literature has focused attention on the doctor as the probable first responsible contact with child victims of abuse. Doctors may be the first "outsiders" with opportunity to see and examine the child, and the first competent persons capable of assuming responsibility for positive action on behalf of the child. Thus, they are seen as the best resource for early identification and reporting of such cases as are brought to them for treatment.

But are doctors willing to voice their suspicions by reporting these cases when the diagnosis of inflicted injuries is not clear cut – particularly in the face of a denial by the parents? Would such reporting expose doctors to the possibility of a legal action for money damages? Would doctors feel that such reporting runs counter to ethical considerations in regard to privileged communication between doctor and patient?

To overcome these blocks to free reporting, legislation has been enacted making reporting of child abuse mandatory, and providing immunity from legal action to persons making a report. These laws also include a waiver of the doctor-patient privilege. Waiver of the husband-wife privilege frees a spouse to testify about abuse committed by the other spouse.

Procedural matters regarding the manner and method of reporting are dealt with. An immediate oral report by telephone to be followed by a written report is commonly required. Also included are requirements covering content, i.e., age of the child, names, addresses, etc.

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PHILOSOPHY AND PURPOSE OF REPORTING LAWS

The most important consideration in the concept of mandatory reporting is a statement of the purpose to be served by the report. Obviously, the core objective is early identification of children who have been physically abused, so that they can be (1) treated for present injuries and (2) protected from further abuse.

Achieving the first prong of this objective—treating children's injuries—presents no serious problem except in cases where parents, for religious or other scruples, may refuse permission for needed medical care. Depending on the specifics of each such case, that problem can be dealt with by invoking the authority of the juvenile court to order necessary medical care over parental objections.

The second part of the objective is one where different approaches may be, and are being, used. Here we are looking at the pattern a community creates for treating the situation so as to protect the child from further injury. Consideration of

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This is not to say that parents should never be prosecuted for child abuse. Certainly, the community has a duty to act against parents who commit heinous criminal acts against children. Where a felony has been committed this duty cannot be evaded. But the decision of whether or not to prosecute in a given case should rest with the county prosecutor. In making this decision he must also consider what happens to children. No decision to prosecute parents can afford to overlook the necessity for adequate planning for the abused child and other children in the family.

SOCIAL PLANNING FOR CHILDREN MEETS THEIR NEEDS BEST

The second approach is rooted in a philosophy which sees the purpose of casefinding to be the discovery of children who, because of abuse, need the care and protection of the community. The community carries out this responsibility by making available the protective social services which will (1) prevent further abuse of the child and (2) meet the child's needs through social services and

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With these philosophical considerations as a background let us examine the legislation enacted to implement them.

LEGISLATIVE ACTION

The grim reality of child abuse and the shocking revelations of research in this area spurred communities into social action. Public concern and recognition of need pressured legislative bodies into giving attention to the problem at a pace with little precedent in recent legislative history.

In the span of four legislative years all 50 states enacted laws seeking reports of injuries inflicted on children. The rush to go on record on behalf of child victims of abuse began with the introduction of 18 bills in 1963. Of that number, 11 achieved passage that year. These were the first such laws anywhere.*

The tempo continued in 1964, a legislative off-year, with 10 additional states passing similar laws. The momentum reached full pitch in 1965 when 26 states

Reporting laws are digested and cited in relation to 14 basic elements. To permit an understanding of the laws and the analytical discussion, these elements are defined below

1. Statement of Purpose

State policy in regard to the subject matter of a specific law is often found in a purpose clause which defines the intent sought to be served by a particular legislative act. In that statement, the legislature goes on record with an expression of the ultimate goals and objectives which it seeks to achieve by the law. If there be ambiguities in the legislative language the purpose clause serves as a guide for interpreting or resolving doubts created by other language.

Review of the 53 laws reveals that 34 states, the District of Columbia,

The effect of this language is that the reporter's diagnosis need not be absolute. He does not have to prove conclusively, even to himself, that the child is a victim of inflicted injury. If the circumstances are such as to cause him to feel doubt about the history given; if he has cause to doubt the truthfulness of the person who tells him about the alleged accidental cause of the injury; or if X-ray or other examinations reveal symptoms and facts inconsistent with the circumstances described, then he has sufficient "reasonable cause to suspect" that the injuries may have been inflicted rather than accidental. This would be enough to satisfy the requirements of the law.

4. Definition of Abuse

Eighteen states have attempted to enlarge upon "reportable conditions" by including a definition of abuse in their reporting laws. The degree of specificity

Should the maker of the report be obliged to identify who injured the child? Does not this requirement constitute a serious block to reporting?

Meeting this obligation places the reporter in an accusatory role. Where the reporting law is housed in the criminal code (in 14 states and the Virgin Islands) the person reporting is in effect asked to make allegations of criminal activity. And where reportable abuse includes only those injuries inflicted intentionally or willfully (in seven states), the reporter is required to make a determination of intent. It is far less demanding upon the reporting source to report only cases where the circumstances are suspicious without the necessity for identifying either *intent* or the *perpetrator.*

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7. Report – How Made

An overwhelming majority of the states emphasize the importance of urgent action in reporting suspected inflicted injury. Usual language is the phrase, "an immediate oral report shall be made by telephone or otherwise." Another common phrase is "forthwith by telephone or otherwise." Most of the states calling for an immediate oral report have the added requirement that this be followed by a report in writing.

The usual requirement is that the reporter furnish identifying data such as names and addresses of child and parents, the child's age, the nature and extent of the injuries, evidence of prior injuries, and any additional information that might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

All fifty states, the District of Columbia, Guam and the Virgin Islands include an immunity clause in their law.

11 Waivers

Because the medical profession expressed concern over the propriety of divulging confidential matter disclosed to them in the doctor-patient relationship, reporting acts provide a waiver. Thus, a doctor is freed from legal or ethical restrictions against revealing confidential information in 39 states, the District of Columbia, Guam and the Virgin Islands.

There is a like privilege between a husband and wife in many states. Neither may divulge information damaging to the other in any criminal procedure without a release from the spouse against whom the evidence is being given. Many of the reporting laws make the husband-wife privilege inapplicable in child abuse cases because quite frequently the only witnesses are the parents themselves. Explicit waivers of this privilege are found in 31 states, the District of Columbia and the Virgin Islands. In nine more states and in Guam the statutory language is not clear but there is inference to support thinking that this waiver is included. In these states

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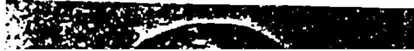
CHILD ABUSE:
ATTEMPTS TO SOLVE THE PROBLEM BY REPORTING LAWS

By Rowine Hayes Brown, M.D., J.D.*



the problem.[6] Reporting statutes would be ineffective unless reported children are, in fact, protected from further injury and offered a chance of a brighter life with a foster family, should remaining at home prove impossible or unsafe.

Child protection and welfare must

laws. It was felt that the larger the scope of the reporting group requesting immunity, the smaller the chance that the legislature would enact an immunity clause to cover all of them. Immunity does not deprive one of his constitutional rights to sue, but precludes monetary re-

in existence at the same time,

3. any child with repetitive trauma,
4. any child with many scars, or
5. any child whose injuries could not be caused in the manner stated in the history.

As suggested by the Children's Bureau,[24] the majority of child

depend somewhat upon the agency receiving the report under the statute, usually either: Police, the prosecutor, Department of Social Welfare, or the Juvenile Court. The original plan to report to the police was based upon the fact these departments are always open and that their help is always available. Many

in fact been previously reported as a battered child. Such a registry, is of additional value for statistical studies and research. In 4 states, central registries were established by the statute.[33] In Illinois, the central registry is located in the main offices of the Department of Children and Family Services,[34] the welfare agency to whom reports must be made.

are omitted from the child abuse statutes.

In 30 of our states,[38] the statutes relate that the physician-patient privilege is not a bar to testimony on the basis of privileged communication and therefore in these jurisdictions, physicians would be expected to disclose in a forum, facts learned

Results of the Legislation

After the announcement of the mandatory reporting laws, numerous reports of child abuse were received throughout the United States. The number of reports were far in excess

onset and that more serious penalties should be enacted to punish physicians who fail to report cases. In my opinion, the problem cannot be "legislated out of existence".[42] If child welfare agencies are to be given more responsibility concerning these cases, their authority and

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1. R.C. Helfer & C.H. Kempe, The Battered Child 8 (1968). Infanticide was practiced by the ancient Egyptians, Greeks, and Romans.
2. These children were hospitalized at the Cook County Children's Hospital between July 1, 1965, and June 30, 1973.
3. In 1962 the Children's Bureau of the Department of Health, Education and Welfare, conducted a symposium on this problem in Washington, D.C., and suggested a model statute.
4. For a listing of each statute, see Paulsen Child Abuse Reporting Laws: The Shape of the Legislation, Columbia Law Review, Vol. 67, No. 1, January 1967, p. 2.
5. Brown, R.H., Fox, E.S., Hubbard, E.L. Medical and Legal Aspects of the Battered Child Syndrome; Chicago-Kent Law Review, Vol. 50, No. 1, (1973), p. 63.
6. Brown, R.H., The Battered Baby, 76 Chicago Medicine, No. 6 (1973).
7. Nebraska, Tennessee, Utah.
8. Arizona, California, Colorado, Connecticut, Delaware, Florida, Idaho, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, Ohio, Pennsylvania, Rhose Island, South Carolina, Texas, Vermont, Washington, Wisconsin.
9. Illinois H.B. 32, 78th General Assembly, 1st Session (1973).
10. Alabama, Alaska, Arkansas, Georgia, Iowa, Kansas, Maryland, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Virginia, Wisconsin.

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Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act".

Child Abuse Prevention and Treatment Act
88 STAT. 4

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

88 STAT. 5
Establishment

(b) The Secretary, through the Center, shall—

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect;

Annual research summary.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect;

Information clearinghouse

(3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

Study

(c) The Secretary may carry out his functions under subsection (b) of this section either directly or by way of grant or contract.*

Amended January 3, 1975 by P.L. 93-644.

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be —

Grants and contracts.

(1) for the development and establishment of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect;

88 STAT. 6

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel which are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Not less than 50 per centum of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.

(b) (1) Of the sums appropriated under this Act for any fiscal year, not less than 5 per centum and not more than 20 per centum may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.

Grants to States

(2) In order for a State to qualify for assistance under this subsection, such State shall —

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting.

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

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(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians;

88 STAT. 7

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and appropriate State agencies providing human services;

(G) provide that in every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;

(H) provide that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects;

(I) provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect; and

(J) to the extent feasible, insure that parental organizations combating child abuse and neglect receive preferential treatment.

(3) Programs or projects related to child abuse and neglect assisted under part A or B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), and (F) of paragraph (2).

49 Stat. 627.
81 Stat. 911.
42 USC 601, 620.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.

(e) For the purposes of this section, the term "State" includes each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, the Virgin Island, Guam and the Trust Territories of the Pacific.*

Amended
January 3, 1975
by P.L. 93-644.

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purposes of this Act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, and $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal year.

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the date of enactment of this Act, appoint an Advisory Board on Child Abuse and Neglect (hereinafter referred to as the "Advisory Board"), which shall be composed of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.

Membership.

Functions.

(b) The Advisory Board shall prepare and submit, within eighteen months after the date of enactment of this Act, to the President and to the Congress a report on the programs assisted under this Act and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.

Report to President and Congress.

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or $1,000,000, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

*Amendments Section 2(c) and Section 4(e) added by P.L. 93-644, approved January 3, 1975.

LEGISLATIVE HISTORY

HOUSE REPORT No. 93-685 (Comm. on Education and Labor).
SENATE REPORT No. 93-308 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
July 14, considered and passed Senate.
Dec. 3, considered and passed House, amended.
Dec. 20, Senate agreed to House amendments with amendments.
Dec. 21, House concurred in Senate amendments.

CHILD ABUSE: MARYLAND STATE CHILD MALTREATMENT LAW

Article 27, Section 35A, Annotated Code of Maryland

An ACT concerning

Child Abuse

For the purpose of expanding the definition of child abuse, defining sexual abuse, requiring reports to include information on sexual abuse; clarifying language; providing immunity from civil liability and criminal penalty for physicians or health care institutions examining or treating a child without the consent of the parents or guardian in certain cases; and providing for payment to physicians or health care institutions for charges incurred.

By repealing and re-enacting, with amendments,

Article 27 - Crimes and Punishments
Section 35A
Annotated Code of Maryland
(1971 Replacement Volume and 1973 Supplement)

Section 1. Be it enacted by the General Assembly of Maryland, that Section 35A of Article 27 - Crimes and Punishments of the Annotated Code of Maryland (1971 Replacement Volume and 1973 Supplement) be and it is hereby repealed and re-enacted, with amendments, to read as follows:

Article 27 - Crimes and Punishments

35A.

The General Assembly hereby declares as its legislative intent and purpose the protection of children who have been the subject of abuse by mandating the reporting of suspected abuse, by extending immunity to those who report in good faith, by requiring prompt investigations of such reports and by causing immediate, cooperative efforts by the responsible agencies on behalf of such children.

(a) Any parent, adoptive parent or other person who has the permanent or temporary care or custody or responsibility for the supervision of a minor child under the age of eighteen years who causes abuse to such minor child shall be guilty of a felony and upon conviction shall be sentenced to not more than fifteen years in the penitentiary.

(b) Wherever used in this section, unless the context clearly indicates otherwise:

1. "Health practitioner" includes any physician, surgeon, psychologist, dentist and any other person authorized to engage in the practice of healing, any resident or intern in any of these professions, and any registered or

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2. "Child" means any person under the age of eighteen (18) years.

3. "Local department of social services" and "local state's attorney" refer to the jurisdiction in which the child lives, or where the abuse is alleged to have taken place, if different.

4. "Educator or social worker" shall mean any teacher, counselor, or other professional employee of any school, public, parochial or private, or any caseworker or social worker or other professional employee of any public or private social, educational, health or social service agency or any probation or parole officer or any professional employee of a correctional institution.

5. "Law-enforcement officer" shall mean any police officer, or State trooper in the service of the State of Maryland or any county or municipality thereof.

6. "Law-enforcement agency' shall mean any police department, Bureau or force of any county or Baltimore City, any police department, bureau or force of any incorporated municipality or the Maryland State Police.

7. "Abuse" shall mean any: (A) physical injury or injuries sustained by a child as a result of cruel or inhumane treatment or as a result of malicious act or acts by any parent, adoptive parent or other person who has the permanent or temporary care or custody or responsibility for supervision of a minor child. (B) Any sexual abuse of a child, whether physical injuries are sustained or not.

8. "Sexual Abuse" shall mean any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy or unnatural or perverted sexual practices on of child by any parent, adoptive parent or other person who has the permanent or temporary care or custody or responsibility for supervision of a minor child.

(c) Every health practitioner, educator or social worker or law-enforcement officer, who contacts, examines, attends, or treats a child and who believes or has reason to believe that the child has been abused is required to make a report in the form and manner provided in the following subsection, notwithstanding any other section of the law relating to privileged communications; provided, however, that if the educator or social worker or law-enforcement officer or health practitioner examines, attends, or treats the child in the capacity of a member of the staff of a hospital, public health agency, child-care institution, juvenile detention center, school or similar institution, the health practitioner, educator or social worker or law-enforcement officer, shall also immediately notify and give all necessary information required by this section to the person or persons in charge of the institution or a designated representative thereof.

(d) Each such report made pursuant to the provisions of subsection (C) shall be made to the agencies as provided for hereinafter, both orally and in written form; both the reports to be made as soon as is reasonably possible in the case, the written report must be made within forty-eight (48) hours of the contact, examination, attention or treatment which disclosed the existence of possible abuse. The oral report shall be made either by telephone or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately notify the other agency. Nothing however, shall prohibit the local department of social services and the appropriate law-enforcement agency from jointly agreeing to cooperative arrangements. The written report required to be made shall be made in all cases to the local department of social services and a copy sent to the local State's attorney.

The oral and written reports shall contain the following information, or as much thereof as the person making the report shall be able in the circumstances to furnish:

(1) The name and home address or addresses of the child or children and the parent or other persons responsible for the care of the child or children in question;

(2) The present whereabouts of the child or children if not the same as the home address or addresses;

(3) The age or ages of the child or children;

(4) The nature and extent of the injuries or injury or sexual abuse of the child or children in question, including any evidence or information available to the person or agency rendering the report of previous injury or injuries possibly resulting from abuse or previous sexual abuse.

(5) All such information available to the reporter which would be of aid in establishing the cause of the injuries or injury and identity of the person or persons responsible therefore.

(e) Any person other than a health practitioner, educator or social worker, or law-enforcement officer who has reason to believe a child is abused shall so report to the local department of social services or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately notify the other agency. Nothing, however, shall prohibit the local department of social services or the appropriate law-enforcement agency from jointly agreeing to cooperative arrangements. A report made by such person may be either written or oral, or both, and such report shall be regarded as a report within the provisions of this section, whether or not the report contains all of the required information provided for in subsection (d).

(f) The local department of social services or the appropriate law-enforcement agency as the case may be, or both, if jointly agreed upon, shall make a thorough investigation promptly upon receiving a report of probable

violation of this section, and the primary purpose of the investigation shall be the protection of the welfare or the child or children. The investigation shall include a determination of the nature, extent and cause or causes of the abuse, if any; upon validation of the suspected abuse, the investigation shall then ascertain the identity of the person or persons responsible therefor, the name, age and condition of other children in the same household, an evaluation of the parents and the home environment, and all other facts or matters found to be pertinent. The local department of social services, and the appropriate law-enforcement agency if that agency participated in the investigation, shall render a complete written report of its findings to the local State's attorney within five (5) working days of the completion of the investigation, which shall be within ten (10) days of the receipt of the oral or written report first disclosing to the local department of social services the existence of a possible violation of this section. Upon request by the local department of social services, the local State's attorney shall assist in the investigation.

(f-1) If, in the course of the investigation conducted by the local department of social services under the provisions of sub-section (e), a representative of the department has probable cause to believe that the child or children is or are in serious physical danger and that an emergency situation exists, the representative may enter the household, if the representative has been previously denied the right of entry. A law-enforcement officer shall accompany the representative, and he may use reasonable force, if necessary, to assure that the representative is able to gain entry. If the danger proves to be genuine, the representative may remove the child or children from the household temporarily without prior approval by the juvenile court.

If the child is removed from the household under the provisions of this section, the local department of social services shall have the child thoroughly examined by a physician, and the report of this examination shall be included in the report made under the provisions of subsection (e) within the time specified.

(g) Based on their findings, the local department of social services shall render the appropriate service in the best interests of the child, including, when indicated, petitioning the juvenile court in behalf of the child for the added protection to the child which either commitment or custody would provide. The local State's attorney and other appropriate law-enforcement agencies having jurisdiction shall take such lawful action as may be appropriate in the circumstances.

(h) (1) Any person, including a health practitioner, educator, or social worker or law-enforcement officer, participating in the making of a good faith report pursuant to this section or participating in an investigation

or in a judicial proceeding resulting therefrom shall in so doing be immune from any civil liability or criminal penalty that might otherwise be incurred or imposed as a result thereof.

(2) Any physician licensed to practice medicine in Maryland who shall be presented with a child pursuant to an order of a court of competent jurisdiction, or by a law-enforcement officer or by a representative of a local department of social services who states he has the child in his custody as a child whom he has reason to believe is an abused child, shall examine said child with or without the consent of a parent, guardian or custodian of said child to determine the nature and extent of injury or injuries or sexual abuse, if any, to said child. Any such physician and any public or private health care institution with which he might be affiliated or to which the child might be brought, and those persons working under the control or supervision of said physician or such health care institution who shall so examine or participate in the examination of said child shall be immune from civil liability and/or criminal penalty that might result from failure to obtain consent from the parent, guardian or custodian to examine the child.

(3) Any physician licensed to practice medicine in Maryland who shall be presented with a child pursuant to an order of a court of competent jurisdiction, or by a law-enforcement officer or by a representative of a local department of social services who states he has the child in his custody as a child whom he has reason to believe is an abused child, who shall have examined any child pursuant to the provisions of section (1) who shall determine that immediate medical treatment is indicated may provide such treatment to said child with or without the consent of a parent, guardian, or custodian of said child. Any such physician or health care institution and those persons working under the control or supervision of said physician or health care institution so treating said child shall be immune from civil liability and/or criminal penalty that might result from the failure to obtain the consent from the parent, guardian or custodian for the treatment of the child.

(4) Whenever any child is examined or treated pursuant to section (H) (2) and section (H) (3) the local department of Health and Mental Hygiene shall be responsible for the payment of all reasonable physician and/or health care institution charges incurred and the parents or the guardian of the child shall be liable to the local department for such payments.

(i) The State Department of Social Services shall and each local department of social services may maintain a central registry of cases reported under this section, which data shall be furnished by the respective local departments of social services throughout the state of Maryland and this data shall be at the disposal of local departments of social services, social agencies, public health agencies, law-enforcement agencies, as well as licensed health practitioners and health and education institutions licensed or regulated by the State of Maryland.

Section 2. And be it further enacted, that this act shall take effect July 1, 1974.

CHILD NEGLECT: MARYLAND STATE CHILD MALTREATMENT LAW

Annotated Code of Maryland
Courts and Judicial Proceedings

Subtitle 8. Juvenile Causes

Section 3-801

(c) "Child" means a person under the age of 18 years.
(d) "Child in need of assistance" is a child who needs the assistance of the court because
 (1) He is mentally handicapped or is not receiving ordinary and proper care and attention, and
 (2) His parents, guardian, or custodian are unable or unwilling to give proper care and attention to the child and his problems provided, however, a child shall not be deemed to be in need of assistance for the sole reason he is being furnished non-medical remedial care and treatment recognized by State law.

Section 3-802

(a) The purposes of this subtitle are:

 (1) To provide for the care, protection, and wholesome mental and physical development of children coming within the provisions of this subtitle and to provide for a program of treatment, training, and rehabilitation consistent with the child's best interests and the protection of the public interest;

 (2) To remove from children committing delinquent acts the taint of criminality and the consequences of criminal behavior;

 (3) To conserve and strengthen the child's family ties and to separate a child from his parents only when necessary for his welfare or in the interest of public safety:

 (4) If necessary to remove a child from his home, to secure for him custody, care, and discipline as nearly as possible equivalent to that which should have been given by his parents.

 (5) To provide judicial procedures for carrying out the provisions of this subtitle.

(b) This subtitle shall be liberally construed to effectuate these purposes.

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Section 3-814 Taking child into custody.

(a) A child may be taken into custody by any of the following methods:

(1) Pursuant to an order of the court.
(2) By a law enforcement officer pursuant to the law of arrest.
(3) By a law enforcement officer or other person authorized by the court if he has reasonable grounds to believe that the child is in immediate danger from his surroundings and that his removal is necessary for his protection, or

(4) By a law enforcement officer or other person authorized by the court if he has reasonable grounds to believe that the child has run away from his parents, guardian, or legal custodian.

(b) If a law enforcement officer takes a child into custody he shall immediately notify, or cause to be notified, the child's parents, guardian, or custodian of the action. After making every reasonable effort to give notice, the law enforcement officer shall with all reasonable speed:
(1) Release the child to his parents, guardian, or custodian or to any other person designated by the court, upon their written promise to bring the child before the court when requested by the court, and such security for the child's appearance as the court may reasonably require, unless his placement in detention or shelter care is permitted and appears required by 3-815, or
(2) Deliver the child to the court or a place of detention or shelter care designated by the court.

(c) If a parent, guardian, or custodian fails to bring the child before the court when requested, the court may issue a writ of attachment directing that the child be taken into custody and brought before the court. The court may proceed against the parent, guardian, or custodian for contempt.

Section 3-815 Detention and shelter care prior to hearing.

(a) Only the court or an intake officer may authorize detention or shelter care.
(b) If a child is taken into custody, he may be placed in detention or shelter care prior to a hearing if:

(1) Such action is required to protect the child or person and property of others;
(2) The child is likely to leave the jurisdiction of the court; or
(3) There are no parents, guardian, or custodian or other person able to provide supervision and care for the child and return him to the court when required.

(c) If the child is not released, the intake officer shall immediately file a petition to authorize continued detention or shelter care. A hearing on the petition shall be held not later than the next court day, unless extended by the court upon good cause shown.

Reasonable notice, oral or written, stating the time, place, and purpose of the hearing, shall be given to the child and, if they can be found, his parents, guardian, or custodian. Detention and shelter care shall not be ordered for a period of more than 30 days unless an adjudicatory hearing is held.

(d) A child alleged to be delinquent may not be detained in a jail or other facility for the detention of adults, or in a facility in which children who have been adjudicated delinquent are detained.

(e) A child alleged to be in need of supervision or in need of assistance may not be placed in detention. If the child is alleged to be in need of assistance by reason of a mental handicap, he may be placed in shelter care facilities maintained or licensed by the Department of Health and Mental Hygiene or if these facilities are not available, then in a private home or facility located in Maryland and approved by the court. If the child is alleged to be in need of assistance for any other reason, or in need of supervision, he may be placed in shelter care facilities maintained or approved by the Department of Employment and Social Services, or the Juvenile Services Administration, or in a private home or shelter care facility approved by the court.

(f) The intake officer shall immediately give written notice of the authorization for detention or shelter care to the child's parent, guardian, or custodian, and to the court. The notice shall be accompanied by a statement of the reasons for taking the child into custody and placing him in detention or shelter care. This notice may be combined with the notice required under subsection (c).

Section 3-818 Study and examination of child, etc.

(a) After a petition has been filed, the court may direct the Juvenile Services Administration or other qualified agency designated by the court, to make a study concerning the child, his family, his environment, and other matters relevant to the disposition of the case. The report of the study is admissible as evidence at a waiver hearing and at a disposition hearing, but not at an adjudicatory hearing. However, the attorney for each party has the right to inspect the report prior to its presentation to the court, to challenge or impeach its findings, and to present appropriate evidence with respect to it.

(b) As part of the study, the child or any parent, guardian, or custodian may be examined at a suitable place by a physician, psychiatrist, psychologist, or other professionally qualified person.

Section 3-820 Disposition.

(a) If the court, after an adjudicatory hearing, adjudicates a child as being delinquent, in need of supervision, or in need of assistance, it shall hold a separate hearing to determine an appropriate disposition unless the hearing is waived in writing by all the parties.

(b) The overriding consideration in making a disposition is a program of treatment, training, and rehabilitation best suited to the physical, mental, and moral welfare of the child consistent with the public interest. The court may:

(1) Place the child on probation or under supervision in his own home or in the custody or under the guardianship of a relative or other fit person, upon terms the court deems appropriate;

(2) Commit the child to the custody or under the guardianship of the Juvenile Services Administration, a local department of social services, the Department of Health and Mental Hygiene, or a public or licensed private agency.

(c) A guardian appointed under this section has no control over the property of the child unless he receives that express authority from the court.

Section 3-821 Right to counsel.

A party is entitled to the assistance of counsel at every stage of any proceeding under this subtitle.

Section 3-822 Emergency medical treatment

The court may order emergency medical, dental, or surgical treatment of a child alleged to be suffering from a condition or illness which, in the opinion of a licensed physician or dentist, as the case may be, requires immediate treatment, if the child's parent, guardian, or custodian is not available or, without good cause, refuses to consent to the treatment.

Section 3-823 Limitations on place of commitment.

(a) A child may not be committed or transferred to a penal institution or other facility used primarily for the confinement of adults charged with or convicted of a crime, except pursuant to 3-816 (b).

(b) A child who is not delinquent may not be committed or transferred to a facility used for the confinement of delinquent children.

Section 3-826 Progress reports.

If a child is committed to an individual or to a public or private agency or institution, the court may require the custodian to file periodic written progress reports, with recommendations for further supervision, treatment, or rehabilitation.

Section 3-827 Order controlling conduct of person before court.

Pursuant to the procedure provided in the Maryland Rules, the court may make an appropriate order directing, restraining, or otherwise controlling the conduct of a person who is properly before the court, if:

(i) The court finds that the conduct:

(a) Is or may be detrimental or harmful to a child over whom the court has jurisdiction; or
(b) Will tend to defeat the execution of an order or disposition made or to be made; or
(c) Will assist in the rehabilitation of or is necessary for the welfare of the child; and

(ii) Notice of the application or motion and its grounds has been given as prescribed by the Maryland Rules.

Section 3-828 Confidentiality and expungement of records.

(a) A police record concerning a child is confidential and shall be maintained separate from those of adults. Its contents may not be divulged, by subpoena or otherwise, except by order of the court upon good cause shown. This subsection does not prohibit access to and confidential use of the record by the Juvenile Services Administration or in the investigation and prosecution of the child by any law enforcement agency.

(b) A juvenile court record pertaining to a child is confidential and its contents may not be divulged, by subpoena or otherwise, except by order of the court upon good cause shown. This subsection does not prohibit access to and the use of the court record in a proceeding in the court involving the child, by personnel of the court, the State's attorney, counsel for the child, or authorized personnel of the Juvenile Services Administration.

(c) The court, on its own motion or on petition, and for good cause shown, may order the court records of a child sealed, and, upon petition or on its own motion, shall order them sealed after the child has reached age 21 years of age. After a child has reached 21 years of age, the court may, upon petition or on its own motion, expunge records of the child in a case in which an adjudication of the child as delinquent, in need of supervision or in need of assistance has not been made. If sealed, the court records of a child may not be opened, for any purpose, except by order of the court upon good cause shown.

trial without first preparing witnesses. Neglect trials are no exception. Unfortunately, many county attorneys are plagued by high caseloads and cannot always prepare a case as well as they should. However, if the worker has kept a complete, accurate case file, pretrial conferences will be productive.

Conferences will be necessary prior to petitioning the case, as well as prior to trial once the case has been petitioned. At the petitioning conference, the worker should be prepared to tell the county attorney which sections of the neglect statute are alleged to have been breached; how they have been breached; who will provide the initial information showing the breach; the status and location of the child; a brief summary of what efforts have been made to preserve the family unit; and why

defensive when asked for this information. It must be remembered that the information is solicited not for the purpose of embarrassing or second-guessing the worker, but merely to strengthen the case. The worker's testimony, like the testimony of all witnesses, should be stringently evaluated for flaws. Information must be current and first-hand. Potential bias and contradictory statements must be discovered and anticipated prior to cross-examination. Lapses in memory must be accounted for.

The delivery of testimony must also be prepared. It should be gone over several times to ensure that nothing is forgotten. Simulated direct examination should be attempted. Generally, answers to questions should be concise, precise, responsive, and devoid of jargon, con-

attorney can determine which are necessary. Production at the conference will help avoid admissibility problems at the trial.

Finally, the worker will often be aware of the possible defense that could be raised in a case by the parent. Since the county attorney must meet these defenses by cross-examining witnesses for the parents as well as by the presentation of rebuttal evidence, any assistance the worker can provide will be important.

It is essential that workers be absolutely candid with the county attorney and with the attorney for the child in those jurisdictions where they are permitted. Few things are more uncomfortable for an attorney than being surprised at trial. A well-prepared worker can obviate the possibility of surprise. Certainly, disagreements between the county attorney and the worker may arise. But since their goal is the same, these problems must be resolved. The conference, and not the trial, is the place for their resolution.

New Directions

The increased provision and accessibility of training and knowledge in juvenile and family law to child welfare workers is imperative. Knowledge and skills in juvenile law and trial procedures would complement the training in psychology and human

Notes and References

1. The term social worker in this paper is used to denote those who engage in child protection work and includes but is not limited to child welfare worker and caseworker.

2. Julian Mack, "The Juvenile Court," *Harvard Law Review* 23 (1909): 104, 119–120.

3. For a fuller history of the juvenile court, see Jacob L. Isaacs, "The Role of the Lawyer in Representing Minors in the New Family Court," *Buffalo Law Review* 12 (1963): 501, 503.

4. *Kent v. United States*, 383 U.S. 541 (1966); *In re Gault*, 387 U.S. 1 (1966); *In re Winship*, 397 U.S. 358 (1970); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

5. See, for example, *In re B.*, 30 N.Y.2d 352, 282 N.E.2d 288 (1972).

6. The National Conference of Lawyers and Social Workers, *Law and Social Work* (Washington, D.C.: National Association of Social Workers, 1973), p. 32.

7. The National Conference of Lawyers and Social Workers, "Lawyer-Social Worker Relationships in the Family Court Intake Process," Publication no. 4 (1967): 4.

8. Kimberly B. Cheney, "Safeguarding Legal Rights in Providing Protective Services," *Children* 13 (May-June, 1966): 89.

9. Patrick Tamilia, "Neglect Proceedings and the Conflict Between Law and Social Work," *Duquesne Law Review* 9 (1971): 585.

10. Richard Steven Levine, "Caveat Parens: A Demystification of the Child Protection System," *University of Pittsburgh Law Review* 35 (1973): 17 citing Keith-

22. Ibid., 413.

23. The out-of-court statements of parties to the action are admitted as exceptions to the hearsay rule.

24. In *C.S. v. Smith*, 483 S.W.2d 790 (Mo.Ct.App. 1972). The court ruled that the agency (usually represented by a social worker) or a juvenile officer must establish that the "natural parents were fully aware of their right to visit their children and of their obligation to furnish support and other incidentals which demonstrate their interest in the children" before termination of parental rights could be ordered when the proceedings were based on willful neglect and abandonment. *Accord S.L.K. v. Smith*, 480 S.W.2d 119 (Mo.App. 1972).

In re Deerwester, 131 Ill.App. 952, 267 N.E.2d 505 (1971). The court found that the mother did not fail to maintain a reasonable degree of interest regarding the child's welfare since she "made periodic inquiries to and appointments with child's caseworkers and made plans to visit the child, which plans were not carried out because of difficulties in arranging with caseworkers for visits and by mother's lack of transportation."

25. *Stanley v. Illinois*, 405 U.S. 645 (1972) requires that putative fathers be given an opportunity to be heard regarding fitness.

26. *Patton, supra* at 353.

27. *In re M.J.M.*, 483 S.W.2d 795 (Mo.Ct.App. 1972).

28. The American Humane Association, "Identify-

29. Kane, "Look to the Record."

30. McCormick, *Evidence*, 2nd ed. (West Publishing Co., 1972).

31. See note 24, *In re Deerwester*.

32. *In re Involuntary Termination of Parental Rights*, 449 Pa. 543, 297 A.2d 117 (1972). Court reports may be admitted at dispositional hearings, e.g., D.C. Code 16-2319 and review hearings. *In re Raymond G.*, ___ Cal.App. 3d ___, 110 Cal.Rptr. 81 (1973).

33. E.g., 28 U.S.C. 1732.

34. *Harter v. Iowa*, 260 Ia. 605, 149 N.W.2d 827 (1967).

35. *New York Life Insurance Co. v. Taylor*, 79 U.S.App.D.C. 66, 147 F.2d 297 (1945).

36. *In re Involuntary Termination.*

37. It would be helpful to qualify workers as experts so that they may testify regarding conclusions as well as facts. This point is made by Rowine Brown, Elaine Fox, and Elizabeth Hebbard in "Medical and Legal Aspects of the Battered Child Syndrome," *Chicago—Kent Review* 50 (1973): 45–76:

> [W]orkers have had special training in tactful interviewing and are apt to elicit information of extreme importance for the hearing. They are also trained in the observation of people and their reactions. The social worker may readily perceive when the parent, maintaining a defensive or hostile

The Problem of the Battered Child

by
Gloria Belgrad

Maryland Law Forum, 2(1972)
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Editor's note: Although child abuse can hardly be considered a new socio-legal phenomenon, the apparent magnitude of the problem and an increasing public awareness of its existence prompted the editors of the FORUM to include "The Battered Child" in this issue. It becomes quite obvious from the article which follows that more than mere judicial or legislative efforts will be necessary to even begin to deal with the complexities involved. Mrs. Belgrad, whose interest in this topic began while participating in a Legal Medicine Seminar at the University of Maryland School of Law, was graduated from The John Hopkins University (B.S., 1959) and the University of Maryland School of Law (J.D., 1970). Since her graduation from law school, she has been active in serving as a supervisor of the mental health—clinical education program recently instituted at Spring Grove State Hospital. She is, in addition, a research associate with the Baltimore law firm of Frank, Bernstein, Conaway and Goldman.

I. Introduction

For several years now thousands of long-suffer- ... dren as the natural objects of our love and protection. Most persons of ordinary sensibilities simply cannot bring themselves to believe that any adult, much less a parent, could deliberately inflict suffering on a helpless child.[3] Even those with some appreciation of history, mindful perhaps of the horrors of child labor, uncomfortably relegate child abuse to those shadowy practices of less-enlightened ages which, like bear-baiting, civilized man outgrew and discarded; or, at most, think of it as confined to that netherworld of poverty and pathology from which the average citizen is gratefully, if somewhat uneasily, insulated by social worker and law enforcement officer. But now and then a shocking incident splashes across the pages of newspapers and television screens, exploding all such pallisting misconceptions. Face to face with the spectre of child abuse, the ordinary person is frightened, disgusted, and filled with a desire to flee as from a nightmare. This near-universal repugnance from which even professionals are not immune[4] is too readily translated into ostrich-like avoidance or else a furious wish to have the authorities punish the guilty offenders severely.[5] Such reactions, of course, merely serve to foster evasion or suppression of

... et to be devised.[8] Yet more than one observer has expressed concern that all this activity may have a cathartic effect on the still-eagerly-... public, easing its conscience by lulling it to believe that "everything that can be done has been done."[9]

It is the purpose of this article to review the developing body of knowledge and theory of child abuse, analyze the measures thus far adopted to eliminate or control it, and, wherever possible, suggest avenues of improvement.

II. Historical Perspective

This much, at least, is certain: the maltreatment of children is not the invention of modern society. Children have been beaten, maimed, and put to death by their elders since the dawn of recorded history. Although the circumstances and details have varied widely with time and place, at least four broad causes can be discerned: 1) the conviction that severe physical punishment was essential for proper discipline and education; 2) religious and superstitious beliefs; 3) cultural eccentricities; and 4) economic considerations.[10]

From the schools of ancient Sumer over 5000 years ago to the little red schoolhouse of American lore, the whip, the switch, the ruler and the hairbrush have been employed with varying degrees of severity to force children to "behave" and to cause them to be "receptive" to learning.[11] The biblical concept of sparing the rod and spoil-

standard of beauty. This is most clearly exemplified by the foot-binding of the Chinese, and the cranial, neck and lip deformations of the Africans.

"Forms of mutilation which were clearly vicious were done by speculators who trafficked in children to set them up as professional beggars . . . (L)isted among the deformities inflicted upon children (were) gouged eyes, amputated or twisted arms and legs and broken or deformed feet."[18] To fill the family purse, fathers often sold their daughters into prostitution or their sons into slavery.[19] With the advent of the industrial revolution, children were obliged to undergo the novel tortures of the factory system with which every schoolboy is familiar and which need not be catalogued here.

Finally, to these four broad categories of cause and justification must be added the numerous injuries and deaths which have always occurred miscellaneously as a result of the heat of anger, the indulgence of sadism or the outright abandonment of infants.[20]

This, by no means comprehensive, litany of brutality is relevant to the subject of contemporary abuse in a number of ways. First, as has already been pointed out, it is often initially necessary to adduce a mass of shocking facts in order to brush away the webs of sentimental disbelief which preclude consideration of abuse as one of the possible sources of injury to children.

of maltreatment that will be designated and acted upon as abuse. To this end, child abuse must be distinguished from the "ordinary" or "normal" exercise of parental discipline; from manifestations of parental neglect; and even from the random or isolated episode of parental cruelty.

A. *For Purposes of Legislation:* Although there is a considerable variety in the statutory language employed to define the jurisdictional element of injury, all statutes exclude those injuries which may be properly attributed to accident. Twenty-two states, the District of Columbia and the Virgin Islands do so explicitly by speaking of the physical injuries inflicted by "other than accidental means;"[22] the remaining states do so by clear implication from discussion of cause in terms of "brutality," "abuse," and "maltreatment."[23] Beyond this, there is a division of opinion as to whether the reportable injury must have been *intentionally* inflicted. A block of states, including Maryland, leave little doubt that intent is an essential component of the offense by requiring that the injury be inflicted "intentionally," "willfully" or "maliciously,"[24] or by housing their statute in the penal code. Other states have taken a more expansive view. In these states it is not necessary for the injury to have resulted "from a deliberate act of commission, or omission. All that is required is an injury to the child resulting from some act, or from an omission, without regard to intent."[25] These statutes tend to blur the dividing line between abuse and neglect; indeed, excepting only accidental injuries, they list "neglect" or "willful neglect" as a cause

The forms or types of abuse inflicted upon children is a negative testimony to the ingenuity and inventiveness of man. By far the greater number of injuries resulted from beatings with various kinds of implements and instruments. The hairbrush was a common implement used to beat children. However, the same purpose was accomplished with deadlier impact by the use of bare fists, straps, electric cords, T.V. aerials, ropes, rubber hoses, fan belts, sticks, wooden spoons, pool cues, bottles, broom handles, baseball bats, chair legs, and, in one case, a sculling oar. Less imaginative, but equally effective, was plain kicking with street shoes or with heavy work shoes.

Children had their extremities—hands, arms and feet—burned in open flames as from gas burners or cigarette lighters. Others bore burn wounds inflicted on their bodies with lighted cigarettes, electric irons or hot pokers. Still others were scalded by hot liquids thrown over them or from being dipped into containers of hot liquids.

To complete the list—children were stabbed, bitten, shot, subjected to electric shock, were thrown violently to the floor or against a well, were stamped on and one child had pepper forced down his throat.[31]

And, surely in a class by herself, was the "mother who rubbed red pepper into the genitals of her five year old daughter and then beat her when she screamed in agony. . . ."[32]

date suggests that the psychopathologies of neglect and abuse are significantly different, with the neglecting parent being a somewhat likelier candidate for successful rehabilitative casework than his abusive counterpart.[34]

But, while comparisons between neglect and abuse are undeniably useful and practical, the natural thrust of research, and ultimately the most illuminating, is to explore the differences between what is "normal" on the one hand and "abnormal" on the other. To erect a standard of parental behavior and then designate all departures from it, of whatever shade or degree, as aberrations, is no mean task, especially in a society such as ours which prizes individualism and diversity so highly. To say that in each case the actions of parents must be judged with reference to the welfare of the child, is to beg the question. Yet our juvenile court judges are, perforce, unabashedly making such determinations every day. And if the law of torts can live with that ephemeral creature, the reasonably prudent man, then the law of child protection can live with the concept of the reasonably-well-cared-for child. This is, after all, one area in which the requirements of the law,[35] the constucts of the social scientists and the instincts of laymen can coincide without too much strain. At a *bare minimum*, the "normal" parent is conceived of as one who makes a *bona fide effort* to provide his child with the basic necessities of life—food, clothing, shelter, medical care[36]—to the extent that his resources (or those of the State available to him) will permit, and, crucially, attempts to structure

abusing parent is seen as pursuing punishment as an end in itself, unrelated to anything the child has done or left undone:

> This is the outline of abuse. It is not the impetuous blow of the harassed parent nor even the transient brutality of an indifferent parent expressing with violence the immediate frustrations of his life. It is not the too severe discipline nor the physical roughness of ignorance. It is the perverse fascination with punishment as an entity in itself, divorced from discipline and even from the fury of revenge. It is the cold calculation of destruction which in itself requires neither provocation nor rationale. . . . The one invariable trademark of the abusing parent regardless of economic or social status is this immersion in the action of punishing without regard for its cause or purpose . . . not punishment to fit the crime but punishment without crime. . . . Like an earthquake it (strikes) without warning, and this (is) part of its terror.[38]

An offshoot or variant of this view is that "cause" for punishment does exist somewhere in the nightmarish recesses of the parent's mind; that pain is inflicted on the child because he has —predictably—failed to conform to his parent's bizarre, unrealistic expectations.[39]

But as epidemiological studies of the subject progress, a new view appears to be emerging.[40] It holds that it is quite improper to speak of

It is probably still premature to hazard a final judgment, but it is possible that what appears to be an irreconcilable theoretical dispute may yet be resolved by the simple expedient of sorting out and standardizing terminology,[42] and then awaiting the statistical results of further studies. Upon a little reflection, it becomes apparent that the areas of agreement between the two schools of thought may be significantly broader than their areas of disagreement. Though the qualitative-difference thesis of the "psychosis school" suggests a monolithic approach, even its most ardent proponents recognize that there are various degrees of abuse, from the more moderate to the grossly severe.[43] They tend to gloss over the former and to concentrate on the latter; but there is in this at least implicit recognition that abuse may well be a plural phenomenon. The "cultural school," on the other hand, readily admits that the more brutal or bizarre manifestations are probably psychotically induced, yet they contend that these cases are proportionately overshadowed by the instances of discipline-gone-awry. Analysis thus suggests that both schools are simultaneously talking about the same thing under different labels—(a) "Psychotic Abuse" and (b) "Moderate" or "Disciplinary" Abuse—with each side emphasizing the type that figured most prominently in its statistical sampling; and that broader-based future studies will succeed in bringing them closer together still.

IV. The Parent in Profile

An editorial in the Journal of the American Medical Association made the dire prediction that abuse "will be found to be a more frequent cause of death than such well-recognized and thoroughly studied diseases as leukemia, cystic fibrosis and muscular distrophy

a number of children in the family.[48] Such selectivity is somehow inconsistent with the picture of the "good" intentions gone sour. It may just be that these are the cases in which the boundary of pathology has been crossed; but if this is so, it has not been clearly expressed in these terms in the published research to date.

The classic picture of aberrational abuse is that of the father who methodically wraps newspapers around his son's arm and then sets them ablaze.[49] The question is, what causes such destructive behavior? Some psychiatrists have apparently entertained the theory that certain people are congenitally pre-disposed to excessive violence and that only differences in environment will determine whether such tendencies will be encouraged or suppressed.[50] The more conventional explanation is that forces in the parent's own life-history produced a severe "defect of character"[51] typical of the sociopath, or else produced outright psychosis. This view is heavily indebted to a number of studies which compiled data on the basis of interviews with the abusing parents themselves (or knowledgeable relatives) along with supportive data garnered from the observations of trained workers. From these studies there emerged the tragic realization that most, if not all, abusing parents have themselves been the victims of neglect or abuse during childhood, and that as adults, they are "following a distortion of the golden rule, 'Do unto others as you have been done unto' . . . often despite very conscious resolves to do differently."[52]

This pattern of demand and criticism produces low self-esteem, a profound lack of self-confidence and an intense, unsatisfied yearning for affection or approval, accompanied by a persistent disbelief in the possibility of ever finding it.[56] Transferring towards the rest of society attitudes originally felt towards parents, and expecting only further rejection, the abusing parent withdraws "to lead a life which is described as alienated, asocial or isolated."[57] When he marries, "like many other neurotic people (he) demonstrates an uncanny ability to become involved with . . . (a person) who tends to accentuate rather than solve (his) problems . . . needy, dependent, unable to express clearly (her) needs, and at the same time demanding, critical and unheeding. . . . The marriage (becomes) one more situation reinforcing (his) sense of disappointment and hopelessness."[58]

But when his own child is born, the abusing parent has "one hope left. When all of the rest of the world has failed him, (he) will look to the child in a last desperate attempt to get comfort and care."[59] The sought-for role reversal is, of course, doomed to failure. The child's own needs are too imperious; it is he who, in his helplessness, requires the comfort, the care and the protection of his parent. When the child cries, or soils himself[60] or fails to obey instantaneously, or in any other way intrudes his own needs into the situation, he destroys this cherished illusion of panacea. The parent either interprets the

logical factors which "are potent accessories in instigating abuse and in determining which infant is selected for attack; three such factors (being) unresolved sibling rivalry, an obsessive-compulsive character structure and unresolved Oedipal conflicts with excessive guilt."[66] And finally, they point out the role that other, more "objective" factors may play in the instigation of abuse: the sex of the child (a boy when a girl was wanted); the innate characteristics of the child (whether placid or aggressive); the health status of the child (whether born with congenital defects requiring a greater degree of attention); and the time of the birth (whether the result of a premaritally conceived pregnancy or an accident too soon after the birth of a previous child).[67]

Seen in this light, the abusing parent is no longer quite the monster of first impression, but a tragically unbalanced individual whose need for treatment must take second place only to his child's need for protection. Given the present state of knowledge, there does not appear to be any viable alternative to accepting this hypothesis, at least with regard to the psychologically-motivated forms of abuse, if not with regard to the culturally-induced forms. To reject the thesis is to be left with the monster unexplained, untreatable, unsalvageable and fit only for the tender ministrations of the criminal law, if and when he is apprehended.

replying, 302 such cases were reported to have occurred; 33 of the children died; and 85 suffered permanent brain injury."[71] The American Humane Association released in 1963 its findings based on a nationwide survey of press reports of abuse during the previous year: 662 cases were uncovered, 178 of which were fatal.[72] One study revealed that 71 cases of abuse were reported in Iowa in a 6 month period[73] and another survey showed that Cook County Hospital admits abused children at the rate of approximately ten a day.[74] In Maryland, in the second six month period following enactment of the child abuse reporting statute, 187 incidents of suspected child abuse involving 224 children were brought to the attention of the authorities. Of these, Baltimore City reported 65% and the Counties 35%.[75] During 1965 Brandeis University conducted a study "designated to provide an indirect estimate of the actual incidence of child abuse."[76] The survey provided "an estimate of the upper limit in the total United States population of the incidence of child abuse known beyond the confines of the abused child's home. The upper limit for the year ending October, 1965, was between 2.53 to 4.07 million for a population of about 190 million, or about

[The] abusing parent is no longer quite the monster of first impression, but a tragically unbalanced individual whose need for treatment must take second place only to his child's need for

agencies or emergency facilities of hospitals where visibility is enhanced, and reporting more likely to occur. Finally, somewhat more men than women are involved in abusing children, but more women than men are apparently the perpetrators in the fatal accident situations. "This may be related to the younger age of the fatally injured children as compared to the age of all abused children and to the fact that women have a larger part than men in the care of younger children."[62]

VI. The Identification of Abuse

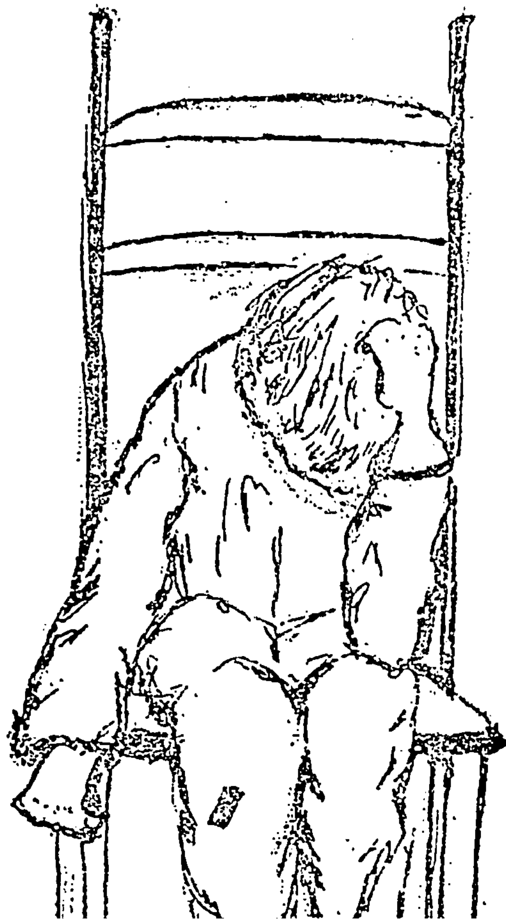
In 1946 Dr. John Caffey alerted the medical profession to the problem of child abuse by noting the frequency with which multiple fractures of the long bones of unknown origin were associated with subdural hematomas of traumatic origin.[83] Dr. Caffey concentrated on the condition of the child and did not speculate on the possible source of the trauma. In the early fifties, articles by Drs. Lis, Frauenberger and Smith, focusing again on this coincidence of fracture and hematoma, suggested tentatively that parental carelessness might be somehow involved.[84] Drs. Woolley and Evans, in 1955, made an enormously important contribution by demonstrating that the radiologic manifestations of abuse and of accidental injury are significantly different, and by emphasizing undesirable environmental factors, including uncontrollable aggressions of parents as a cause of the child's injuries.[85] Returning to the subject in 1957, Dr. Caffey further highlighted the misconduct of parents by drawing attention to the frequency with which the history or explanation give the appearance of being non-accidental in origin? Fifth, is there subdural hematoma, especially in the child who is too young to crawl or walk? Sixth, is there evidence of other injuries in varying stages of healing suggestive of prior instances of abuse? Seventh, is the history elicited from the parents too improbable or incompatible with the nature of the injuries?[91] And eighth, do any new lesions occur during the child's hospitalization or does he thrive under proper care and supervision?

It need hardly be said that the early identification of abuse is the *sine qua non* of treatment and future protection. The doctor who because of incredulity fails to consider or rules out parental abuse as a source of injury may unwittingly, and despite the noblest of intentions, contribute to the further injury or even the death of that child.

VII. The Legislation

State legislatures had four model statutes upon which they could draw. These were proposed by the United States Children's Bureau, the Council of State Governments, the American Humane Association, and the American Medical Association. The model draft which proved to be the most influential was that of the Children's Bureau.[92]

The statutes have been so ably and comprehensively analyzed in a number of publications,[93] that to do so here would be needless duplication. The basic statutory scheme is as follows: there may or may not be, at the outset, a statement of



courses of action to cover unforeseeable contingencies, is not clear.[102]

The lines of argument in favor of selecting either a law enforcement agency or a social welfare agency are, despite their crucial importance, relatively simple. Those who favor reporting to the police or prosecutor[103] point out that in many communities. law enforcement agencies are the only resources available to cope with emergencies on a twenty-four hour basis; that the agency designated to receive the report is also mandated to investigate the circumstances and possibly prepare the case for presentation in court, a function for which the police are eminently suited by training; that after all, assaults on children are crimes and, therefore, necessarily within the province of law enforcement; and that finally, the quick intervention of the police followed by conviction of the abusing parent can prevent a repetition of assaults of the child, if only by virtue of removing the perpetrator from the home.

Proponents of the social welfare approach[104] counter by arguing that the intrusion of the police on the threshold of investigation necessarily imparts a punitive flavor to the entire proceeding which may cause undue embarrassment for families ultimately found to be innocent, or generate such hostility and fear in the abusing

> There is thus general agreement that for every case which is brought to the attention of the authorities, one or more cases go unnoticed, mis-

equipped and not infringe upon the other's prerogatives. But as a practical matter this is impossible in an area such as child abuse where responsibilities overlap and become almost indistinguishable. An interdisciplinary approach is almost mandated by the necessities of the situation, and what is called for is ever greater cooperation between the personnel of both groups. One solution, adopted in Maryland, is to channel the initial report to the social welfare agency for preliminary investigation and then require a summary of findings to be forwarded to the State's Attorney's Office for his decision as to the wisdom of pursuing or foregoing prosecution. This approach, however, requires the establishment of easy avenues of communication between the two offices and the development of mutual confidence and respect, which can be readily frustrated by the notoriously high rate of personnel turnover in social service agencies. Another solution, and one which is likely to be easier to implement in the big cities than in the rural counties is to establish within the designated agency a specialized unit with "postgraduate" training—an elite corps of social workers within the welfare agency, tutored in the arts of investigation and case preparation; or a special Youth Division within the police department outfitted with the social worker's manual.

B. *The Immunity Provisions*

To encourage reporting, and to free the reporting source from fear of retaliation by the infuriated parents, every one of the statutes included a provision granting some form of immunity.

The American physician has been accused of suffering to "Lexphobia,"[109] the failure to act for fear of incurring some form of legal liability. This phenomenon is usually discussed in the context of the need for good samaritan legislation, but it is peculiarly appropriate for consideration within the context of the child abuse problem (where there is necessarily such heavy reliance on the physician's skill) because "a doctor who is burned at the jurisdictional stake once is not likely to play with diagnostic matches."[110] There is supreme irony in all of this because such fears are largely irrational, with little or no basis in the law:

> . . . Such potential liability might be in the nature of civil or criminal responsibility for defamation, civil liability for invasion of privacy by disclosing of "private facts" or by placing parents in a false light, or the possible civil liability for breach of confidence. Yet every reported American case in which a physician has made disclosures concerning patients for the protection of third parties has resuted in recognition of a privilege on the part of the physician and a denial of liability.[111]

Protection in the law for the reporting physician is of a two-edged variety. In a tort action against him, the doctor could raise the defense of absolute or qualified privilege to make good faith reports to the authorities concerning suspected criminal or tortious conduct.[112] In a suit for breach of the statutory[113] physician-patient privilege for confidential communications, the

to his home.[117] This decision often has the direst consequences for the child. While no conscientious judge can be expected to ignore the rights of the parents, however abhorrent their actions, it is submitted that there is no justification for giving them undue weight or importance either. The safety and well-being of the child must take *actual* as well as theoretical precedence. In the light of the shocking rate of repeated abuse, doubts must be resolved in favor of immediate removal of the child from the injurious environment, regardless of whether other means for improving the family situation are adopted or not.

In addition to establishing and adhering to a hierarchy of priorities, the courts must somehow resolve the perplexing evidentiary problems which beset the attempt to deal with abuse in a legal framework. The dilemma is perhaps more intense when the litigation takes the form of a criminal prosecution, but with the Supreme Court's recent forays into the area of juvenile court procedure and due process, such distinctions are likely to fade in importance. The problem is elementary: evidence of abuse that will "hold up" in court is extremely difficult to obtain; there are either no witnesses to the abuse or else no witnesses who are willing to testify. Yet, a failure to "prove" abuse may result in returning the child to the

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[illegible] parents [illegible] psychotic and no childhood history was obtainable. Easson and Steinhilber studied eight boys who had made murderous assaults; in two cases there was a clear history of habitual brutal beating by a parent and in three cases there was a suspected history of abuse.

Although the child who comes to the hospital dead or who dies shortly after admission creates the most attention in the medical and lay press, there are many more children who leave the hospital with physical disabilities or residual mental retardation and others who leave the hospital with psychological disabilities which may restrict the child's development and may lead him to become the battering parent of tomorrow. By treating the syndrome as soon as it is suspected, one not only prevents possible permanent injury or death of the child, but one also may break the "violence breeds violence" cycle.

Child Abuse Laws

As of June 1, 1967, 50 states, the Virgin Islands and the District of Columbia have statutes on child abuse, with legislation pending in Puerto Rico. In 1962, the Children's Division of the American Humane Society initiated a study of the child abuse problem in America. Based on the findings of the study, an Advisory Committee to the Children's Division endorsed mandatory reporting of suspected inflicted injuries on children. In 1963, the Children's Bureau of the Department of Health, Education and Welfare proposed model legislation on reporting the case of the physically abused child. This model act has several basic features: (1) it recommends reporting by physicians or institutions of any case in which there is reasonable cause to suspect a battered child; (2) it suggests procedures for this reporting; (3) it provides immunity from liability for the physician; (4) it establishes that neither the physician-patient privilege or the husband-wife privilege can be a ground for excluding evidence if the court so chooses; (5) it states that anyone not reporting a suspected case of a battered child would be guilty of a misdemeanor. Many states in addition have initiated a central registry by which any patient suspected of child abuse is recorded on a file which is available to every physician. This central registry helps to pick up those children who are brought to different hospitals or different physicians with each injury and, therefore, are not picked up as recurrent child abuse cases.

From the beginning, the medical, legal and social work professions have been concerned with the effectiveness of such a law. Rinehart and Elmer feel that the law's concentration on the one child seen by the doctor failed to mention possible dangers to other children in the household. In addition, they emphasized concern that the law might increase hazards for the injured child in that the publicity accorded in a mandatory reporting law could result in fewer injured children being brought to the doctor. Finally, they questioned the soundness of the suggested language of the law which appeared to recommend the police as the appropriate agency to receive reports of the alleged child abuse.

The General Counsel of the American Medical Association expressed concern over the new legislation in April, 1964. The major concerns noted were (1) that legislation should infer immunity from litigation and damage, not only on physicians, but also on lawyers, nurses, social workers, and others who seek to protect abused children by reporting; (2) that compelling the physician alone to report singles him out unwisely or causes the parent or guardian, for his own protection, to put off seeking

medical care; and (3) that mandatory reporting in and of itself will not eradicate undesirable social conduct. The Committee on the Infant and Pre-School Child of the American Academy of Pediatrics recently stated, "Mandatory reporting by physicians of suspected cases of child abuse is justified and that legislation for this purpose should be primarily of a protective rather than a punitive nature."[54]

There is concern that publicity on child abuse and the mandatory reporting laws could have a negative effect. Parents who accidentally injure their child or who do not know how an injury occurred might delay or avoid seeking medical help for fear that they will be labeled "child abusers."

Paulson[55] reviewed the legislative history of the child abuse reporting laws and expressed concerns about the future:

> "Many supporters of child abuse reporting legislation viewed enactment as a means of strengthening the network of child protective services. The services are needed, but are by no means universally available . . . Existing statutes will require additional appropriations for expanding children protective services (for) as child abuse reporting legislation (becomes) effective, it will add to the existing overburdened case load of the agencies."

He concluded, "To be a wise program for action, it should evolve on a solid basis of medical, psychiatric and social research. Legislation should be formulated only after proposals are fully examined by a partnership of individuals, voluntary associations and state government." Paulson,[56] in a study of the legal protections against child abuse, again expressed concern with reporting laws:

> "Reporting is, of course, not enough. After a report is made, something has to happen. A multidisciplinary network of protection needs to be developed in each community to implement the good intentions of the law. . . . The legislatures which require reporting but do not provide the means for further protective action delude themselves and neglect children."

The author[1] following a survey of physicians in one metropolitan area, concluded that, "Methods of communication from medical professional or[illegible]ations and from government and com[illegible]gencies have not been completely eff[illegible] familiarizing the physicians in the metropolitan area with the battered child syndrome or with the community procedures to be used for reporting. Child abuse laws will not be enough until these lines of communication are improved. There are several areas of resistance which inhibit some physicians from reporting suspected cases of child abuse. A need exists to further educate physicians, to clarify many basic terms and concepts and to define the responsibility and limitations of the individuals and agencies involved in cases of child abuse (e.g., physician, child welfare agency, child protective service, police, juvenile court and criminal court)."

Community Procedures

In general there are three different types of community approaches to the problem of child abuse in this country. The protective services program involves a social service representative who goes to the family of the child suspected of abuse and evaluates the situation offering what assistance might be needed. The social agency representative says, in essence, to the family, "Your child has been injured. This suggests that there is a family difficulty. May we be of help to you in working out the family problem?" If the child is in danger, the social agency representative may obtain a court action to remove the child from the family;

however, the major emphasis is in helping the family and not in penalizing the parent. In some cases time is lost in obtaining a court action, time which sometimes proves fatal to the child.

Another community approach operates through the police department. Here, a representative of this department investigates the family first. Although the officer is interested in evaluating the situation and protecting the child, the uniform or police badge may make the parents defensive and often may result in their being less receptive to social service assistance at a later date. The police department, after its evaluation, may directly remove the child or may require a court order, depending on the community procedure. Social service agency participation may also be requested. Since the police department is the only 24-hour service available in all communities, the model laws have recommended the police as the best reporting agent.[illegible]

A third approach is the combined use of police and social service agency personnel in which representatives from each go to the home together, each evaluating his particular area of concern; however, each presenting himself as a representative of the community who wishes to help the family with its difficulties.

The author feels that the best approach is a form of the social service approach in which the major goals are to protect the child and to assist the family in making use of whatever community facilities it may need. After evaluating the parent or parents, appropriate action can be initiated. Some parents may need social or psychiatric help, some parents may need hospitalization, other parents may need criminal court action. Penalizing the parent or placing the parent in jail does not help the problem; in fact, in many cases it may complicate the problem by depriving the family of the wage earner or by removing the mother, thus creating even greater disruptions of family life and creating the need for a variety of community services, such as public assistance, foster home placement, homemaker service or other supportive measures. It is felt that the first task is to protect the child. Following this the major emphasis should be in helping to minimize the family or intrapsychic stress which created the battering need. By offering help and not prosecution, the parents will be more available to look at the family difficulties and to accept community assistance in coping with the difficulties.

Regardless of the community approach, problems exist in defining terms, in determining the role of community agencies, and in deciding when a community agency should intervene in a family crisis.

Cheney,[57] in discussing the legal problems of providing protective services, focuses on such problems. He questions the definition of "neglect":

> "Neglect" . . . is a concept which permits no degree of certainty, either in legal defitions or social application . . . Most neglect statutes . . . define the conditions on which the State may act (using) standards (that) do no more than import vague subjective tests into a legal criterion.

He also questions the spectrum of clinical or social situations which could fit within certain basic definitions, and he wonders where professional groups should draw the line. For example, at what degree of family deterioration is intervention by a social agency to take place? Cheney raises the question of the possible continuum of situations in which the term "neglect" could be used. Is emotional and social neglect the same as physical neglect? He feels that before emotional and social neglect can be dealt with as is physical neglect,

psychiatrists need better to delineate standards of psychological welfare. As he notes, "The need for action in behalf of emotionally disturbed children is difficult to translate into legal standards because the medical guidelines themselves are uncertain." In the same discussion, Cheney notes that there are almost no written juvenile court opinions dealing with neglect, and few appellate decisions. Thus, a child-protective service worker, in determining whether to refer a case to court, must rely on his personal or hearsay knowledge of what the judge has done in the past.

Each physician must familiarize himself with the procedures in his community for handling child abuse cases: If no procedures currently exist, he needs to encourage his community to establish such procedures. In addition, each physician must decide how he will handle cases of child abuse.

The Committee on Infant and Pre-school Child of the American Academy of Pediatrics feels that the practicing physician might be handicapped when encountering a case of suspected maltreatment in his office practice because of the traditional physician-patient relationship, and because of the lack of time for obtaining an accurate history.[34] Also, it is suggested by this committee that the physician may lack laboratory facilities, X-ray, etc., to make a suitable evaluation. They recommend that the physician hospitalize the child for such an evaluation.

The willingness of hospitals to accept the challenge presented by the Committee on Infant and Pre-school Child of the American Academy of Pediatrics in suggesting to physicians that they depend on the hospital for medical evaluation, diagnosis and disposition in cases of child abuse has not been fully explored. There is no question that such a diagnostic evaluation would be more complete, would support the private physician in his role with the family, and would minimize the involvement of the private physician in legal suits or time lost in legal actions.

Conclusions

That the Child Abuse Syndrome exists and exists to a greater degree than current statistics show cannot be denied. Legislation making child abuse a reportable public health concern is necessary. Community programs to deal with cases of child abuse with a protective, assistance-oriented approach rather than with a punitive approach are necessary. However, the physician is the central person in the child abuse problem; he must be alert to the possibility of the Child Abuse Syndrome. After making this diagnosis, he needs not only to treat the medical pathology but to assist in treating the social pathology.

The purpose of this paper has been to review the literature from all of the disciplines in the hope that such a summary will assist the practicing physician to become more alert to the Child Abuse Syndrome and to his role in working with his community. In addition, the author has attempted to integrate the information from the literature with his own experiences in working with hospital staffs, practicing physicians and representatives from community and private agencies in order to illustrate some of the questions still unanswered.

The medical profession must spearhead the efforts of those individuals and groups concerned with the child abuse problem with the ultimate goal of an integrated program for prevention, protection and assistance for the abused child and the family.

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UNIT VI

Child Maltreatment: Help and Hope

VI. CHILD MALTREATMENT: HELP AND HOPE

--- What Can Be Done About It?

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UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One for Generalizations A and B

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES TO THE PROBLEM OF CHILD MALTREATMENT WHICH PROVIDE HELP FOR BOTH THE CHILD AND THE CARETAKER.

Generalizations for Unit VI.

A. Through the individual's response to the problem of child maltreatment, there is help for the maltreated child.

B. Through the individual's response to the problem of child maltreatment, there is help for the caretaker.

C. Through society's response to the problem of child maltreatment, there is hope for prevention.

Performance Objectives for Generalizations A and B

1. IDENTIFY the kinds of responses which help the maltreated child.
2. DESCRIBE the kinds of help available to the maltreated child.
3. IDENTIFY the kinds of responses which help the caretaker.
4. DESCRIBE the kinds of help available to the caretaker.

Instructional Objective Two for Generalization C

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES WHICH PROVIDE HOPE FOR PREVENTION OF CHILD MALTREATMENT IN SOCIETY.

Performance Objectives for Generalization C

1. IDENTIFY those in society who must respond to the problem of child maltreatment.
2. DESCRIBE the kinds of responses which provide hope for prevention of child maltreatment in society.

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One

The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

Performance Objectives for Generalization A

1. IDENTIFY the kinds of responses which help the maltreated child.
2. DESCRIBE the kinds of help available to the maltreated child.

Generalization A

THROUGH THE INDIVIDUAL'S RESPONSE TO THE PROBLEM OF CHILD MALTREATMENT THERE IS HELP FOR THE MALTREATED CHILD.

Sample Content

1. How to respond:
    a) Recognize child maltreatment.
        1) Indicators of child maltreatment
        2) Problems inhibiting personal involvement
    b) Report child maltreatment.
2. Kinds of responses:
    a) Treatment or hospitalization
    b) Individual and/or family therapy
    c) Supervision at home
    d) Court protection
    e) Provision for alternative care

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One

The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

Performance Objectives for Generalization B

3. IDENTIFY the kinds of responses which help the caretaker.

4. DESCRIBE the kinds of help available to the caretaker.

Generalization B

THROUGH THE INDIVIDUAL'S RESPONSE TO THE PROBLEM OF CHILD MALTREATMENT, THERE IS HELP FOR THE CARETAKER.

Sample Content

1. How to respond:
   a) Recognize child maltreatment.
      1) Indicators of child maltreatment
      2) Problems inhibiting personal involvement
   b) Report child maltreatment.
2. Kinds of responses:
   a) Counseling by the helping professional
      1) Medical practitioner, psychiatrist
      2) Social worker, mental health assistant
      3) Pastor, trained lay person
   b) Government Services
      1) Protective Service Agency
      2) Department of Welfare
      3) Department of Health
      4) The Judiciary
      5) Law enforcement agency

c) Community and Volunteer Agencies

1) Parental Stress Service, Hot Lines

2) Parents Anonymous, Families Anonymous

3) Group therapy programs

4) Residential programs

d) Education

1) Increased knowledge of self and others

2) Parenting skills

3) Home management skills

4) Financial management skills

5) Job training skills

6) Other

<u>Suggested Classroom Activities and Procedures for Performance Objectives A and B 1 through 4</u>

1. Prepare students for an understanding of Unit VI through utilization of:

   Unit I B

   Unit V D

2. Introduce Generalizations VI A and VI B, and write on board for students.

3. Refer students to Mont omery County Health Department Indicators of Child Maltreatment (VI.1) and Mo ery County Health Department Child Abuse/Neglect Information (. for discussion.

4. Develop VI A and B Sample Content 1 a), 2) Problems inhibiting personal involvement in the problem of child maltreatment, using examples such as:

   a) Indifference (It's not my problem.)

   b) Copout (I'll wait and see if it happens again.)

   c) Standoff (One instance isn't proof enough.)

   d) Disbelief (I really don't believe it.)

e) Dilemma (I just don't have enough facts.)

f) Traditional (It's the only way some kids will learn.)

5. Review selected case histories from Unit II, and slides depicting the maltreated child.

6. Review the local reporting process, utilizing for discussion:

   A Policy Statement on Child Abuse and Neglect; More About Project PROTECTION (VI.3)

   Protect a Child Help a Parent Our Community Responsibility (II.4)

7. Contact the local Child Protection Agency and report current local statistics along with current national statistics, as available (Transparency 1).

8. Review II A and B as necessary.

9. Develop VI A and B Sample Content 2 for both the maltreated child and the caretaker, utilizing for class discussion:

   Montgomery County Services for Maltreated Children and Their Families (VI.5)

   Even Parents Sometimes Lose Control (VI.6)

   The Extended Family Center (VI.9)

   Working With Abusive Parents, A Social Worker's View (VI.10)

   Working With Abusive Parents, A Psychiatrist's View (VI.11)

   Working With Abusive Parents, A Parent's View (VI.12)

   C.A.L.M.--A Timely Experiment in the Prevention of Child Abuse (VI.7)

   Child Neglect: Reaching the Parent (VI.8)

10. Invite a speaker from the local Child Protection Agency to discuss the role of the child protection team.

11. View the videotape "The Battered Child", an interview with Montgomery County Child Protection staff.

12. Conclude with assessment measures for Performance Objectives A and B 1 through 4.

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UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective Two

The student will be able to recommend responses which provide hope for prevention of child maltreatment in society.

Performance Objectives for Generalization C

1. IDENTIFY those who must respond to the problem of child maltreatment.

2. DESCRIBE the kinds of response which provide hope for the prevention of child maltreatment in society.

Generalization C

THROUGH SOCIETY'S RESPONSE TO THE PROBLEM OF CHILD MALTREATMENT, THERE IS HOPE FOR PREVENTION.

Sample Content

1. Those who must respond:
    a) Enlightened parents
    b) Concerned citizens
    c) Alerted medical practitioners
    d) Informed social workers, teachers, and law enforcement authorities
    e) Dedicated legislators and social policy makers

2. Kind of responses:
    a) Recognition and protection of the rights of children
    b) Improved environment for children
    c) Greater dissemination of knowledge about child maltreatment
    d) Adequate funding for child maltreatment prevention programs
    e) Increase in available community resources and services
    f) More compassionate understanding of the problem of child maltreatment

Suggested Classroom Activities and Procedures for Performance Objectives C 1 and 2

1. Prepare students for an understanding of Generalization VI C through in-depth review of Unit I The Phenomenon of Child Maltreatment and Generalization II C.
2. Introduce Generalization VI C, and write on board for students.
3. Have students read and discuss in class:

   Why Most Physicians Don't Get Involved in Child Abuse Cases and What to do About It (VI.14)

   Understanding and Helping Child-Abusing Parents (VI.15)

   Project PROTECTION, A School Program to Detect and Prevent Child Abuse and Neglect (VI.16)

   Child Abuse: Detection and Prevention (VI.17)

   Battered Children and Counselor Responsibility (VI.18)

   Preventing Child Abuse (VI.19)

   The Abused Parent of the Abused Child (VI.20)

   The Rights of Children (VI.21)
4. Students may:
   - Invite a member of the Montgomery County Task Force on Child Abuse, and write a paper on the subject of what steps are necessary or involved in establishing community action on child maltreatment
   - Interview a member of the Special Child Abuse Team, Children's Hospital, Washington, D.C.; and write a paper on what is involved in planning a program to help the maltreated child and the caretaker

- Interview the Montgomery County Child Protection Coordinator, and write a paper on the problems involved in coordinating community help for the maltreated child and the caretaker
- Interview a juvenile officer from the Montgomery County Police Department, and write a paper on citizen responsibility for the prevention of child maltreatment
- Interview at the state level one of the following, and write a paper on the subject of State legislative action on child maltreatment:
  - a) Montgomery County Delegate
  - b) Prince George's County Delegate
- Interview at the federal level one of the following, and write a paper on federal legislative action on child maltreatment:
  - a) An official of the Office of Child Development (HEW) on the subject of 1) child advocacy or 2) funding for child protection programs
  - b) A member of the Senate Subcommittee on Children and Youth on the subject of federal legislation to protect the rights of children
- Make art posters for school display to promote better understanding of child maltreatment
- Write an article for the school or local newspaper on some aspect of prevention of child maltreatment in society
- Sponsor a school assembly or PTA program to develop better understanding of child maltreatment

5. Conclude with assessment measures for Performance Objectives C 1 and 2.

EVALUATION

for

VI. Child Maltreatment: Help and Hope

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SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 --
UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One: The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. IDENTIFY the kinds of responses which help the maltreated child.		The student will give correct information by utilizing the resources listed below: VI A Sample Content 1
2. DESCRIBE the kinds of help available to the maltreated child.		VI A Sample Content 2

Key Word[1] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

1 Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 --
UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One: The student will be able to recommend responses to the problem of child maltreatment which providehhelp for the caretaker.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. IDENTIFY the kinds of responses which help the caretaker.		The student will give correct information by utilizing the resources listed below: VI B Sample Content 1
2. DESCRIBE the kinds of help available to the caretaker.		VI B Sample Content 2

Key Word[2] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or /to/list the characteristics of a person, place, thing, or event

2 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 --
UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective Two: The student will be able to recommend responses which provide hope for prevention of child maltreatment in society.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. IDENTIFY those in society who must respond to the problem of child maltreatment.		The student will give correct information by utilizing the resources listed below: VI C Sample Content 1
2: DESCRIBE the kinds of responses which provide hope for the prevention of child maltreatment in society.		VI C Sample Content 2

Key Word[3] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

3 Evaul.

CLASS RECORD FORM

S = SATISFACTORY

U = UNSATISFACTORY

UNIT VI: CHILD MALTREATMENT: HELP AND HOPE

CLASS ______________________ PERIOD ____________

INSTRUCTIONAL OBJECTIVE ONE: The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

INSTRUCTIONAL OBJECTIVE TWO: The student will be able to recommend responses which provide hope for prevention of child maltreatment in society.

NAME	Inst. Obj. One Performance Obj. 1	2		Inst. Obj. Two Performance Obj. 1	2	Average % S	U
AVERAGE %	S					CLASS AVERAGE	
	U						

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE ______

TOTAL % UNSATISFACTORY for COURSE ______

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

VI. Child Maltreatment: Help and Hope

1. Indicators of Child Maltreatment, Montgomery County Health Department (VI.1)
2. Child Abuse/Neglect Information, Montgomery County Health Department (VI.2)
3. "A Policy Statement on Child Abuse and Child Neglect"; "More About Project PROTECTION" (VI.3)
4. "Protect a Child Help a Parent, Our Community Responsibility" (VI.4)
5. Montgomery County Services for Maltreated Children and Their Families (VI.5)
6. "Even Parents Sometimes Lose Control" (VI.6)
7. "C.A.L.M.--A Timely Experiment in the Prevention of Child Abuse" (VI.7)
8. "Parental Stress Service--How It All Began" (VI.8)
9. "The Extended Family Center" (VI.9)
10. "Working With Abusive Parents, A Social Worker's View" (VI.10)
11. "Working With Abusive Parents, A Psychiatrist's View" (VI.11)
12. "Working With Abusive Parents, A Parent's View" (VI.12)
13. "Child Neglect: Reaching the Parent" (VI.13)
14. "Why Most Physicians Don't Want To Get Involved in Child Abuse Cases and What To Do About It" (VI.14)
15. "Understanding and Helping Child-Abusing Parents" (VI.15)
16. "Project PROTECTION: A School Program to Detect and Prevent Child Abuse and Neglect" (VI.16)

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17. "Child Abuse: Detection and Prevention" (VI.17)

18. "Battered Children and Counselor Responsibility" (VI.18)

19. "Preventing Child Abuse" (VI.19)

20. "The Abused Parent of the Abused Child" (VI.20)

21. "The Rights of Children" (VI.21)

22. Instructional Materials for Units I, II, III, IV, and V

23. Classroom learning center for child maltreatment

Film

Don't Give Up On Me Produced for the Metropolitan Area Protective Service and the Illinois Department of Children and F mily Services for use in case workers awareness training. This film uses real people in real situations to probe the reasons behind the child abuse pattern. A mother of two small children is in danger of having her daughter taken by the court, and the assigned social worker struggles to have the distraught mother come to grips with her problem.

Motorola Teleprograms, Inc. 1976 16mm color 28½ min.

Available from HELP Resource Project
1123 North Eutaw Street
Baltimore, Maryland 21201

CHILD MALTREATMENT: HELP AND HOPE (VI.1)

MONTGOMERY COUNTY
Health Department

INDICATORS OF CHILD MALTREATMENT

SUSPECT MALTREATMENT

When the child:

has unexplained injury
has injuries not mentioned in history
has multiple injuries
has injuries of different ages
has history of repeated fractures
has characteristic x-ray of long bones
is neatly but inappropriately dressed
is generally poorly cared for
is unusually fearful or stoic
shows evidence of sexual abuse
takes over and cares for parent's needs
has serious burns

When the parent:

gives history inconsistent with injury
gives contradictory history
projects cause of injury on sibling
delays bringing child for treatment
shows evidence of losing control
over-reacts or under-reacts to the situation
persistently complains about irrelevant problems
is uncooperative
"hospital shops"
cannot be located
is psychotic or psychopathic

Children who may be at risk at birth:

premature baby
unwanted or unplanned baby (not equivalent of illegitimate)
baby of addicted parent(s)
baby in family with previous history of abuse
twins or triplets
baby with major anomaly
bonding failure (mother on maternity ward seems unrelated to neonate)

OFFICE OF HUMAN RESOURCES
Project PROTECTION
November 1975

MONTGOMERY COUNTY, MARYLAND
Health Department

Child Abuse/Neglect Information

COMPARISON OF ABUSIVE AND NON-ABUSIVE PARENT-CHILD INTERACTIONS

Abusive	Non-Abusive
Emergency Room	**Emergency Room**
1. Paradoxical dress--child appears in clean clothes inappropriate to illness or injury	1. Child appears in clothes worn at time of accident or illness
2. Parent shows over--or under-concern (cover-up for guilt feelings). May be hesitant to talk about injury; contradictions in story about events surrounding injury; improbable explanations as to cause of injury. May refuse permission for further diagnostic tests--may change hospitals.	2. Parent reports details surrounding injury/illness with consistency, accuracy, and spontaneity. History seems appropriate to clinical findings. Shows concern about injury and treatment.
3. Infant's crying is interpreted as a demand; and parents' response is thus angry and rejecting.	3. Parent tolerates crying and gives comfort to child.
4. Pre-school child: Is fearful of unpredictable environment and thus remains either immobile, or passive; there may be catatonic-like posturing; wide-open, unblinking visual gaze; examination not difficult as child is so docile.	4. Pre-school child: Clings to parent; rejects strangers; avoids eye contact with strangers; seeks to return to parent if separated; may scream, cry, kick, bite during procedures.
On Ward:	**On Ward:**
1. Parent raises no fuss about child being separated; lack of trust may keep him/her from expressing needs.	1. Parent wishes to remain with child, asks questions, exhibits appropriate affect and concern; visits frequently, brings toys and gifts; asks questions about discharge.

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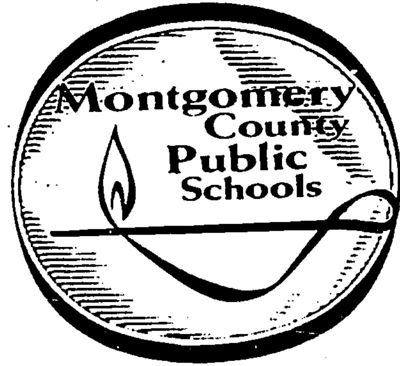
Parent becomes involved with care, touches child, not upset with normal body functions (e.g., vomitus or urination).

Parent is able to interpret child's needs and provide comfort and reassurance. (e.g., honesty in explanations, calming voice tones, assistance by holding child).



Revised, August 26, 1974

a policy statement on

Child Abuse and Child Neglect

POLICY

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position to identify and report child abuse. Every effort must be made to identify abused children and to prevent repeated abuse.

All Montgomery County Public Schools employees are required by law to report *suspected* cases of child abuse. As soon as an employee has reason to believe that a child may have been abused, he must call the Protective Services Section of the Montgomery County Department of Social Services, 279-1758, or the Juvenile Section of the Montgomery County Police Department, 762-1000. Simultaneously, the reporting person shall notify the principal that a report has been made. The obligation of the principal to report cases of suspected child abuse brought to his attention by his staff is not discretionary, and he shall assure that the case is duly reported if the reporting person has not done so.

When a report of suspected abuse has been made, a police officer accompanied by a social services worker will respond at once.

Within forty-eight hours, the person making the original oral report must send a written report of the incident to the Department of Social Services, with copies to the Montgomery County State's Attorney, the Juvenile Section of the Montgomery County Police Department, and the Supervisor of Pupil Personnel at the central office. One copy of the report will be kept in a confidential file by the principal but not placed in the pupil's folder. Montgomery County Form 335-44

Purpose of Intervention

:eports of suspected child abuse are carefully investigated :ly by the Police Department's Juvenile Section ctives and social workers from the Department of Social ices. Each case receives a professional evaluation leading to :ever civil action may be necessary to ensure treatment for family. Treatment may include a full range of therapeutic rams. The abuser is not subject to indiscriminate criminal :cution. The State's Attorney and the police work closely all involved professional personnel and authorities to plish alternatives to prosecution, whenever possible.

REPORTING CASES OF CHILD NEGLECT

he Montgomery County Department of Social Services has legal responsibility for evaluating reports of suspected l neglect and for taking legal action to protect a child re necessary. Under Article 77, Section 116A of the otated Code of Maryland, any educator who acts upon onable grounds in the making of any report required by rule, or regulation or who participates in judicial eedings which result from such report shall be immune ı any civil liability which occurs. A neglected child may be of the following:

. Malnourished; ill-clad; dirty; without proper shelter or

MONTGOMERY COUNTY GOVERNMENT Rockville, Maryland	REPORT OF SUSPECTED CHILD ABUSE/ CHILD NEGLECT

Instructions: Respond to each item even if reply is "unknown" or "none." For suspected child abuse, this report must be filed within 48 hours after oral report. Retain original, send copies as indicated below to Department of Social Services, your agency's administrative office, State's Attorney's Office and Police Juvenile Section. For suspected child neglect, retain original; send copies to Department of Social Services, and your agency's administrative office. Destroy others. Type or print firmly on hard surface. (See reverse side for definitions and additional instructions.)

Check type of referral: ☐ SUSPECTED CHILD ABUSE ☐ SUSPECTED CHILD NEGLECT

TO: MONTGOMERY COUNTY DEPARTMENT OF SOCIAL SERVICES

FROM:

Name ______________________ Agency/school ______________________

Address ______________________ Phone ______________________

NAME OF CHILD

ADDRESS (WHERE CHILD MAY BE SEEN)

AGE OR BIRTHDATE

NAME OF PERSON(S) RESPONSIBLE FOR CHILD'S CARE (Parents/Guardian)

Father ______________________ Phone ______________________

DEFINITIONS OF CHILD ABUSE AND CHILD NEGLECT

CHILD ABUSE

Any physical injury or injuries sustained by a child under the age of eighteen (18) as a result of cruel or inhumane treatment or as a result of malicious act or acts by any parent or other person who has the permanent or temporary care or custody or responsibility for supervision of the child.

Whether physical injuries are sustained or not, any sexual abuse of a child under the age of eighteen (18) by any parent or other person who has the permanent or temporary care or custody or responsibility for supervision of the child.

"Sexual abuse" is defined by Maryland law as "any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy, or unnatural or perverted sexual practices."

ADDITIONAL INSTRUCTIONS FOR REPORTING CHILD ABUSE

1. A report must be submitted on any case in which child abuse is suspected. It is not necessary to observe outward signs of injury to the child. Neither is it necessary for the reporter to establish proof that abuse has occurred. Protection of the child is paramount. If abuse is suspected, a report must be submitted.

2. Every health practitioner, educator or social worker or law-enforcement officer, who contacts, examines, attends, or treats a child and who believes or has reason to believe that the child has been abused is required to make a report to either,
   Social Services, 279-1758 or Police, 24 hours, 762-1000

3. Each such report shall be made both orally and in written form; both the reports to be made as soon as is reasonably possible in the circumstances, but, in any case, the written report must be made within forty-eight (48) hours of the contact, examination, attention or treatment which disclosed the existence of possible abuse.

Timely information about what one school system is doing about child abuse and neglect.

Diane D. Broadhurst is the Coordinator and Maxwell C. Howard is Curriculum Specialist of Project PROTECTION, Montgomery County Public Schools, Rockville, Maryland.

More About PROJECT PROTECTION

Diane D. Broadhurst and Maxwell C. Howard

IN 1972 the brutal death of a nine-year-old child and the indictment for murder of her father and stepmother shocked the citizens of Montgomery County, Maryland. This case soon became the catalyst for an intensive community effort to alert residents to the phenomenon of child abuse and neglect and to improve methods of reporting and handling such incidents.

Since then Montgomery County, one of the largest school districts in the nation, has made

THE SCHOOL-BASED PROGRAM: FOUR PHASES

Already a leader among school systems in the nation with regard to child-protection activities, Montgomery County intensified its efforts in August 1974 by initiating a school-based program, Project PROTECTION: A Multidisciplinary Approach to Educational Problems Associated with Child Abuse and Neglect. This project is

Staff development, the largest part of Project PROTECTION, was carried out as a three phase operation, beginning in September 1974 with a one day conference for all public school administrative and supervisory personnel. This conference was followed by an intensive two-day seminar for school pupil services administrative staff. Finally, the pupil services administrative staff conducted local staff development programs during regularly scheduled faculty meetings in each of the county's 201 public schools. The local school presentations reached a total of 6,000 staff members and helped them recognize indicators of child abuse and neglect. Besides being informed of their legal responsibility to report and the immunity granted by law, they were briefed on the proper referral procedures. Similar programs were also offered to staff members in county nonpublic schools. A number of high school and college classes, as well as PTAs and service groups, also requested informational programs on child abuse and neglect.

The direct service phase of Project PRO

badly bruised mouth. Gently questioned by the teacher, Jennie said, "Mommy got mad and hit me."

Jennie's teacher had been concerned about her for some time. Withdrawn and isolated, Jennie remained apart from her classmates. Although Jennie said she liked school, she was frequently absent and took little part in classroom activities. Yet she was always the last to leave the room and sometimes cried when it was time to go home.

Investigation confirmed that Jennie had been abused. Her back was covered with new and healing scars, marks of previous injuries. X-rays revealed several old rib fractures; there were circular burn marks as well. Mrs. K explained that she had never liked Jennie, who was "just like" Mr. K., from whom she was divorced. She added that she did not want children and had "gotten rid of" her other pregnancies.

After a court hearing determined that the continued risk to Jennie was substantial, the girl was placed in foster care. She is now living with

that Eric was of normal intelligence though seriously disturbed. Physically he was small for his age and undernourished. There was no evidence of physical abuse.

The Protective Service investigation revealed that both Mr. and Mrs. T. were alcoholics. Unable to hold a job for any length of time, they lived a hand-to-mouth existence. Largely ignored, Eric was left alone to survive as best he might.

Eric is now in foster care where he is receiving psychiatric counseling. The school provides special tutoring, and Eric is beginning to catch up academically. Mrs. T. has agreed to accept alcoholism counseling. Mr. T. refuses all offers of help. The prognosis for the family is uncertain.

Tom—Buckle Discipline

Only rarely is it necessary to remove a child from his home. Jennie and Eric are extreme examples. A more typical case is that of Tom B., an upper elementary grade boy.

One morning Tom complained to his teacher of having been beaten by his father the night before. The teacher's first instinct was to dis-

EMPHASIZING PREVENTION

The curriculum development phase of Project PROTECTION addresses the prevention aspects of child abuse and neglect. If we are ever to reduce the number of abused and neglected children, we must look to prevention, and that begins with today's students—the parents of tomorrow. The project is preparing a course of study on the child maltreatment syndrome, designed for use at the secondary level. The course will focus upon understanding nurturing in infancy and early childhood in relation to the ability to achieve emotional maturity in later life. It will also be concerned with understanding how the use of violence in the home results in a cycle of violence in both the individual and in society. Finally, the course will promote understanding of stress, its manifestations in society and in the individual, and how the individual copes with stress. Selected modules of the course are being piloted during the current school year.

Even in its first year of operation, Project PROTECTION has demonstrated that a school

ERIC Full Text Provided by ERIC

you elp...

ren is not new, but it ve find it hard to be- en may be harmed by ts. Yet child abuse can nily, regardless of in- color.

ecomes overwhelmed as unemployment, coholism, or isolation, bused or neglected. ho abuse their children mistreated as children; s, including those who ct their children, want nts.

e first link between a and needed help.

how can you help...

To help break the cycle of neglect and abuse, children and parents involved must first be identified. Since parents and children are often reluctant to ask for help, you can help by reporting cases of suspected abuse and neglect.

Maryland law requires every person to report suspected child abuse and extends immunity from civil liability or criminal penalty to all who report in good faith.

Child abuse includes: any physical injury to a child under 18 by a parent or caretaker, as a result of cruel or inhumane treatment; any sexual abuse to a child under 18 by a parent or caretaker whether physical injuries are sustained or not.

While there is no requirement to report neglect, reporting is highly encouraged. Neglect can be harmful to a child and and may even be the forerunner of abuse. Neglect includes such things as: emotional deprivation, malnourishment, lack of essential medical care, unlawfully being kept from attending school.

what to look for...

A child who is physically abused may have bruises, welts, or burns which do not fit with the explanation of how the injury occurred. Or the child may complain of having been beaten or sexually abused.

A neglected child may appear tired, listless, hungry, or be left unsupervised at odd hours. The child may be forced to assume adult responsibilities at an inappropriate age.

ERIC Full Text Provided by ERIC

you
l help ...

gry with your kids
ɔu'll hurt them . . .

be a better parent, but
ere to turn for help . . .

ine 949-6603

day, 7 days a week

ays available to listen
ıbout your problems—
t, understanding, help.

TO REPORT SUSPECTED ABUSE/NEGLECT

DEPARTMENT OF SOCIAL SERVICES
Protective Services 279-1758
(24 hours a day)
(After some hours this phone
will be answered by police)
5630 Fishers Lane
Rockville, Md. 20852

FOR INFORMATION OR TRAINING SESSION

OFFICE OF HUMAN RESOURCES
Child Protection Coordinator
279-1512
301 E. Jefferson St.
Rockville, Md. 20850
Or
DEPARTMENT OF SOCIAL SERVICES
279-1751
5630 Fishers Lane
Rockville, Md. 20852

TO "RAP" ABOUT YOUR PROBLEMS
HOTLINE 949-6603

MONTGOMERY COUNTY
GOVERNMENT
Office of Human Resources
279-1512
5/75

ERIC

VI. CHILD MALTREATMENT: HELP AND HOPE (VI.5)
MONTGOMERY COUNTY SERVICES FOR MALTREATED
CHILDREN AND THEIR FAMILIES

Many community resources are available to the individual in Montgomery County. A Directory of Community Resources may be found in libraries throughout the county. For information or help in locating appropriate resources, telephone 279-1900. The following is a general description of services by agency.

DEPARTMENT OF SOCIAL SERVICES

The Protective Service Unit of the Montgomery County Department of Social Services investigates and evaluates all reports of suspected child abuse and neglect to determine the validity of the allegation. Twenty-four hour response to reports of abuse and serious neglect is provided. Continuing services are provided on behalf of abused and/or neglected children who remain in their own homes, in the home of relatives, or in short-term placements through casework and group-work services.

The Maryland Child Abuse Law mandates that reports of suspected abuse be made either to the local department of social services or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately contact the other.

Unique to Montgomery County is the manner in which abuse reports are investigated. In all such reports, the investigation is conducted by a social worker and a Juvenile Aid officer of the police department and is begun within

ERIC

1. Public Assistance (Aid to Families with Dependent Children, General Public Assistance, and General Public Assistance for Employables)

2. Food Stamps

3. Medical Assistance

4. Emergency Shelter Care Placement -- a local policy and an additional bed subsidy maintain homes to receive children requiring immediate placement 24 hours per day

5. Foster Care -- including the purchase of specialized foster home care, group home care, or institutional care from other agencies.

6. Single Parents Service -- a specialized counseling and planning service for those with unplanned pregnancies

7. Adoption -- including subsidized adoption and permanent foster care

8. Homemaker Service

9. Day Care -- both in family homes and in centers. Montgomery County has 15 non-profit full day centers. Subsidized day care is available in non-profit or proprietary centers.

3. Health Department Comprehensive Care Clinics (Areas I and IV)

4. Maryland Medical Assistance Program -- sick care provided through the private physician

5. Maternity and Family Planning Services

6. Mental Health Services including purchasing treatment from the Community Psychiatric Clinic. (These services use a sliding scale fee based upon income.)

Among relevant county-wide health services provided centrally are the following:

1. Specialty,consultation services such as those for seizure and cardiac, orthopedic, and multihandicapping problems

2. Passage Crisis Center

3. Juvenile Court Evaluation Team

4. Drug Alternatives Program

5. Day Care Licensing and Consultation Services (health component)

supervisor from Montgomery County Public Schools; a lawyer from the County Attorney's office; and a psychiatrist in private practice. The team meets weekly to staff cases of child abuse and neglect and to make recommendations for case handling.

MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)

MCPS provides case-finding and family services through its pupil personnel services. A broad range of educational diagnostic services, psychological services, and special placements are available.

OTHER COMMUNITY SERVICES

Within the community, Montgomery County has the following services:

1. Public Housing through the Montgomery County Housing Authority

2. Family Services of Montgomery -- a private United Way counseling agency

3. The Community Psychiatric Clinic -- a large private treatment clinic

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EVEN PARENTS SOMETIMES LOSE CONTROL

ERIC

Since 1970, Enid Pike has been Executive Director of C.A.L.M., a pioneer program to prevent child abuse and neglect in Santa Barbara. A graduate of the University of California at Santa Barbara, Mrs. Pike, a grandmother, is currently working toward a Social Services Certificate. She was Co-Founder and Director of a school for Japanese brides of United States servicemen in Tokyo.

C.A.L.M. – A TIMELY EXPERIMENT IN THE PREVENTION OF CHILD ABUSE

By ENID L. PIKE

It has always been the prerogative of parents to handle the disciplining of their children in whatever way they choose and to administer punishment in whatever degrees of intensity they determine. Not until very recently has any widespread concern been shown for abusive action against children. However, an intense awareness of the syndrome is spreading readily among legal, medical and social workers, students in colleges and high schools, and among enlightened citizens everywhere. As a direct result of one woman's work and concern with the problem, a new exciting, experimental project has developed in Santa Barbara, California. Child Abuse Listening Mediation, or "C.A.L.M." as it is better known, is a unique pioneering venture in *prevention* of child abuse and neglect.

Three years ago a Santa Barbara physician's wife, Mrs. Harold Miles, attended the indictment of a nineteen year old college student who was accused of beating his child to death. He was dry-eyed throughout the proceedings. Stony faced, he heard the charges against him. Before he was led out of the courtroom, an older man, a social worker, with compassion showing in his face, placed his hand on the boy's shoulder and said gently, "Son, why don't you tell me what really happened?" The boy disintegrated in tears. This man's expressions of kindness and concern were the first indications anyone had

The statistics Mrs. Miles gathered regarding other communities pointed out their need for services to combat the problem where it had been established that child abuse existed. But who would believe that such a problem exists in the small, retirement, vacation center of Santa Barbara? Mrs. Miles needed evidence. She devised a daring, imaginative plan and solicited help from a Santa Barbara *News-Press* reporter, Jenny Perry, who covered her experiment in three consecutive Sunday news items. Mrs. Miles had a private, unlisted telephone installed in her home for thirty days. Headlines of the first article on March 15, 1970, read: KNOW OF MISTREATED CHILD? TELL SOMEONE THE SITUATION. Beneath a large picture of a telephone was the caption: "Information about maltreatment of children is being collected this month by Mrs. X, who plans to sit by the phone through April 14 answering all who call 964-4415. Information about the community problem, not punishment, is the point, she says." During the thirty days, twenty-eight cases of child abuse or neglect were reported anonymously.

Supported by this proof that Santa Barbara shares the problem of child abuse with other communities everywhere, Mrs. Miles brought together a steering committee, and with the help of a young attorney, Robert Monk, a proposal for a

devoted entirely to prevention.

C.A.L.M.'s program began October 1, 1970, and early on that first morning a call came in from a distressed mother, Ruth Lee. Her three children, all younger than five, were getting too much for her to handle alone. Her husband had divorced her right after the birth of their third child. For awhile, he had sent what money he could to help, but he could not hold a steady job. Later he moved away and communications from him ceased. Through a friend, Ruth learned that he was out of work and living a deplorable existence himself. No help would come from him. She was forced to apply for assistance from welfare, which served to meet only the bare essentials of their needs. Most of all, she explained, she felt trapped and unable to cope with the stresses of poverty and trying to meet the needs of her three active sons alone. She wept as she told her story. Her mother was dead – her father an alcoholic. She had no one to turn to but had grasped at a straw when she read C.A.L.M.'s ad in the personal column of the daily *News-Press:* "Is your child abused, neglected? Let us share your problems. Keep C.A.L.M. in mind. Call 963-1115 for help."

After an hour of talking, Ruth had regained her composure. She responded warmly to the listener to whom she had poured out her story. She learned about C.A.L.M.'s volunteers, who could visit with her once in a while, maybe stay with the children sometimes and let her get away to refresh her spirits. Ruth's response was eager and full of hope. She was promised a call from a volunteer the next morning. As soon as they had hung up, Mrs. Pike called one of C.A.L.M.'s twenty-three volunteers, a young mother herself, who had seven children and understood very well the pressures of motherhood. Mary Ligman took the case. She and Ruth met and formed a friendship which still exists. At first Ruth called Mary very fre-

tact made. From that point on, the volunteer is expected to continue helping the client in any way possible while a need for such help exists. A friendship is originated which has no artificial termination date pre-established. As the client's self-image improves and the scope of interests, friends and activities broadens, dependency upon the volunteer gradually decreases. Eventually, the client becomes self-sufficient enough to release the volunteer to begin working more intensely with a new client. No volunteer is ever assigned more than two clients at one time.

C.A.L.M.'s volunteer program is based on the concept of "Mothering" as defined by Dr. C. Henry Kempe and his staff and upon the need in every human being to feel a sense of being worthy and cared about in a consistent, meaningful way. Most of C.A.L.M.'s clients have never had anyone on whom they could depend consistently to answer their emotional needs. Frequently their emotional development has been inhibited. Many clients have experienced a series of rejections throughout their lives. C.A.L.M.'s volunteers provide caring friends who are nonjudgmental and dependable, who are available whenever the clients need help, and who are dedicated to preventing child mistreatment through their understanding, unselfish service.

Close cooperation exists between C.A.L.M. and other organizations in the community. All third party reports dealing with suspected or known incidents of mistreatment are referred by C.A.L.M. to whatever agency has the best professional facilities to answer the problems involved. Referrals are made to C.A.L.M. by other agencies when a preventive effort is indicated and physicians also use C.A.L.M.'s service frequently. During the first two years of C.A.L.M.'s existence, four hundred eighty-one cases were handled. Forty-seven percent of these were self-referrals. In most instances, the

held through appropriate court action and assigned to a foster home until the mother regains her mental health through the help of extensive professional counseling.

Although C.A.L.M. deals with all calls for help, the most important goal is to PREVENT mistreatment by reaching out a helping hand to frustrated parents before they focus their anger on their innocent children. Child abuse is most often a vicious cycle, repeated from one generation to the next. C.A.L.M. is committed to stopping this cycle!

C.A.L.M.
P. O. Box 718
Santa Barbara, Calif. 93102

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Carole Johnstone, a graduate of Western Washington State College and Dominican College of San Rafael, California, taught at Washington State before becoming a Counselor at the Youth Guidance Center in San Francisco. She is the Founder and Director of Parental Stress Service, a hot-line for potential child abusers serving Berkeley and the East Bay.

PARENTAL STRESS SERVICE – HOW IT ALL BEGAN

By CAROLE JOHNSTONE

I am a single parent. I am divorced and have one son now 8 years of age. When he was two, my marriage began to break up and the pain, hurt and frustration I was feeling was vented on him. I wasn't aware of what was really happening until one day when Danny messed his pants and I exploded. I caught myself just as I was ready to ram his head through the floor. I left him there on the bathroom floor, shakily made my way to the telephone, called the one friend I had and asked her to come and take Danny for awhile. She was there in fifteen minutes. She asked no questions; she simply accepted me as a person and a friend. Because she did not condemn me as a person for having feelings of not wanting my son around, of not knowing how to cope with all the feelings going on inside me and because of her continued support and friendship, I was able to turn to her before things really got bad, and I was able to seek professional counseling.

Two and one-half years later, I moved from the small town we were living in to a large metropolitan area. I was struck by

When you call *Parental Stress Service*, you can find help in the following ways:

- An active listener . . .
  - pour out your anger, hurt, problems.
- A trained volunteer coming to your home . . .
  - to help work through a crisis;
  - to provide a respite from 24-hour a day parenting.
- Information and referral
  - to help you, a concerned relative or neighbor;
  - to help families in stress find longterm professional help.
- A speakers' bureau.

Specific Aims of *Parental Stress Service*:

1. Interrupt the cycle of child abuse If parents' needs can be met, the abuse might not occur and healthy child-parent relationships can be passed on to the next generation.
2. Aid caretakers of children who are afraid of losing con-

Reprinted from
Children Today
3(March-April 1974)

THE EXTENDED FAMILY CENTER

The "battered child syndrome" became acknowledged during the 1950s as a recognizable and treatable entity. Usually, battered—or abused—children are first seen by a doctor or nurse when they are brought for treatment of injuries which range from bruises and burns to multiple bone fractures. Sometimes they are discovered when a parent brings a child to a hospital, well-baby clinic or other facility for examination or treatment unrelated to the non-accidental injury.

Recognition of the battered child is the first, crucial step in treating child abuse. Medical personnel have to maintain a high index of suspicion about how a child was injured because parents will rarely admit to abuse and children are generally too young or too frightened to tell what happened. When it appears that a child could not have received his or her injury accidentally, the doctor or clinic in all states is required to bring the family to the attention of the authorities, to obtain protection for the child and rehabilitation for the

parent and in those where two parents are present. It occurs among all races and economic groups, and among the employed and the unemployed.

But there are some common denominators among cases of child abuse, factors that characterize abusive parents and their family situations. The dynamics that usually set abusive parents apart are the lack of positive mothering they themselves experienced during childhood, their own inaccurate perceptions of the child, social stresses within the family and, often, their belief that physical violence against children is an appropriate disciplinary action.

Most abusive parents were themselves mistreated as children and most never experienced the positive parenting that would help them later to love and nurture a child. As a result, these parents grow up to be deprived, needy adults. As parents whose own needs have not been met and who have seldom been recognized as individuals of worth, they find it difficult and sometimes impossible to tolerate the demands and needs of young children, demands and needs that really

under stress, the child often becomes the easiest target upon which to release their frustrations. Marital problems, financial problems, and sometimes even so trivial an event as a washing machine breaking down can result in a child being abused. Usually, these stresses are heightened by the isolation and lack of support experienced by most abusive families. Parents often act out against their child because there is nowhere for them to turn to relieve their tension or stress.

How Can Such Families Be Helped?

Our project, The Extended Family Center, was established with support from the Office of Child Development in February 1973 as a treatment center for abused children and their parents. Sponsored by the Mission Child Care Consortium, Inc., a Model Cities day care program that serves a multiethnic section of San Francisco, it is funded by OCD as a 3-year research and demonstration project. It also receives funds from the California State Department of Health and a private foundation, the Zellerbach Family Foundation.

The center is presently serving 25 through violence against their children. Since one of the most needed services for all the families is relief from 24-hour care of their child, the program includes day care services that give relief to the parents while helping the child.

The center is open from 9 a.m. to 6 p.m. and emergency telephone coverage is provided after hours. During the first phase of the project, when we were serving only 10 families, the children were cared for together, in the day care center on the first floor of our storefront building. (The second floor houses the parents' center rooms and offices.)

Treating The Children

We have found that all of the children who come to the center need specialized attention. At first, they exhibit behavior that is either very withdrawn or overactive. All are mistrustful of their environment and many are violent in their responses to both staff members and other children. Their mistrust is particularly apparent at nap time and in their fear of such routines as having their diapers changed. All have great difficulty falling asleep and need one-to-one attention to relax and rest.

As a result, the staff's initial involvement with the children consists of helping them gain trust in their environment. Our consistency, lack of pressure, and acceptance of regression help them to do this.

Most of the children in the program go through an initial adjustment period of four to six weeks, during which time their overactive or withdrawn behavior lessens. Limit-setting is particularly important during this period. Abused children have not been exposed to appropriate limits for their age and behavior and they desperately need them to learn how to

the child care staff has been to help these children, who have been continually exposed at home to inappropriate expectations, to develop their potential at their own pace.

We have found that the children, particularly the preschoolers, regress in the center. But once they find that limits do exist they begin to respond to more age-appropriate expectations. With the safety of their environment established, the children are ready to begin to take risks and explore learning with the staff.

Surprisingly, the children have had little difficulty adjusting to the differences between the center and home. Most of them are aware of what behaviors are allowed at the center and what is allowed at home. However, for those who had been most severely battered the discrepancy between home and center has been the greatest and we are watching to see what long-range effect this will have on them. It is our hope that the freedom of the center and the positive support the child receives will help him or her better cope with the limitations at home.

More challenging has been the need as the parents receive support from all the staff, they begin to relax and develop relationships with the teaching staff. Parental participation in programs for the children is encouraged and parents have helped paint the center and built play equipment for the yard.

Parent Treatment

Our philosophy of parent treatment is based upon the belief that the parents themselves, with support from professional workers, are the best source of treatment. Through the use of groups the staff helps parents give support and understanding to each other. Initially, the staff provided most of the direct help and treatment. Gradually, we have seen the parents themselves begin to offer advice, sup-

I try to teach my fellow workers what it is like being on the other side... As for the parents I work

frequently will make contact to help the resistant parent work through his or her difficulty. The parent board meets weekly with staff to discuss problems at the center and all staff members and parents meet once every six weeks to talk over the program and any needed changes.

A vital part of the parent program is the role of the parent consultants—two formerly abusive parents who are employed as full-time staff. Both consultants are mothers who once abused their own children and are now not only able to provide good care to their families but can also act as liaison persons to help develop trust and communication between parents and professional staff. Their participation and openness about their own past abusive behavior has greatly lessened denial and hostility among the parents enrolled in the program and it has encouraged their cooperation and participation.

All parents are required to participate in four hours of treatment per week at the center. The treatment includes weekly group therapy led by a male social worker and female parent consultant. This group is a

occupational therapist once every six weeks to discuss her assessment of the parent's work and behavior in the group meetings. Some characteristics of parents' behavior and functioning which the use of craft work as a diagnostic tool have revealed are: inability to complete projects, difficulty in relating to authority, unwillingness to try new things and lack of self-confidence or self-esteem. Through their participation in occupational therapy, parents have learned to understand their behavior better.

Emergency Service

The center also provides an emergency service for parental support after hours. A 24-hour-a-day, 7-day-a-week emergency phone line is available to the parents and arrangements can be made to care for children and families after hours in emergencies. We have found that the provision of such emergency care has been vital to the center's ability to protect children. Parents have learned that they have a stop gap for pressure that might otherwise have been turned on to the child. Emergency calls have varied

difficult to feed, and screamed constantly. The mother was a lonely proud woman who spoke no English. She was overwhelmed by the change in culture from Puerto Rico, from where she had emigrated several years ago, and she was particularly upset because she was not married to Maria's father.

A Parent

port her mother was able to allow Maria to be messy while eating and she even became successful in feeding her.

Solving the feeding problem was a major step in improving the mother-daughter relationship. When allowed on the floor at the center, Maria quickly began to move about and she reached normal developmental milestones in about two months. At the same time, her mother began to take Maria out of her crib more often at home.

Now 18 months old, Maria is a happy, alert baby who is walking and beginning to talk. Her mother is also much happier and relaxed with her child and after 11 months in our center, the Gomez family will soon be graduating. Ms. Gomez plans to go to work and have Maria cared for by a babysitter. The center will help her carry out her plans.

Very different problems are involved in our work with the Smith family, which was referred to us by the Juvenile Court.

Elaine Smith was three months old when she was admitted to a hospital

would sit and not move unless picked up by a staff member. She would become very anxious and unhappy when she was being dressed or undressed; she would not nap and rarely played with toys. Now, after 11 months in the program, she is gradually beginning to relax and is much more active. She plays easily but is quite violent towards other children, scratching and biting when she is approached.

Elaine has become attached to staff members and is eager to attend the center, but she continues to be very quiet when she is with her parents and usually appears quite fearful in their care.

Despite the Smiths' participation in the program, the staff has been unable to help them solve their primary problem, drug addiction. Through their involvement at the center both parents began to trust the staff enough to be honest about their drug usage and its effect upon their lives. With the help of the teaching staff, the Smiths finally admitted to the negative effects of their drug usage upon Elaine and they are beginning to struggle with the need to involve themselves in a drug treatment program. They have both stopped using drugs intermittently, but have not had suffered many unexplained injuries at home. The family was referred to the Juvenile Court which agreed not to remove the children as long as the family cooperated with the center.

The staff is really warm. I was afraid to come here, afraid they'd take my little girl away. But they want to know how you feel. They don't turn you off. They really want to help. People said they would-but I didn't believe them at first... The hot line here

independent and a person of value separate from her husband and children. Mr. Goodman has found supportive help for his frustrations and alternatives on how to handle his anger.

Both children enjoy the center program and are beginning to respond to staff attention. Billy is now speaking and Susan, although very wary, is now playing with other children. The hospital staff had reported at the time of referral that they had never seen the children smile during any of their contacts with them. After three months in the center, both children smile and laugh easily and with enthusiasm.

To augment the more formal aspects of the program, each family is assigned an individual worker who is responsible for coordinating the center services with those provided by other agencies. All workers provide an atmosphere of nurturing and support that gives the parents the emotional resources they need to better care for their children.

This type of service is extremely demanding on staff. Rarely is it formal therapy that brings about changes

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WORKING WITH ABUSIVE PARENTS

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A Social Worker's View

by Elizabeth Davoren

Working with the problem of abused and neglected children means being a witness to the effects of violence and--sometimes--death. It means being involved in "parents' rights," "children's rights" and a diversity of views on how to bring up children. These loaded subjects stir the feelings of everyone involved. Reactions range from disgust ("How can anyone hurt a helpless little child?") to identification ("I've often felt like hurting my own child--I don't know what kept me from doing it").

People who identify strongly with parents have found one way or another to ignore child abuse: "It's none of my business." "It really didn't happen." "The child deserved it." "I don't know what to do about it" or "What while, at the same time, encouraging recognition of the child abuse problem. When parent and child are treated as a unit in need of help, rather than as wrongdoer and victim, there can be positive results from the recognition and report of child abuse. If reporting child abuse results in treatment, it is no longer perceived as a terrible action taken against the parent.

The child is also safer in every way when he or she is not made the adversary of the parent. The reality of court trials or hearings is such that their outcome may not result in child protection when needed. A child may be returned to a home where he has been abused and where the situation remains essentially unchanged. This doesn't mean that law enforcement is an unnecessary or undesirable tool in

or how much care they were able to provide their parents in this turn-about process, it was never enough. *They were no good and they deserved to be hit.*

- They learned that their parents could not see what they were like, how they functioned, or what their needs were.
- They learned that having children was a way for *parents* to be taken care of and loved.
- They learned that children must be punished to achieve desired results.
- They learned that the day would come when they could release stored up hostility without fear of reprisal.

All they had to do was to survive, grow up, and have children.

This destructive childrearing method, passed on from generation to generation, produces adults who, first of all, have an understandable stake in having children. They want children to provide for them what they tried to provide for their parents. They believe their babies will love them and make them feel better. Since they do not see babies as helpless, taking care of them is not an anticipated problem. The babies will behave, because they know how to make them behave. This misunderstanding of what a child's capabilities are, combined with a willingness to punish as severely as necessary to meet extremely high expectations, often leads to serious physical injury of their children.

Reporting the Parents

If reported for child abuse, these parents—who normally avoid contact with other people—are suddenly brought in touch with a lot of people with whom they have an extremely difficult time in relating. Their incredibly poor opinion of themselves, and their distrust of all others, make it hard for these parents to like or to be liked. They are also frightened and deal with their fright by either acquiescence or threats.

Their acquiescence, based on childhood experiences of being forced to meet parental expectations, is backed by extraordinary sensitivity to the expectations of others. They can be so skillful at saying what they are expected to say that it is often difficult to know when words have been put

way toward reducing the parents' fright and, in turn, their anger. Questions like: "What did your child do that upset you?", "Is your youngster hard to handle?" and "Does your baby need too much attention?" can show parents that their feelings count. At the same time, questions like these help workers find clues to both parent-child interaction and the parents' need for help.

Another way of relieving tension around abuse reporting procedures is to make sure the parents have an accurate picture of what is going to happen to them. If there are specific people who can help them, such as a public defender, they should be told who is available. Offering practical and specific help in contacting family members, finding child care for other children in the family and obtaining transportation—or simply thinking through with parents how they can do these things—will help them be more open to treatment.

Treatment

The kind of help abusive parents have responded to involves relationships that are more intense and more personal than the usual professional therapeutic relationships. Some call it "reparenting" or nurturing. What it means in practice is fulfilling parents' needs in the following areas:

- Parents need help to feel good about themselves, to make up for the devastating belittling they've experienced in their own lives.
- Parents need to be comforted when they are hurt, supported when they feel weak and liked for their likeable qualities—even when these are hard to find.
- Parents need someone they can trust and lean on, and someone who will put up with their crankiness and complaining. They also need someone who will not be tricked into accepting their low sense of self-worth.
- Parents need someone who will not be exhausted with them when they find no pleasure in life and defeat all attempts to help them seek it.
- Parents need someone who will be there in times of crisis and who can help them with their practical needs, by leading them to resources that they can use or by giving more direct help.

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It also requires workers who can share themselves without sharing their problems and who can befriend while maintaining awareness of their helping role. Workers must also be able to think first about the parents' needs and not their own, and they should have a sense of self-worth and achievement that will sustain them through work that is demanding and brings few immediate rewards.

Even when workers feel strong within themselves, and have reasonably fulfilling lives of their own apart from their work, the nurturing of abusive parents can be quite exhausting. The parents' needs are extensive—at times like bottomless pits. Workers calling on their own emotional resources are constantly aware of themselves, their own upbringing and the way they are raising their own children, if they have any. This awareness can be wearing. But the most draining part of caring for these parents is knowing that a child may be seriously injured or neglected, or even die, if the worker misjudges the parents' capacity to care for the child.

Workers' unreal estimates of how much parents have been helped and how well they are doing have sometimes proved fatal for children. Moving abuse cases from one worker to another, or one agency to another, has resulted in losing track of the cases—and in fatalities, too.

Some communities are using interagency committees or multidisciplinary teams to keep track of abuse cases, and to provide workers with a support system in making decisions on diagnosis, treatment and final disposition. The composition of such a team depends upon who deals with child abuse problems in the community, but in general the fields of medicine, law enforcement, education and social service are represented. Involving consumers abusive parents who have had treatment adds an important dimension to the team.

The teams provide interdisciplinary education for their members and can serve to educate the community as well. But most of all the use of such teams means that the workers who handle child abuse cases, and the agencies they represent, are no longer making what can be life and death decisions without others to help and share responsibility.

Public health nurses, trained and given supervisory support, can be the primary workers in child abuse cases. A public health nurse can also function as the person responsible for keeping a very close watch over the children so that the family's worker can focus on concern for the parents. Health services are usually easy for the parents to accept.

A hotline, available 24 hours a day, 7 days a week, is a necessary adjunct of treatment.

Day care is one useful way of relieving the parent from too close contact with his or her child while at the same time providing more nurturing for the child. The day care staff can be strong allies of the parent's worker, if they have the time, capacity and know-how to help parents better understand their children. A staff that can also recognize the parents' capabilities is invaluable. Day care staff members, however, almost always identify so strongly with the children that being able to understand the parents' needs, and then to help meet them, is very difficult. Perhaps the most that can be expected of the staff is that it *not* compete with the parents for the child's loyalty, and that it *not* let the inevitable parent complaints about how staff members deal with the child threaten them.

Crisis nurseries can relieve parents by their immediate availability in times of unresolvable parent-child tension. They safeguard the child and allow parents distance and time to discover more about the source of their tension, be it the child or something else. A positive attitude of nursery staff members toward the parent helps, of course. Their concern is with the child, and asking them to do much for the parent in the temporary crisis situation is out of place. But alliances for abusive parents develop in unexpected ways, and with each exposure to a person who might want to help comes the possibility of the parents finding the kind of support that is right for them.

Emergency shelter care deals with parent-child crises without separating parent and child, since a shelter will have a full time staff to care for the child if necessary. Rarely available, emergency shelter care is ideal. It can allow the parent to separate from the child for part or all of the day, which

By sharing the know-how of child abuse treatment with staff members of various community services through seminars, training programs or written material, we can expand the growing list of facilities that can help the abused child and his or her parents.

Meeting the Parents

When the parent's first contact is with hospital trauma workers or protective service workers who are trained to understand abuse and neglect, intervention has a more useful beginning. Offering help to people who don't believe there is such a thing, or don't believe they need it, requires more than an average amount of skill. If the worker who does the reporting or takes the complaint to the parents is also to treat the parent, he or she will need even more skill and much more self-assurance.

Being able to stay with the parent throughout the reporting process, and going to court with them when that is necessary, can strengthen a relationship, provided this is done well and with sensitivity to the potential for parental acquiescence. Having one worker report and a different worker treat has the advantage of giving parental resentment a focus outside of the treatment relationship. But parents who are forced to see many people in the course of referral for child abuse, and to go through their story over and over again, are likely to be much harder to reach with an offer of help. To take an extreme situation—but one that actually happens—parents may be seen first by an emergency room physician, who has seen the injured child; then a medical social worker, who prepares them for the fact that the injury must be reported, by a policeman who responds to the report that has been made, and then by a juvenile police officer, a probation worker and a protective service intake worker—all before being assigned to the protective service worker who will continue seeing them. Even if all people interviewing the parents are understanding, it takes a lot more strength than most people have to go through all those explanations and interviews. Such "institutional abuse" of abusive parents is a

Workers need to find their own ways of relating to parents because genuine, honest, forthright behavior is the only kind that means anything to them. Such parents quickly spot pretense. When a parent feels threatened or angry or distrustful, or all three, the reaction may be hostile silence. A sincere worker may be genuinely ill at ease and find it hard to think of what to say. But it doesn't matter if the words seem silly or not right because wanting to do right is what comes across. The important point is that parents matter: they are a necessary part of the program and will determine what happens in treatment and its outcome.

Showing honest respect for the parents and their capabilities helps put parents at ease and parents need to feel at ease if they are to engage in a useful dialogue. Information given by parents early in the contact is often unreliable. For one thing, these parents have been wrongly perceived so often by their own parents that they are confused about themselves. They "misperceive" themselves, so to speak. Furthermore, when they don't trust their workers —and they usually don't—incorrect information may serve as a camouflage and a protection from feared punishment. Or they may simply be trying to say what they think they are supposed to say. When two workers are seeing the same parents they are often astonished by the different impression each gets of the parents—based on the completely different stories parents tell them. As parents feel more trusting, talk becomes more useful to both parent and worker and what is said is usually more realistic.

There is no orderly progression to treatment. Much needs to be worked on simultaneously. For instance, exploring what parents want for themselves and for their children can be done more successfully after parents feel more trust. However, exploring what parents want shows them that their opinions matter, which in turn helps them develop trust.

In the beginning abusive parents are less likely to know what they want to accomplish for themselves because they don't believe they are capable of doing anything. They usually wish passively, but without much hope, to have things done for them. They will say that they want their

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Detroit, Michigan and Columbus, Ohio do not provide the Department of Social Services with legal services for their social workers.

- The death rate of physical abuse among children is approximately three to four percent and the permanent injury rate approximately 25 to 30 percent unless treatment is initiated quickly.
- In 1972, 2,300 cases of child abuse were reported in New York City. Eight of these reports came from private physicians.

These facts present some very troubling issues and problems which need to be resolved. I would hope they gain the attention of physicians and others. I would now like to review some of the reasons for physicians' reluctance to become involved.

Eight Reasons for Minimal Involvement

Medical school training was insufficient. Most physicians in practice were given minimal training in the areas relating to child abuse and neglect. We, as physicians, were not told about the dynamics of abuse, nor were we given any information about long-term treatment programs. For the most part, these data have been developed over the last 10 years, and many medical schools, even today, are not teaching about family dynamics and the interaction between parent and child in "normal" situations, much less in abnormal ones. Consequently, we have a group of physicians currently in practice who have been insufficiently trained and who, unless they have kept pace with current thinking in this area, are not up-to-date. While a physician may know a good deal about physical injuries that a child can incur, and the treatment for these specific injuries, some of the subtleties of the problem of abuse and neglect may not be understood. This lack of content material is a critical gap in our knowledge base.

Physicians are not trained in interpersonal skills. Only a handful of present-day medical schools are taking the time to train their medical students in the area of interpersonal skills. Even fewer schools were doing this some years ago. All doctors can think of experiences that illustrate this gap in training. When I asked a nurse, "Can you give me an example of how physicians have trouble with interpersonal skills?" she said:

"I overheard a mother talking to the neurosurgeon about her child who had fallen and suffered a head injury. The neurosurgeon said to the mother, 'If there are any changes in the child, I want you to call me.' The mother replied, 'What kind of changes should I look for?' His immediately reply was, 'Don't worry; if they happen, you'll know it.'"

In response to the same question, another nurse said: "My 17-year-old boy had a car accident not long ago and

The Child Abusive and Neglecting Pattern*

In order for a child to be physically injured or neglected by his parents or guardian, several pieces of a complex puzzle must come together in a very special way. To date, we can identify at least three major criteria.

First, a parent (or parents) must have the potential to abuse. *This potential is acquired over the years and is made up of at least five factors:*

- *The way the parents themselves were reared, i.e., did they receive a negative "mothering imprint?"*
- *Have they become very isolated individuals who cannot trust or use others?*

in the expected manner; or possibly one who really is different (retarded, too smart, hyperactive, or has a birth defect). Most families in which there are several children can readily point out which child would have "gotten it" if the parents had the potential. Often a perfectly normal child is "seen" as bad, willful, stubborn, demanding, spoiled or slow.

Finally, there must be some form of crisis, or a series of crises, that sets the abusive act into motion. These can be minor or major crises—a washing machine breaking down, a job lost, a husband leaving,

was in a cast for three months. The cast came off and he limped badly. I took him to the orthopedist and said, 'I'm worried about his limp.' The orthopedist's comment was, 'You may be worried, but I'm not.' " The mother did not know whether the orthopedist was not worried because he was not the one who was limping or because he thought the boy would get better.

Another example occurred at the University of Colorado when a student was being videotaped during an interview with a mother regarding her school-aged child. The student asked, "Everything is going along all right at school, isn't it?" The mother said, "No." And the student immediately replied, "Tell me about his cough."

Limited training in the area of interpersonal skills makes physicians most uncomfortable in dealing with difficult situations, as when they are confronted with children whose parents may have been abusive or neglectful. Many of these parents are not easy to like and talking with them may well be very difficult. Most of the parents find it hard to look directly at the doctor or to show their appreciation for any interest he expresses in them. They often use phrases and language that may well be misunderstood. It is not easy to communicate with these parents even with the best of skills and the utmost training. Having minimal training in this area puts most physicians at an extreme disadvantage.

Doctors have great difficulty working with members of other disciplines as peers. Let me review why this seems to be the case. Most physicians decided to go to medical school about a year or two after entering college. We then embarked on a 3-year pre-medical program and, after getting into medical school, continued a 4-year training period. After graduating and receiving our M.D. degree, we had a 3-year residency. We, therefore, had approximately 10 years of very isolated life, having minimal communications with people outside of the medical field. Suddenly we find ourselves in a world that calls us "Doctor" and puts us on some kind of a pedestal. This makes it difficult because we have never been trained to deal with other professionals as peers, and so we withdraw behind our "Doctor" shield and maintain our isolation by becoming very busy.

The field of child abuse and neglect demands that doctors deal with nurses, social workers, court people, police, lawyers and others as *peers*. We, as physicians, are very uncomfortable in a setting that puts us in this position. This should be understood as not being a conscious behavior. Physicians who are busy in practice do not have the time to drop everything and run off to spend eight to 10 hours with a family during an acute crisis centering around the problem of child abuse and neglect. It is next to impossible to have 30 to 40 patients waiting to be seen in the office and be asked to stop all office activity and spend four to five hours with a child—who has been admitted to the hospital with an acute problem—and his family. We find it difficult enough to spend this time when we have had training in the area which has precipitated the crisis. Asking a physician, for example, to go to the hospital to care for a child with acute meningitis is a little bit more realistic because our training has given us the background and experience needed to handle this difficult problem. But asking us to go to the hospital, or some other place, to do something for which we have had little training and experience is unrealistic.

Being unable to care for the office patients is only one of the many difficulties that arise. Getting sufficient money to "pay the rent" for a case of child abuse or neglect is equally difficult since third party payment systems do not give us the kind of remuneration that is necessary for the amount of time spent. For example, for seeing a child in a child abuse case, Medicaid, Blue Shield or some other source is charged approximately $40 to $50 for the consultation. But after I spend approximately 30 minutes with the child, I then spend four to five hours over the next two to three days with the parents. In some difficult cases, I have spent as many as 40 hours dealing with a serious problem. It is most difficult to get reimbursed for this amount of time expenditure. The busy practitioner not only fails to *make* money, he is also unable to "break even" because of the high overhead of his office which usually remains open while he is spending time in the hospital with the family in crisis.

The drain on emotions is equally as serious. The problem of child abuse and neglect is life-threatening; both death and permanent injury are seen all too often. If correct decisions are not made and a full assessment of the environmental situation in which the child is living is not forthcoming, the physician will not be in a position to feel comfortable about the decisions made in regard to long-term care. This creates an emotional burden that is most uncomfortable.

Physicians have a fear of testifying in court, part of which is justified. Most of us have never been trained to assume this role. The only times we think about court

We, like the parents we are trying to help, have been trained in a very isolated system.

Court too because we do not understand the workings of these courts and are not prepared to wrestle with the questions of an astute attorney who may "wish to rake us over the coals." I believe requesting such testifying is analogous to asking a physician to do his own cardiac catheterization without ever training him in this skill. We would never think of asking one to do this, and yet we do ask an inexperienced physician who has never been in court to testify.

For example, a lawyer once asked me, "Did you examine the child completely?" Now think for a moment about that question. A "yes" answer would set me up for a barrage of picayune questions, one of which would surely be deadly. On the other hand, an answer of "no" would make me appear rather ridiculous. If one has experience in testifying in court, the stance that must be taken is to pause, look nervous, act flustered and then with great confidence say, "My examination was sufficiently complete to permit me to make my decision." Then the lawyer will pause, look nervous and act flustered.

There is minimal personal reward and these rewards are hard to identify. Abusive families are isolated, distrustful, frightened people. They don't know how to give feedback to those who work with them. They don't expect people to help them. These parents find it hard to show up on time, to pay bills, to smile or to say "Thank you." And, of course, if things go wrong, you know they may beat their child again.

One of our parent-aides put it very clearly when she said, "You know, this mother doesn't do anything for me. She doesn't smile, she doesn't call me, she doesn't say thank you. She doesn't do *anything*." And a nurse in Chicago once told me, "I would be happy if at least this mother would get out of bed when I come to see her." My comment was, "Be happy she's at home."

The main things we look for in handling difficult cases are rewards and feedback. Parents who are abusive have never learned how to respond to help offered, much less to do something as a positive reward for someone. These families are very difficult, even when one is able to identify the minimal rewards that do come eventually, such as showing up *almost* on time, seeing a faint smile, phoning with a question.

anxious to make waves which may disrupt our lifestyle. There are some noted exceptions, some very capable doctors who are agents for change. For the most part, however, physicians are not about to try to bring about changes in the community. Physicians may feel threatened by the requirement that they report suspected abuse or neglect, particularly if their livelihood depends on a positive image and referrals. But the law requires that a report be made, and a few doctors have lost legal suits for *not* complying.

All this is somewhat analogous to telling doctors, "There is a state law that requires you to go off and listen to a large number of children to see if they have heart conditions." We say, "Well, that's not so bad." Most of us have been trained to listen to hearts and to determine if major heart disease exists. You then tell him, "Also, the state law requires you to report your findings, and if you think there is need for an x-ray study, you have to do it; a cardiac catheterization, you have to do that; surgery, you have to do that also." The doctor will say, "That's ridiculous!" and he won't comply. We have placed physicians in an almost impossible situation and consequently they are most reluctant to become involved, much less act as an agent for change to rectify many of the problems.

What Can Be Done

I have three recommendations to help alleviate this difficult dilemma.

- *All physicians must be trained* in the area of child abuse and neglect. Every residency, whether it be in pediatrics, family medicine, obstetrics, internal medicine, neurology or surgery, as well as every undergraduate educational program (i.e., medical schools), needs to include learning experiences in child abuse and neglect during this critical period of formal education.
- In addition to this general education, *we must train specialists in pediatrics* in the area of child abuse and neglect. These specialists would acquire the extensive knowledge and skills necessary to work with these difficult families.
- *These pediatric consultants must be subsidized* and affiliated with a community and/or hospital-based, multidisciplinary child protection team.

My feeling is that general training in medical schools

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parents and teachers. Extensive training in interpersonal skills is critical for these specialists. The typical pediatric training program does not provide this type of training, and yet without such an in-depth knowledge and skills specialists in child abuse and neglect will be severely limited. Training programs in this field must include course work in early child development, the acquiring of interpersonal skills and counseling methods, extensive experience with the effects that trauma and neglect have upon the *growing* child and, finally, methods of implementing change within his or her community.

This pediatric specialist in child abuse and neglect would have to be subsidized. As with most other specialties of pediatrics, the time needed to spend with a given family, to care for a child, to do specialized diagnostic procedures, to counsel the parents and to participate in conferences and case discussions with other professionals prevents the fee-for-service system from supporting this endeavor. There are few pediatric specialists who can provide comprehensive services to children and their families, regardless of whether they are in neurology, nephrology, cardiology or the like without some form of subsidy. The child abuse and neglect specialty is no different.

The Physician as an Agent for Change*

The cause of a very serious, life threatening disease is known and treatment programs which can be effective for some 70 75 percent of these families are available.

And Yet,

Our "Delivery of Services" system is not implementing what can be done.

Physicians have the capability of influencing this system and making it move from single disciplines working in isolation to a trusting multidisciplinary community program.

And Yet,

Around the country the cry is, "Physicians just won't get involved!"

All physicians who work with any family member need to know the basic causes and present therapeutic concepts involved in child abuse and neglect.

And Yet,

It only takes one physician in a community to exhibit concern and commit himself or herself to seeing that change does occur.

are available when they need it. This is very much like any other serious problem confronting the physician in his practice.

The child protection team of which our pediatric specialist is a member would include a community protective service worker, public health nurse, pediatric specialist, psychologist, hospital social worker, lawyer and, occasionally, a law enforcement person. This concept is discussed in some detail in a new OCD manual. *

What Can Be Done Now

"All this is well and good," said a social worker from a local community with whom I discussed these proposals, "but we need doctors now." I agreed that waiting for curriculum revision in medical schools and residency training programs cannot solve a community's problems. Instead I suggested, "Stop looking for *doctors* to solve your problem and seek out one *doctor* or maybe two in your community." Once a single physician (usually a pediatrician or family practitioner) is identified as having even a slight interest in this area, you are beginning to make progress. You may then proceed as follows:

1) Arrange for this doctor to see a patient or two in consultation.

2) Ask him or her to attend a conference about the family. This conference should be well organized and no more than an hour in length.

3) Subtly increase the physician's involvement until you have him or her "hooked."

At this point a priority problem will develop. If the doctor is in practice, his private office patients will begin to be neglected and a serious financial problem will occur. If he or she is salaried, then the boss will begin to complain about time commitments. Communities have faced these issues in a variety of ways, but some funds (relatively a small amount at the outset) will be necessary as a token of their appreciation. Pooling the limited financial resources of several groups and agencies will help.

Eventually, one or two pediatric specialists in child abuse must be an integral part of *every* Protective Services program in the country.

In summary, by providing early child development specialists in pediatrics and/or family medicine to deal directly with the problem of child abuse and neglect—and by providing these specialists with a salary—we will have available the kind of consultants who can make the specialty of child abuse and neglect a legitimate enterprise.

There are very good reasons why physicians are reluctant to become involved in the problem of child abuse and/or neglect. These reasons are real and well embedded in our system. And this situation must be changed. Modi-

understanding and helping child-abusing parents

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Owen L. Caskey
Ivanna Richardson

The problem of child abuse has been described by Kempe (1969) as a disease of epidemic proportions in the United States. This problem can be divided into three broad and complex areas that span legal, medical, and social fields: casefinding, immediate treatment and protection of the child, and treatment of the abusing adult to improve the home situation to enable a child to return to it and grow safely within it. This article will discuss factors relevant to the last point.

The definition of child abuse varies in state laws pertaining to it. Some states include starvation, malnutrition, sexual abuse, and failure to thrive in the definition; other states use broad language such as "serious physical injury" or "injuries inflicted upon him other than by accidental means." The Colorado law, for example, states specifically that:

> Abuse means any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive, or death, and such condition or death is not justifiably explained, or where the history given concerning such condition or death may not be the product of an accidental occurrence. (De Francis 1970, p. 113)

Arizona, on the other hand, recently broadened "abuse" to mean

> . . . the infliction of physical or mental injury or the causing of deterioration of a child and shall include failing to maintain reasonable care and treat-

The recently enacted 1974 Texas Family Code was intended to represent a broadened redefinition of abuse, with the mandate to report violation of compulsory school attendance laws on three or more occasions.

In a symposium on the problem of child abuse conducted by the American Academy of Pediatrics in 1962, Kempe directed attention to the seriousness of the problem by proposing the term "the battered child syndrome." In a period of six years, the term received national attention and, along with publication of national surveys of child abuse, generated such great interest in the problem that reporting laws in all 50 states were passed with regard to child abuse. Since that time, Kempe is of the opinion that the term "battered child" has achieved its purpose and that the term describes only a narrow part of the syndrome and tends to be prejudicial. For this reason, he now believes that the terms "nonaccidental injury," "abuse," or "failure to give reasonable care and protection" are preferable to the earlier terms (Kempe & Helfer 1972). For whatever reason, it appears the "abused child" has been the term most frequently found in the professional and popular literature since the early 1970s.

Extent of Child Abuse

Despite attempts to identify child abuse cases, there are no accurate national statistics on the incidence of child abuse. The authority most often cited is Gil's (1970) compilation of the number of physically abused children during 1967 and 1968; yet he cautions extrapolation of his findings beyond the tabulation of reported abuses and deaths, which numbered 5,993 and 6,617 for the reporting years. Other writers, even in professional journals, make general estimates without citation or cite newspaper articles as sources of the extent of child abuse. These estimates range from 10,000 to 500,000 cases of child abuse annually. The 10,000 cases reported in 1969 by the American Humane Society probably represents the most conservative estimate, the 50,000 annual incidence estimate of the U.S. Children's Bureau a modest appraisal, and perhaps 200,000 children annually in need of protective services

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the extent of the problem. Add to this the definitional difficulty (what constitutes "abuse"?) and the natural reluctance to report suspected cases, and the logical extension of reported cases of child abuse by severalfold becomes a most reasonable estimate.

Child Abuse Legislation

After decades of concern for punishing those who would abuse a child, but little in the way of preventive legislation, national interest was focused on the need for reporting laws, first by the 1962 study of the Children's Division of the American Humane Association tabulating severe abuse incidents, and later by the extensive studies of the quality and quantity of the abuse of children in the United States conducted from 1965 through 1968 by the Children's Bureau of the Department of Health, Education and Welfare. During the four-year period from 1963, when the first law was passed, until 1967, state legislatures in all 50 states passed child abuse reporting statutes. Initially, these statutes were directed toward encouraging reports from the medical profession, but later statutes and amendments established a trend toward broadening the base for reporting and identifying child abuse cases for appropriate response, both punitive and protective.

Mandatory rather than permissive reporting is generally required, with only two state statutes (North Carolina and Washington) avoiding mandatory statements by 1974 and with at least 25 providing criminal penalties for failure to report. Although there is some doubt that these provisions are rigorously enforced, they are intended more to give the prospective reporter added motivation. Those required to report suspected child abuse most frequently include those in the medical profession (47 states). Following, in order, are social workers (22 states), teachers (16 states), school authorities (13 states), and an all inclusive "any person" category (3 states). There is some overlap in the teacher-school authority reporting groups, but some states do separate the categories. California, for example, requires school administrators but not teachers

act upon child abuse reports and the creation of a central registry to aid in the identification of reported abuses. By 1970, 45 states maintained a register by either legislative mandate or administrative order. All states except Colorado grant immunity to persons required by law to report, although some states limit such immunity to situations involving civil liability. Finally, 39 states have provisions releasing reporters from privileged communication restrictions which may be imposed by professional codes of ethics, or, in some cases, by conflicting practitioner-client and husband-wife privilege statutes.

Abusive Parents

Characteristics

Violent behavior by a parent toward a child was once regarded as the result of hardships produced by immigration, war, poverty, ignorance, or industrialization. It has since been pointed out that such behavior is not exclusive to any particular class or cause. A sociological explanation by itself is inadequate, and child abuse is not directly related to race, color, creed, sex, income, or education (Wasserman 1967). Kempe (1969) believes that child abusing behavior may be intensified by poverty, overcrowding, or unemployment or modified by the number of doors that can be closed in the home between the injured child and the parent, but that its deeper cause is psychodynamically determined. It would appear that, regardless of social class, abusive parents have certain psychological and social characteristics in common, but may, in fact, be loving of their children.

The purpose of this review is to direct attention to this group. It has been estimated that 90 percent of abused children can remain with their parents, occasionally with a brief period of separation during an acute episode, provided adequate treatment is planned and implemented for them. In the remaining 10 percent of the cases, permanent separation will need to be requested following psychiatric examinations (Kempe 1969).

In looking at some of the characteristics of the large majority of

hurt feelings that they cannot really sympathize with the feelings of others. Being greatly in need of receiving, they themselves cannot give. Reiner and Kaufman (1969) say this kind of person is unaware that he has a buried feeling of "embedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act the individual interpreted as rejection of himself. Failing to understand the distressing rejection and not being strong enough to bear it, the person has buried the feeling of rejection and accompanying depression. Explosive, violent behavior becomes a method of numbing the deep hurt or sense of worthlessness. The pattern of aggression and violence is learned, causing the person to inflict on others that which was inflicted on him. Glass (1970) offers support for this belief in his observation that battering parents are adults who were not loved as children and may have been abused themselves, either physically or emotionally, by their own parents.

Steele and Pollock (1968) searched for a consistent behavior pattern which might exist in combination with (but quite independently of) other psychological disorders in parents who abuse children. Abusive parents expected and demanded a great deal from their children. Their demand for performance was frequently beyond the ability of the child to perform or even to comprehend what was expected of him. It was concluded that the parent feels insecure and unsure of being loved and is actually looking to the child as a source of reassurance, comfort, and loving response. It is a case of the parent acting like a frightened, unloved child and looking to his own child as if the child were an adult capable of providing needed comfort and love. Abusive parents seem to believe that children's needs are unimportant and should be disregarded. To the child abuser, children exist primarily to satisfy parental needs and those who do not fulfill these requirements deserve punishment.

In the background and life histories of the parents in the Steele and Pollock study (1968), the researchers found that all had experienced intense parental demands for submissive behavior and prompt obedience accompanied by constant parental criticism. In-

(1956) observed that motherliness is not a prerogative of women alone; it is a human characteristic and is seen as the ability to show tenderness, gentleness, and empathy and to value a love object more than the self. With adequate "mothering," the human being develops a sense of confidence. Abusing adults did not have this confidence-producing experience. They may have a maternal "image" intact and may continue to return to their parents seeking from them some evidence of love, but they usually find the more familiar criticism. Abusing parents feel that it is unrewarding to look to family, friends, or others for need-satisfying relationships. The abusing families tend to lead a life which is alienated, asocial, or isolated. The pattern of lack of confidence engendered early in their childhood with their parents persists. The relationships they describe are meager, superficial, or authority based (Steele & Pollock 1968).

In child abuse incidents, not only a seriously disturbed person is involved but also a disturbed family. Lack of confidence plagues the marriage of the abusing adult. Despite the presence of admirable qualities and abilities, the spouse of the abusing adult is often dependent, unable to express needs clearly, and, at the same time, demanding, critical, and unheeding. Like many neurotic people, abusing adults have usually become involved with someone much like themselves or their parents. Solomon (1973) summarizes the parents, as reported by state central registries, as married, living together, and in their late 20s or early 30s. Helfer (1970) believes that a long unmet need for love motivates the abusing adult to turn to the child in hope of having these needs met. The parent becomes the one in need of receiving mothering. Helfer states that mothering, the ability to accept help from others, and the ability to provide help to others are all learned functions, and, since abusing adults received little emotional support from their parents, they have not learned to establish mature emotional relationships. As a result of the inability to establish mature emotional relationships, they literally do not know how to give to or accept from others. Further, they have usually sought marriage in a desperate attempt to fulfill some of their needs, but have often found spouses who are unable to supply the help and support they need. If a baby is

research which explains child abuse as a function of psychological pathology and instead suggests a multidimensional approach focusing on the sociological and contextual variables associated with abusive parents. Light (1973) holds out little hope that studies will produce a social profile of abusing and nonabusing families which will discriminate adequately between the two groups for purposes of early detection and prevention. Further, he concludes that child development education programs have not been shown to affect problems of child abuse. His recommendations include the need for more family planning education and more careful investigation of reporting systems from which better treatment programs can be devised.

Relating Treatment to Needs

Helfer (1970) maintains that the treatment goal should be to meet the needs of the abusing adult in order to lower the adult's expectations of the child. Kempe (1969) states that the therapeutic goal should be to enable the abusing adult to let go of the child as a source of satisfactions and transfer his needs to someone else. The therapy described by Steele and Pollock (1968) with their study group is a type of reality-based treatment, the goal of which was to provide whatever treatment was necessary in order to make the home safe for the child. In his early papers on child abuse, Kempe (1969) recommended treatment which he called "relationship therapy." In practice this became so demanding on the professional staff that lay workers were introduced into the program at the Colorado General Hospital to meet the increasing caseload. Kempe and Helfer (1972) recommend training of lay workers and use the term "mothering therapy" to describe treatment for the abusing adult. Experiences with introducing a "mothering person" into the situation indicate strongly that this person, whether a professional or a paraprofessional, must be available to the abusing family most of the time and for very long periods. Clearman (1970) and Davoren (1968) see the process as establishing trust and dis-

Working with Abusive Parents

Based on the evidence of the characteristics of child-abusing adults, the following needs should be considered with regard to selecting treatment resources: need for improved social and personal relationships, need for limits and reality learning, and need for both parents to be involved in treatment. A change only in the child-abusing adult may add additional stress to an already stressful home situation, and it is possible that it may lead to abusive behavior in the other parent. Elementary school counselors, school social workers, and school psychologists can aid many abusive parents by including them in ongoing or special groups while at the same time providing counseling and other services for the abused child.

Group Processes

There is some indication that group methods of treatment are desirable, perhaps even preferable, in the treatment of many abusive parents, who may find individual counseling too threatening and anxiety provoking. Such parents have been described as typically unskilled; they tend to deny their difficulties, have problems controlling impulses, and experience difficulties with authority. All of these problems have responded to appropriate application of group techniques. Group work with abusive parents uses group processes to make constructive psychological changes, such as the reduction of anxiety or an increase in self-confidence in individuals in a group setting. The goal in such groups is to effect personal growth and social adjustment and is parallel to the goal for abusive adults seen in individual counseling. The values and objectives of group activities, which help parents gain a fuller realization and acceptance of themselves, look more carefully at their feelings and activities as they interact with others, and learn to alter behavior and attitudes in order to be accepted by the group, seem well-suited to working with abusive parents. Group counseling also has the

Reiner and Kaufman (1969) hold that a group experience has special meaning to persons with character disorders, since, as a result of their fear of close relationships, they experience great loneliness. Since persons become psychologically ill and unhappy in social groups, the premise that they can re-establish their emotional equilibrium in productive human relationships through social interaction is a logical approach and may well be essential for personality change and growth. Such an experience may occur in a group situation where conditions are favorable for gaining new glimpses of one's relationships with others. Reiner and Kaufman report working with several character-disordered mothers who met once a month in a group setting. They observed that the mothers showed a noticeable growth in the handling of their children, and the gains seemed to carry over to other situations.

So-called nontherapeutic groups, such as problem-solving groups, may have therapeutic consequences. Zalba (1966) reports that the Jefferson County Welfare Department in Louisville, Kentucky formed a heterogeneous group of parents of abused and neglected children. The meetings were to supplement and reinforce efforts to help these parents meet others with similar problems, to have a social experience, and to learn about discipline, normal child growth, parent-child relationships, and husband-wife relationships. In the process, group spirit developed, personal problems were discussed, and participants developed in personal and social ways. Most significantly, there was attitudinal change with regard to children as well as improvement in family and marital relationships.

School-Centered Approaches

The bulk of the literature on helping abusive parents centers on the 10 percent who severely injure their children and need highly specific and long-term treatment, just as the professional reports (particularly those in law and medicine) of abused children cite those who are marked by serious physical and emotional scars which will remain for years, even with the best of care. If the conclusion that the greater majority of abusing parents are amenable

In a most general way, this would at least include acquiring knowledge about the problem of abused children and abusive parents, with specific information which is relevant for the legal, ethical, and professional responsibility as it relates to the locale in which they work. Welfare agencies, medical associations, and bar associations at both local and state levels can provide inservice programs to acquaint school special service workers, as well as instructional and administrative personnel, with current directives, responsibilities, reporting channels, and treatment programs.

A second step would be to inaugurate programs which would attempt to involve parents who were suspected of abusive actions in programs which might be of help to them and aid both their children and the family situation. Special encouragement is necessary to involve such parents in child study groups, parent education, or adult education programs, but any activity which can help improve personal-social relationships and understanding would be directly related to areas which have been identified as crucial for abusing parents. When identification of parents with abusive tendencies produces sufficient numbers, special groups or programs for parents or family groups could be attempted following the guidelines used for working with any parent groups, regardless of the problem area. If the typical pattern of loneliness, isolation, and unmet needs exists, getting parents to participate in these activities may not prove to be the problem it appears to be on first contemplating how these parents can be brought together for help.

A third step would be to devise programs designed to serve in identification or treatment of abusive parents or their children in a more direct way. The Adams County (Colorado) project is an example of a county-wide effort using the school as the focal point (Nordstrom 1974). Every school employee is charged with the legal responsibility to report suspected child abuse incidents or see that a report is made. Reports are processed by a task force including a psychologist, a counselor, a social worker, a nurse, and an administrator. During 1972–73, 24 cases were processed by the team, reported to the Welfare Department, and included in a central registry. It is pointed out that the important factor here is the willingness of a school system to reevaluate its responsibility concern-

a very powerful treatment mode in working with abused children. The groups provide an opportunity for the child to behave, interact, receive feedback, and observe more acceptable interaction models. Placing one or two abused children in groups with others can effectively facilitate the re-learning process.

The older adolescent, however, poses a slightly different problem. These clients can usually take full advantage of the opportunity to explore their feelings and emotions concerning earlier abuse. In a small group of previously abused adolescents the counselor must be prepared to help them deal with intense feelings of rejection and loneliness based on the assumption that their parents do not love them. In the majority of cases, this was probably a false assumption. Many child beaters value their children but simply do not know how to interact: nor do they have realistic expectations of young children. The counselor should attempt to explore positive home experiences and carefully avoid rejection of the parent. The goal of counseling is to help the abused deal with the rehabilitation of the family as a unit.

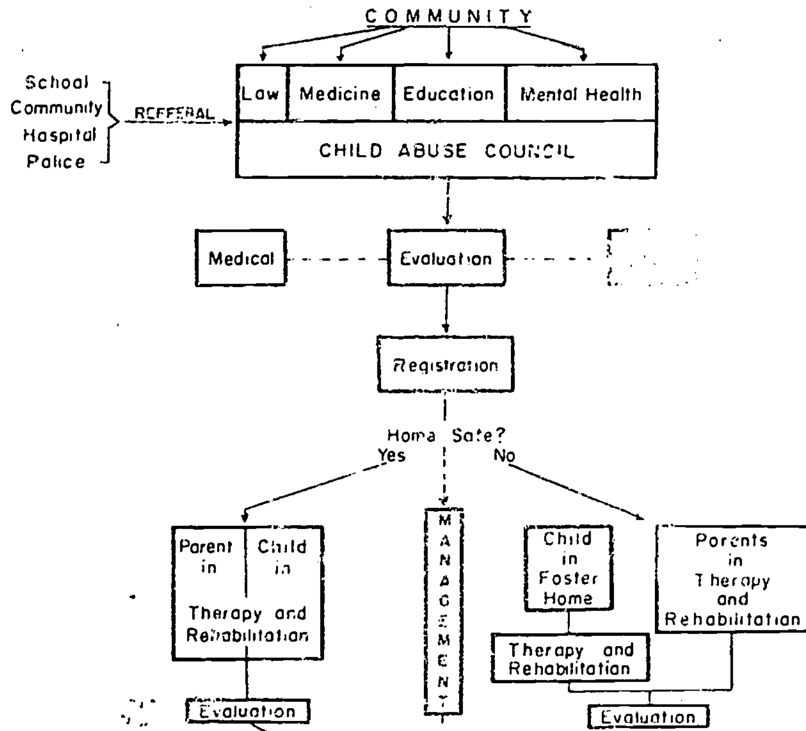
THE COUNSELOR AND THE COMMUNITY

The uniqueness of the child abuse problem necessitates a community-based approach. Since school counselors are often on the front lines of case identification and therapy, it is incumbent upon them also to participate in the community response.

The local child abuse council has been a successful model used by many communities. Ideally, it includes a multidisciplinary representation of the professions of medicine, law, education, and mental health. The council's role generally involves case identification and reporting, management, and the coordination of its resources to help child and family. Often a council will go beyond the administrative function and establish ongoing therapy programs, foster homes, and educational

Figure 1

Child Abuse Council Concept



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RECOMMENDATIONS

Counselors do not see a child abuse case everyday. When such cases do appear, however, the response must be professional, quick, and effective. Counselors should prepare an outline of procedures to be followed when an abuse case is identified or suspected. Telephone numbers of referral sources, legally required reporting procedures, and medical resources should all be quickly available and current. The child abuse case demands a community response in which the school counselor plays an important role.

Counselors should engage in self-education and then provide information to the entire school staff concerning the child abuse syndrome. New and successful treatment programs should be evaluated and explored. Helfer and Kempe (1968, 1972) and the American Humane Association (P.O. Box 1266, Denver, Colorado 80201) are excellent resources.

Medical manifestations and legal considerations should be reviewed since all 50 states now have child abuse reporting laws. In most states reporting is abuse council. If one does not exist, the school, specifically the pupil personnel office, should see that an appropriate community response is formulated.

Finally, an active, preventive mental health model should be pursued. It is important for counselors to become active in the education process to include curriculum revision and course development. Many future child abuse problems may be avoided through training and education. Specifically, children should learn useful child-rearing techniques and mechanisms to use when dealing with small children. The role of the family and family planning should also be studied. Additionally, children must learn how to deal with frustration and identify coping and adjustment mechanisms that will be useful in later life. Parent training clinics could be considered for adolescents and parents who are inadequate in child rearing. Behavior modification training programs such as Parent Effectiveness Training provide useful models to follow. Counselors may be central in providing training or initiating such programs

The battered child syndrome is a

Preventing Child Abuse

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It has been said that a society "succeeds or fails in direct proportion to the way it enhances or impedes the development of its children" (Noshpitz, 1974, p. 96). As is evidenced by the 1974 enactment of the federal Child Abuse Prevention and Treatment Act (Pub. L. No. 93-247) and similar legislation in various states, our society is currently attending to the problem of child abuse. This attention offers us an opportunity to look closely at the way we enhance or impede the development of our children.

When a problem like child abuse captures the attention of a society, the manner in which the society analyzes the problem reveals a great deal about its overall commitment to the development of children. Society's analytic approach defines the problem. By identifying those actions and attitudes directed toward children that the society considers to be abusive, the society reflects its values about children. From these definitions and values emerge the types of legal and social interventions that the society is willing to take in order to eradicate the problem of child abuse.

the successful reinforcement of these programs is discussed as a step in the direction of raising public consciousness about all forms of individual as well as institutional and collective abuse.

Values and Analytic Approaches

The comprehensive approach attempts to make its values about children as explicit as possible and defines child abuse in a broad sense (Gil, 1973). This approach stresses that children have rights comparable to other members of our society. It states that,

> Every child, despite his individual differences and uniqueness, is to be considered of equal intrinsic worth and hence should be entitled to equal social, economic, civil and political rights, so that he may fully realize his inherent potential and share equally in life, liberty and the pursuit of happiness. (Gil, 1973, p. 7)

In addition, the comprehensive approach takes a strong position of value by asserting that children also have rights to the fulfillment of their developmental needs. It asserts that it is a child's

cially segregated and economically impoverished neighborhoods in the United States (Birch & Gussow, 1970; Chess & Thomas, 1970; Deutsch, Katz, & Jensen, 1968; Hunt, 1969; Hurley, 1969; Jones, 1972). Seven million children in the United States are being raised in the abusive child-rearing conditions of poverty (U.S. Bureau of the Census, 1972). Collective abuse also includes those adult supremacy attitudes about the status of children that contribute to the denial of certain legal rights to 67 million children and youths under the age of 18 (Paulsen, 1974). These adult supremacy attitudes also contribute to the toleration and widespread use of physical force as a means of disciplining and controlling children (Gil, 1970). When directed toward adults, these means are illegal and considered personally demeaning.

Institutional abuse refers to abusive and damaging acts perpetrated against children by such institutio[illegible] chools, Head Start agencies, juvenile courts and detention centers, child welfare homes and agencies, correctional facilities, and other institutions with responsibilities for children. Some specif[illegible] mples include policies and practices that prom[illegible] use of physical force with children (Ba[illegible] 973) and policies and practices that promote cycles of psychologically damaging separations for those children who are fated not to be born into even nominally stable family environments (Goldstein, Freud, & Solnit, 1973; Yarrow, 1964).

Individual abuse refers to the physical and emotional abuse and neglect of children that results

The indictments of this comprehensive approach are extremely difficult for our society to deal with because we generally consider ourselves to be a child-centered society (Rodham, 1973). It is probably this type of psychologically threatening challenge to a fundamental myth about our society that contributes to our being more favorably disposed toward a narrower approach to the problem of child abuse.

The narrow approach does not attempt to make explicit its values about children. This approach defines child abuse in a restricted sense because it does not include collective or institutional abuse in its definition. It limits its definition only to individual abuse on the part of parents and other individual caretakers (Helfer & Kempe, 1968/1974; Leavitt, 1974).

It is the narrow approach to the problem of child abuse that is reflected in the federal Child Abuse Prevention and Treatment Act, in most state child abuse acts, and in the child-abuse-reporting statutes (Light, 1973; Paulsen, 1967). This is so because the statutes, federal act, and most state acts fail to explicitly enunciate values concerning children and fail to explicitly recognize the existence of collective and institutional abuse.

Prevention of Child Abuse

With regard to preventing child abuse, the comprehensive and the narrow approaches raise markedly different issues.

From the perspective of the *comprehensive ap-*

form of individual abuse, *physical abuse,* because it is this form that has received the most attention to date.

In focusing on the prevention [illegible] individual physical abuse, I am relying on the [illegible]ntative concepts from the public health fie[illegible] [illegible] this context, primary prevention refers [illegible] prevention of physical abuse before it [illegible] It refers to a before-the-fact or preincidence intervention. It is designed to forestall the physical abusing of children, or, conversely, it seeks to promote the caring of children. Primary preventative interventions are directed toward parents and other individual caretakers and toward the environmental conditions in which child caring takes place.

Secondary prevention is an after-the-fact or post-incidence intervention. Its aim is to shorten the duration, impact, and negative aftereffects of physical abuse by placing heavy emphasis on early identification and prompt treatment of abuse. Secondary preventative interventions are directed toward the abused child, the abusing caretaker, and the environmental conditions in which the abuse took place.

Primary prevention programs and services will have to compete with secondary prevention programs and services for the available federal and local child abuse monies. This will be powerful competition because of the pressing immediate need for secondary prevention services. Each individual case of physical child abuse requires a wide range of prompt treatment, rehabilitation, legal, educational and/or social services. The abused child

abuse money will go toward the creation of primary prevention programs and services.

If this is so, we will probably have to look at already existing programs and services and support those elements of the existing programs and services that have primary abuse prevention potential. We will have to have some ideas about which programmatic elements have primary abuse prevention potential. Some ideas in this regard might be gleaned from the current formulations about the factors that cause or contribute to the cause of individual physical abuse. These causal formulations are based mainly on clinical observations and/or on currently sparse research data.

Causal Formulations

Most current formulations about the causes of physical abuse differ in terms of the emphasis placed on psychodynamic as contrasted to sociocultural factors. This differential emphasis seems to be as much a product of the disciplines of the formulators as it is a product of the wide variety of factors that appear to be of causal importance in different cases of physical abu[illegible]

Formulators from disciplines that have traditionally focused on internal factors as the major cause of deviant behavior (medical/psychiatric and clinical psychology disciplines) have emphasized personality defects in the caretakers (Adelson, 1961; Allen, Ten Bensel, & Raile, 1969; Elmer, 1967; Fontana, 1972; Helfer & Pollack, 1967;

and unrealistic source of love and reassur... al... at personal adequacy. Thus, a crying infant or dis... ...ent child is apt to be seen as rejecting, evoking anger and punishment from the parent. (Kent, Note 1)

On the basis of this type of psychodynamic formulation, it has been proposed that it should be possible to develop psychological profiles that differentiate abusers from nonabusers. For example, if abusers differ markedly from nonabusers on such characteristics as demand for performance from children or aggressive impulse control, it should be possible to construct assessment instruments that differentiate caretakers along these dimensions. If such instruments were to be developed and administered to all caretakers, it could be possible to predict the abuse potential of caretakers and then to intervene preventively where there are high-abuse-potential caretakers before physical abuse occurs.

This type of primary prevention strategy is a logical extension of the narrow approach to child abuse. Its implementation would raise complex moral and legal issues, particularly with regard to intervention in instances of true-positive and false-positive cases. Its implementation would probably also have the dubious side effect of deflecting attention and public responsibility from fact...rs other than psychodynamic ones that contribute to physical abuse.

Formulators of the causes of physical abuse who represent disciplines that have traditionally focused on external factors as the major cause of de...iant behavior have emphasized the causal or contributory role of social, cultural, and economic envir...

interpreted to indicate that "socioeconomic factors sometimes place added stress on the basic weakness in personality structure, but these factors are not of themselves sufficient or necessary causes of abuse" (Spinetta & Rigler, 1972, p. 302).

It would seem that arguments regarding the relative primacy of sociocultural or psychodynamic factors are of limited utility. As Gil (1970) has pointed out, the physical abuse of children is not a uniform phenomenon with one set of causal factors, but a multidimensional phenomenon. It is a phenomenon of uniform symptoms but of diverse causation. Many perpetrators do possess the psychopathological character structures indicated by psychodynamic formulators, while others do not. Many perpetrations seem undeniably to be a result of overwhelming environmental stresses, while others are only partially influenced by these external stresses.

In addition to character defect and environmental stress factors, several other factors have been shown to contribute to causing physical abuse (see Gill, 1970). These factors include deviant or atypical precipitating behaviors on the part of the abused child, environmental chance fac...rs that may transform an otherwise ordinary disciplinary encounter into a tragic event, disturbed intrafamily relationships involving conflicts between spouses and/or rejection of individual children, and combinations among these sets of f...ctors.

...vever, the factor that influences all instances of physical abuse, and upon which all other contr...ut...ry f...tors are superimposed, appears to be ...

practices concerning the use of physical force in child-rearing. (p. 134)

Gil further observes that the

excessive use of physical force against children is considered abusive and is usually rejected in American tradition, practice and law. [However, there are] no clear cut criteria concerning the specific point beyond which the quantity and quality of physical force used against children is to be considered excessive. (pp. 134–135)

Thus, there exists a general cultural toleration of a measure of physical force in American child rearing. There are qualitative and quantitative differences among various subcultural and social class groups in the approval and practice of this measure. There are no clear-cut criteria concerning the point beyond which the measure becomes excessive. And it is this situation out of which the other contributing factors realize their destructive ends.

This discussion of the factors that contribute to the physical abuse of children was stimulated by primary abuse prevention concerns. Specifically, the purpose for exploring these factors and related issues was to arrive at some ideas about which already existing programs and services might be bolstered to assist in the primary prevention of physical child abuse. The programs and services to be reinforced would be those that directly or indirectly address themselves to the contributory factors.

Programs with Prevention Potential

The Education for Parenthood program (Kruger, cessful with children without having to use physical force creates excellent observational learning opportunities for these prospective parents. It is possible that completion of these experiences will lead the future parents to be

sensitive to the central importance of parents in the child's life, to individual differences among children and to the broad range of nutritional, medical and psychological conditions that must be satisfied for a child to develop to his full potential. They will know that there are places to turn for personal help, that there are clinics and other local resources for prenatal and infant care, and that there are agencies . . . that offer helpful publications. (Cohen, 1973, p. 29)

It is also possible that they will have learned to look for such guidance during early pregnancy or even before. "And, perhaps most important, adolescents who have benefited from an Education for Parenthood course will be aware of the value and methods of family planning" (Cohen, 1973, p. 29).

The abuse prevention potential of the Education for Parenthood program could be increased by making the program available in all high schools and by providing additional support and consultation to the teachers and child care workers in the program. Such support and consultation would seem necessary to help the teachers and child care workers deal more effectively with the personal concerns and feelings of the teenagers as they go through the program. The support and consultation could be provided by appropriately trained personnel within the educational setting or from consultants from such agencies as community mental health centers. This additional support and consultation could also be used to raise the level

knowledge and understanding of early childhood development; and helping parents learn how to reinforce their children's positive behaviors.

Because of the range of helping services that these home visitors can deliver or initiate, it is likely that the visitors will develop a good deal of credibility and legitimacy with the families. From this position of legitimate authority, these home visitors certainly could become important partners with the families in preventing physical child abuse.

The abuse prevention potential of the Home Start program could be bolstered by providing home visitors with education and training in the issues and factors related to physical child abuse so that they would become more conscious of and attentive to those aspects of their work which are addressed directly to these issues and factors. These home visitors could also visit homes with children under the age of three. Visitors could draw on the procedures of the infant-stimulation-through-parent-education programs for some additional infant-oriented services (Gordon, 1969; Howard, 1972). By extending the use of these visitors into the homes of infants, the Home Start program would maximize its potential for the prevention of one of the more hideous types of individual abuse, the battering of infants.

The Home Start program grew out of the nationwide Head Start Project. Head Start began in the 1960s. It consists of one-year programs that provide health, nutritional, educational, social, and psychological services to economically disadvan- staffs of Head Start programs with relevant education and training. Such education and training could emanate from the children's services of local community mental health centers as well as from other local educational and training agencies. The avowed partnership for children between the federal agency that sponsors Head Start and the federal agency that supports the community mental health centers (the National Institute of Mental Health) could be actualized to reinforce Head Start's abuse prevention potential.

The children's services of the community mental health centers could deliver mental health education services to parent groups in churches and schools regarding the issues and factors that contribute to physical abuse. As mentioned previously, they could work more closely with prospective parents, new parents, and key social agents who are in contact or influence prospective and current parents.

The public school system's adult education programs could offer parent-training courses that stress alternatives to the use of physical force with children. There are several of these types of parent-training courses that have been successful in teaching parents nonpunitive approaches with children. Two of these courses are the behaviorally oriented child management courses (Becker, 1971) and the parent-effectiveness-training courses (Gordon, 1971). These courses have an additional abuse prevention potential. They often result in the parents developing close relationships among themselves. They meet outside of the training sessions and turn to each other for help during times of

grammatic reinforcements, then there would be evidence that suggests effectiveness.

However, there are many difficulties in using incidence data. It is generally agreed that the reported incidence of all types of individual abuse is severely underrepresentative of the actual occurrence (Light, 1973). This is due to (a) variable reporting requirements in each state, (b) a generally low level of public and professional consciousness about the need to report, and (c) a lack of knowledge and/or confidence in how reporting can be of benefit to the abused child and his or her family. Thus, in conducting a pre- and postincidence analysis of whether abuse prevention programs are effective, the evaluators would have to qualify all statements as a result of severe underreporting. They would also have to consider the possibility that *increases* in the reported incidence may be indicative of program effectiveness, because an increase may reflect heightened awareness of the problem and greater knowledge and confidence in the institutions that are responsible for managing child abuse cases.

Another means of assessing impact is to look for indirect and long-term effects. As has been suggested, if the above and other similar programs were encouraged to specifically address themselves to the prevention of physical abuse, it is likely that public consciousness would be raised markedly. It is also likely that such an increase in public awareness would lead to more discussions of the other types of individual abuse, such as sexual abuse, severe neglect, and emotional abuse.

Overall consciousness raising in the area of individual abuse should lead to the further awareness

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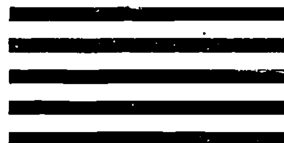

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the ABUSED parent of the ABUSED child

SIDNEY WASSERMAN

Willful intent in parents to injure their own children is an "unthinkable thought" for most of us. Even physicians, persons who seem to be in a position to judge whether violence has been done to a child, are often unwilling to accept the "reality of willful child abuse," according to a recent survey among physicians in the Washington metropolitan area conducted by a group of psychiatrists.[1] A fifth of the nearly 200 physicians questioned said they rarely or never considered the "battered child syndrome" when seeing an injured child, and a fourth said they would not report a suspected case even if protected by law against legal action by the parents. Apparently, they did not believe the evidence would stand up in court.

To accept as fact that some parents intentionally injure their children is difficult and upsetting. Thus, we all tend, like the physicians studied, to give the temptation is great to think of him as being far removed from those of us who do not batter our children. In so thinking, we keep intact our image of ourselves as righteous.

How easy it is to deny that within all of us lies a potential for violence and that any of us could be unreachable! What is more repugnant to our rational, "mature" minds than the thought of committing impulsive, violent acts against a helpless child? We tell ourselves that the primitive, untempered instincts responsible for such acts could not erupt in us. But stripped of our defenses against such instincts and placed in a social and psychological climate conducive to violent behavior, any of us could do the "unthinkable." This thought should humble us: perhaps we are not battering parents only because conditions do not lead us to commit "unnatural" acts.

Historically, the helping professions have viewed physical abuse of children by their parents as the result of poverty, life in the slums, ignorance, and the hardships produced by immigration, war, industrialization, and urbanization. No one can deny that these conditions can be a cause of child abuse. Nevertheless, we are finding that the phenomenon can be found anywhere in society. Once we regarded violence against a child as characteristic of parents in the lower socioeconomic classes. Now we are finding that such behavior is not exclusive with any particular social class but that "better" families can more easily conceal the problem than poor ones. In other words, a sociological explanation by itself is inadequate and simplistic.

Through sometimes frustrating and bitter experience, the professions, and particularly that of social work, have come to see that prosecuting the battering parent solves the problems of neither the child nor the parent. Helping the abused child leads us inevitably to the need to help the battering parent and family. As pointed out by Delsordo,[2] Boardman,[3] Nurse,[4] and others in studies of child abuse, practically all cases of abuse involve longstanding, severe interpersonal conflict either between the parents themselves or between one parent and another member of the family.

Because we are dealing with a complex subject involving many social, psychological, medical, and legal elements, we must narrow our scope and take first things first. Nothing precedes understanding who the battering parent is and what he is. Studies point out that battering parents and families, regardless of class, have certain psychological and social characteristics in common: for example, we are ing parent seldom shows remorse for having hurt his child, but he can be very much concerned about the harm a person in authority might inflict on his own person. When facing a person in authority, he cries out: "What are you going to do to me?"

"Done to"

Obviously, something went haywire or was not touched in the humanization process when such persons were growing up. Apparently, they never had the kind of relations with other people that offers incentives for delaying pleasure or gratification or the feeling that it is worthwhile to yield an immediate, antisocial pleasure for the love and acceptance of another. They have been "done to" both socially and psychologically. A battering adult goes about his daily life with the gnawing, unfulfilled feeling of having been unloved or not having been loved as much as he should have been as a child. His life is focused on his own needs, and he cannot tolerate any frustration to the gratification of these needs. What else can he feel but his own hurt, his own hunger for love? He is anesthetized against feeling compassion for others.

This kind of person, according to Reiner and Kaufman,[5] is unaware that he has a buried feeling of "imbedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act he interpreted as rejection of himself. Unable to understand such a distressing emotional event and not psychologically strong enough to bear it, as a child he buried the feeling of rejection deep within himself and with it the accompanying depression. Because his use of language was not [illegible]

defends his right to act as he has. He seems unable to feel love for and protectiveness toward his child. He can be extremely compulsive in his behavior and make unreasonable demands on his child. Cleanliness, for instance, may be an obsession with some. I have heard of a child being mercilessly beaten for putting chicken bones on a clean tablecloth and of an 18-month-old baby being seated with his buttocks uncovered on a hotplate whenever he soiled himself. Such people are way over their heads when they become parents. How can they give a child what they have never had themselves—security, safety, and love?

The hostility sponge

This description is supported by a growing amount of evidence that when a battering parent becomes violent, he apparently is releasing his rage on a particular child, selected to act as the "hostility sponge" for that rage. The parent views the child as a competitor, as someone taking and getting what belongs to him. The child is an unconscious symbol of someone or something that once caused him pain—a competitive brother or sister, a distrusted parent, his rejected self. Sometimes the parent is reliving a childhood experience that left him traumatized. Some of these parents talk about being rejected by their own parents in favor of a brother or sister.

In many instances the abused child has been conceived out of wedlock. The parent is now punishing him for being the cause of an unwanted marriage. Sometimes a stepfather is the offender. He beats the child for reminding him of his wife's "badness." Or the mother may beat the child because he reminds her of her "badness" or of that "bad" man, his father—

the problem—the parent's need to be protected from himself.

To really help such a parent, we must break the chains he has inherited. To do that, we must clearly understand that intervention should act as a brake on the parent's behavior and that the injuries he inflicts on the child, injuries that bring the attention of the community to them, are his way of saying—"Stop me!" The act of rushing a child to a hospital or of beating him in front of neighbors or strangers carries a message to the community—"Please save me from going out of control. Stop me from going out of my mind. Keep me from—killing!"

We are gradually realizing that in such cases we are dealing not only with a seriously disturbed person but also with a disturbed family. Once the existence of abuse is ascertained and the degree of imminent danger determined, the parent and the family must be dealt with whether or not the child is removed from the home. Even in cases where law enforcement has been effective and community services have been well coordinated, problems in helping the battering parent and the family remain.

According to Zalba,[6] battering parents tend to deny their actions, the husband or wife of the battering parent protects the other, or the children are too young to explain to outsiders what has occurred in the home. The parents also tend to deny the existence of personal or family problems and to provoke judges, lawyers, and social workers by making impossible demands on them; or they rage at everyone in authority and, sometimes, physically attack them.

Firmness above all

In reaching out to the battering parent, we must

To provide this basic treatment requires long-term help from a consistent relationship with one person only. Shifting the parent from one worker to another only stirs up his basic, deep-seated belief that to get close to another human being is to expose one's self to hurt and abandonment. Deep within, he sees himself as the kiss of death in personal relations. He wants to get close to another person, but he thinks that if he does the person will learn to dislike him and will break off the relationship. For a long, indefinite period, the helping person must stand by and support the parent by setting limits and by providing services through community resources. He must not try to get too close to or expect such a person to unload his innermost feelings, especially feelings he is hardly aware of. For such a person, having limits set on explosive, violent behavior provides the kind of protection a good parent would give. The battering parent must be constantly assured that he will not be allowed to get out of control. At the same time, he must be assured that the worker believes that he does not want to hurt his child, that he is capable of change, and that he wants to be a better parent. He needs to learn what the community expects of him and what choices he has. He needs to be helped to understand clearly that consequences will follow his violent act and what those consequences will be.

A long process

In this long and trying process, such a parent will continually test the patience of the helping person and will use every means to provoke rejection to reassure himself that he will not be rejected. For a while his need for violence abandons him and he stops expressing himself through it can he talk about his childhood and begin to come to grips with his problems. Though he improves, he continues to try to provoke the helping person, for he is never convinced that he will not be rejected. However, he does move cautiously toward having a relationship with the helping person, gives up or modifies his violent outbursts, and lets himself be guided toward patterning his actions after the standards of the helping person. In time, the pattern becomes a part of him and a new self appears.

To start and set in motion such a long, painstaking process requires a firm commitment by the community to providing excellent service, a goal not easily attained. To obtain qualified staff members and to train persons specifically as workers are expensive and time-consuming. Often efforts to reach the battering parent are obstructed because workers—nurses, social workers, volunteers—come and go frequently on the staffs of agencies. For the battering parent is likely to regard a change in workers as another experience in rejection. The he[illegible] person may leave the staff at the most cr[illegible]ent—just as the parent is testing the w[illegible] find out if rejection will follow his actio[illegible] parent takes the worker's leaving the agency [illegible]of that it never pays to get close to another person. If only a community or agency could insure permanent service for such troubled human bei[illegible]!

But life affords few oppo[illegible]nities for permanency. We are all only temporary to each other. That is a human condition, and most people accept it. The battering parent cannot. Plans for helping him must include ways to help him accept this truth. We must

ing their problems.[5] Working with such families as family groups has also proved effective.[6]

The community must learn

Beyond the abused child, his parents, and his family is the community around them. Battering parents and their families suffer from a not uncommon malaise often called "community exclusion." In various ways, whether economically, politically, psychologically, or socially, these families frequently suffer exclusion. Unfortunately, when such persons vent their rage on their children and the shocked community retaliates immediately, the family's sense of rejection is increased. A cycle of reciprocal aggression is set in motion and, once set in motion, is difficult to halt. The battering parent often succeeds in provoking hospitals, the police, the courts, and social agencies into treating him as his parents once treated him—the opposite of what he needs. Communities must constantly reexamine ways to set up controls and limits while bringing all families into the community life. When a battering parent has only known "community exclusion," he desperately needs "inclusion" to break the cycle.

Finally, we cannot examine our attitude as a community toward the battering parent without examining what it means to be part of a whole—a State, a nation, or the world. Like it or not, we are bound each to the other and our destinies are interwoven. As we try to understand the battering parent, we must look into ourselves to find out what there is in each of us, in our community, our Nation, and the world that the battering parent takes as a sign that what he is doing is permissible.

To answer this question we must face up to the paradoxes in our moral code that condemn violence in one form, permit it in another. Many Americans seem to persistently dismiss from their thoughts and acts a basic truth—there is nothing more precious than human life, or so it seems to me.

The people of the United States have yet to learn how to convert their tendency to violence into compassion and tenderness. We are in danger of losing sight of one of this Nation's major social goals, one on which it was founded, that is, to tap the humanity and creative potential of all citizens and to provide the environment and resources necessary for the individual citizen to realize his creative potential. We possess the potential both for violence and for humaneness, and are capable of acting in brotherhood and with understanding. If this were not so, we would not now be seeking new and different ways of helping our less fortunate citizens. By seeking to tap the humanity and potential for growth of the battering parent and family, we are tapping our own potential for personal, community, national, and international growth. We must ever encourage the tapping of this potential.

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the rights of children

BY JERRY M. WIENER, M.D.

In an editorial on May 20, 1971, the *New York Times*, in a criticism of the cuts made by New York State in its budget for the Department of Mental Hygiene, commented that the treatment of the mentally ill, the brain injured and the mentally retarded "is a test of how humane any society really is." Using this standard, it is worth asking how our society meets the test. How do we respond to the needs of our children, and particularly those children who are in some way different, deviant or disadvantaged? This group would include the emotionally disturbed, the mentally retarded, brain injured and behaviorally deviant

The White House Conference on Child Health and Protection proclaimed that "the emotionally disturbed child has a right to grow up in a world which does not set him apart, which looks at him not with scorn or pity or ridicule but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibilities." This is certainly an enlightened and noble statement. It is sobering to realize that it was made at the White House Conference in 1930, and if anything we are today further away from securing those rights than we were then.

Let us put the problem in perspective by reviewing some of its truly staggering dimensions. Fifty per cent, or about 100 million of our population, is now under 25 years of age. Of these, about 80 million are 18 or under. Twenty million of these children and youth are growing up under circumstances defined as poverty. Since the ratio of white to minority groups in poverty is one to four, we can estimate that there are 16 million minority group children growing up in poverty of whom the great majority are black and therefore the victims of poverty and racism combined. Now, of all our children (80 million) a probably conservative estimate of 12 per cent *(10 million)* have some significant psychological and/or developmental disturbance. Of these 10 million almost a third

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(2.4 million) are estimated to have a serious mental illness such as childhood psychosis or severe developmental deviations (e.g., language and learning impairments, serious problems in impulse control, antisocial). It is more than safe to assume that minority group children growing up in circumstances of poverty are represented in these figures of handicap far beyond their actual percentage of the population. Furthermore, these figures miss many cases which go undetected, including the more subtle cases of neurological dysfunction, mild mental retardation and untreated physical handicap, all of which also occur in a higher incidence in children of poverty. What does it tell us about ourselves, our decency as a society and about our future when we examine our behavior as a society towards these children?

In 1970 the Joint Commission on the Mental Health of Children submitted a detailed and massive report proclaiming that every infant must be guaranteed seven inalienable rights:

1. The right to be wanted
2. The right to be born healthy
3. The right to live in a healthy environment
4. The right to satisfaction of basic needs
5. The right to continuous loving care
6. The right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society
7. The right to receive care and treatment through facilities which are appropriate to their needs and which keep them as closely as possible within their natural setting.

Rights proclaimed are not the same as rights secured

Rights proclaimed, or even "guaranteed," are not the same as rights secured. I believe few would challenge that the above list does indeed define the basic rights of children because it represents the conditions essential for the fulfillment of the basic needs of children. Yet, upon examination of each, few would claim that we even reasonably approach adequate provisions for any one of them.

1. *The right to be wanted* is surely the least to which an infant is entitled. Yet we fail as a society to provide any reasonable alternative for the thousands of infants and children who are surrendered for adoption or abandoned by their parents. Adoptive homes are unavailable for most nonwhite children. Foster homes are almost equally unavailable for all, and in too many instances are unsatisfactory as well as child-care environments. The nurseries of nonprofit hospitals are accustomed to a population of infants left or abandoned by their mothers, who stay on as long-term residents, often for several months. This occurs more than 20 years after we have documented the destructive effects on personality and intellectual development of deprivation of early stimulation and consistent caretaking. With all our supposed commitment to early childhood we have done little or nothing to insure or provide that only parents who want children should have them or keep them, and that an effective network of infant and child care services is available for infants and children who are not adopted and cannot be placed in quality foster care.

Furthermore, there are millions of unwanted children born each year and allowed to remain, indeed forced to remain, with parents who did not and do

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not want them. Although some states have passed more liberal abortion laws, the large majority still force women to have babies they do not want, who given their choice would not continue their pregnancy, and so must almost inevitably attach feelings of resentment and rejection to that child. It is to my mind an affront to us all that our society, primarily in the form of legislative inaction and resistance, perpetuates legal restrictions on a matter which should be the private concern and decision of private individuals.

About 40 per 1,000 black, ghetto infants die

2. We speak of *the right to be born healthy*, yet we make little provision to insure truly adequate prenatal care. The availability of minimum nutrition, protection against maternal illness damaging to the fetus, and adequate medical care during the delivery and immediately post-partum are essential for healthy babies. Yet it is a fact that the often proclaimed richest nation on earth also has one of the worst infant mortality rates of any developed nation. Even more damning is the sad truth that a white baby born to a suburban mother has as good a chance of survival as any in the world while the mortality rate for black, ghetto infants is two and a half times as high, about 400 per 1000. To quote Dr Joseph Dancis, a New York pediatrician, in an article from a recent issue of *Today's Health*, "Infant mortality is a symptom of the state of a society."[1] To paraphrase Churchill, "Some state, some society." But, to look even further, would it be sufficient if all services necessary to reduce infant mortality to an absolute minimum were actually provided? The answer, I think, would be that this would represent only a necessary first step. Shouldn't we as a society not only provide but require that expectant mothers do what is necessary to protect the health of their babies. We will judge a child delinquent and impose legal penalties, including incarceration, if he fails to attend a school where he cannot learn because he is intellectually impaired perhaps as a result of poor maternal nutrition during the pregnancy. Yet we have no requirements of the mother who is neglectful of her nutrition and prenatal care during pregnancy, often out of ignorance, maybe as often out of indifference. When it comes to care during pregnancy, each mother is an independent entrepreneur. The cost of this freedom in terms of suffering to individual children and to our society as a whole is incalculable. The consequences of poor nutrition and inadequate prenatal care are recorded in terms of prematurity, neurological damage, intellectual deficit and high infant morbidity. We require that children be vaccinated, and have thereby eliminated smallpox, diphtheria, tetanus, polio, and can now see the end to measles, mumps and other illnesses. Why not some type of analogous system that requires of expectant mothers that they do what is necessary to protect the health of their babies?

Pregnant mother is independent entrepreneur

3. *The rights to live in a healthy environment, to have basic needs satisfied and to continuous loving care* are interrelated, and would seem to represent a sensible and minimal standard. Yet as a society we tolerate such conditions, for example, as substandard housing, the exploitation by both employers and parents of the children of migrant farm workers, the unavailability of good health care, and the overt physical abuse and more subtle psychological maiming of defenseless children. We can and should mandate and provide adequate housing, lead-free walls, rat-free rooms, heat in the winter, a bed for each child and easily accessible health care. But at the same time we also fail our children in potentially more pervasively destructive ways by what we fail to require of their parents. How do we go about guaranteeing to each child his right to consistent, protective, nurturing parental care? What is our responsibility, for example, to the first or fifth child born to a woman whose own mothering was

inadequate to provide her a maternal capacity in her own right? What can we do, what should we do for the legions of children born into homes where they will be expected by age five or six to provide parental care to younger siblings or for those siblings who must look for their emotional nurturing to a limited mother or an already deprived and embittered older sibling. How do we protect children from being left to look after both themselves and one another only, as has been the sad outcome in countless instances, to have one of those children set a fire which destroys them all.

As recently publicized cases have informed us, we do not even protect a child from being suddenly removed from a good adoptive or foster home in which secure attachments have been formed, in order to restore him to the biological mother who for good reason or bad wants her child back. Let no one be misled into thinking that the rights and best interests of the child are a serious consideration in most such cases. It is the rights of the mother which are paramount. The child is considered as a piece of property. How can we as a society delegate such a monumental responsibility so exclusively to lawyers and judges, often political appointees, who have no preparation outside the law to rule on such issues?

In custody cases children are treated like property

OUR GREATEST FAILURE

Our lack of true commitment to the right of children to have consistent, warm nurturing care may be our greatest failure, inhumanity and shame as a society. While this is not an issue limited to the children of the poor, I have no doubt that the problem is greater in our deprived and underprivileged groups. We are not completely serious about our concern for children until as a society we are prepared to limit the right of any parents to possess children as property without establishing any standards or requirements of them. We pay huge sums of money to individual and corporate farm establishments not to cultivate their lands; could we not do as much to insure that children obtain adequate cultivation?

We condemn ourselves as a society and generations of our children to despair unless we are prepared to establish a machinery which, first, provides every possible opportunity for needy mothers to enhance and develop their maternal capacity through education, training, support and the supply of direct helping services; and second, places some limits on the number of children in families where it is clear that the child's rights cannot be secured in or by the family. We should have an effective system of child advocacy to supervise this and a coexisting child care system which provides viable alternatives for children removed from their natural parents. We need to establish a network of services offering a range from extended day-care to full-care residential settings staffed by trained child care personnel. Until we are prepared to make a sufficient moral and financial committment to these ends, we only console ourselves by an expression of empty concern for the welfare of those children who grow up outside the mainstream of our society.

One must ask how and by what mechanisms, as individuals and as a society, we have been able for so long to tolerate the poor treatment of underprivileged children. Charles Pinderhughes, a Boston psychiatrist, has extensively studied some of the psychological mechanisms that create and perpetuate racism. He describes a process of nonpathological (in the sense of individual pathology),

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group-related paranoia which serves the purpose of self-aggrandizement, self-enhancement and self-satisfaction by assigning to others any undesirable or renounced aspects of the self. If on the one hand racism is sustained by this process, so also do such mechanisms operate to isolate from our outrage and concern the endless sacrifice of minority group and economically deprived children.

4. Next we consider *the right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society.* The past few years have witnessed a veritable deluge of books, articles, essays and studies about the deficiencies and failures of our urban educational system in providing even the bare minimum essential skills of reading, writing and arithmetic, much less anything more sophisticated, to inner city children. It is a profoundly disturbing failure for which as yet no solution even seems reasonably close to being found. Most would agree that the problem does not begin when the child enters school. Inner-city children bring to the classroom a varying combination of developmental characteristics which on the whole represent liabilities so far as the extant formal academic process is concerned. These characteristics would include lags in language and cognitive development, a different style of impulse control, difficulties with attention span and frustration tolerance, and problems in both self-concept and feelings towards authority figures. The failure of the schools is only one aspect of the failure of our society to provide these children their basic rights. The Head Start Program was a needed beginning. Its results have so far been most promising in the area of improving general child health and disappointing in bringing about identifiable longer-term improvements in cognitive and language achievement.

THE CRISIS IN THE CLASSROOM

Another approach suggests that black children learn best, and perhaps only, from black teachers with whom they can make self-respecting, positive and corrective identifications. New York City has been the most publicized arena in which the battle over this proposition has been engaged, in the form of the struggle for community control. While there is merit to the issue, it is as unreasonable to expect that one group or color of teachers or one teaching method is going to be the answer to the problem as it is unfair and unrealistic to suggest that the problem was caused by a group of teachers of another color or their method. Attempts to answer whether it is the children or the teachers who are primarily responsible for creating the "blackboard jungle" have only further polarized the issues and intensified the conflicts. Whatever solutions are formulated to deal with the crisis in the classrooms will have to include efforts directed toward change in the earliest life experiences of these children. Indeed, there is reason to believe that a sufficiently massive and committed effort to guarantee to children their other basic rights would essentially insure that they would as a result be able to obtain as well their right to a good education.

5. The last right is that *of care and treatment for all children appropriate to their needs.* Simply reconsider that there are an estimated 10 million children in this country who have a sufficiently serious emotional or developmental disturbance to require some therapeutic intervention. Also remember that children belonging to minority groups and from circumstances of economic deprivation are over-represented in these numbers, and it is their needs which are

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particularly unmet and require more intensive services. Even if this were not the case, large areas of the country contain relatively economically advantaged population groups for whom almost no qualified professional help is readily available. To consider how far away we are from even beginning to be able to provide for the special needs of all these children is a nightmare exercise in program planning.

Yet this is not to suggest that the provision of adequate facilities and personnel is beyond the capacity of this country's material and educational resources. But to provide these would require the same degree of national concern and commitment as has been directed, for example, to the space program, the ABM, proposals for the SST, and of course dwarfing all else, the war in Vietnam. The current ordering of our national priorities does not suggest that the treatment needs of emotionally disturbed or mentally ill children rank very high.

Funding of services requires reordering of priorities

The act passed in 1965, providing for the establishment of community mental health centers, seemed a promising beginning. Yet, despite limited and localized examples of progress, sufficient funding has not been available to fulfill the promise. This insufficiency has been most notable in the area of funds for training the large numbers of qualified professionals and paraprofessionals who are needed to staff mental health facilities and provide for the growing needs for services demanded by an increasingly enlightened citizenry.

A reordering of priorities would indeed be required to fund treatment services for the vast majority of the population. To the average or even above-average income family the cost of obtaining appropriate treatment for emotional disturbance, learning disabilities and/or physical handicaps is simply prohibitive, even where available. Most families with children are young families, with years of financial responsibilities ahead of them. Most school systems are already strained beyond the ability of their resources to provide needed counseling, corrective and remedial services. Whether the treatment need is some form of psychotherapy, therapeutic education or institutional care, the need for governmentally supported or supplemented funding is increasingly apparent. And even if all the treatment resources needed were actually available, we would still only be treating the identified casualties and doing little in terms of stemming the flow at its source.

THE STORY OF DROWNING CHILDREN

There is the story of the group of men on a river bank who saw a child floating down the river and formed a chain to rescue him. As soon as they got him to shore, they saw two more in the water, and as soon as these were safe another four appeared, and then another six. One man started to leave the group, and the others shouted to him that there were still more children coming down the river to be saved from drowning. The man replied that they could continue to fish them out, but he was going upstream to find the fellow who was throwing them in. In regard to saving from drowning those already struggling in the water, and even more so in regard to preventing more from being thrown in, we have for many years effectively banished this problem from our serious concern and are only now beginning to acknowledge the insufficiency of our efforts. Perhaps our society has found it easier to tolerate injustice and inhumanity to children in terms of malnutrition, intellectual dulling, neurological damage, emotional neglect and wasted lives in part because the incidence of these damages is

concentrated in the children of poverty and minority groups. But all our children who are deviant, different and have special needs still exist somewhere away from our collective concern, even when they are from more economically advantaged families. They are dealt with as abstractions, dehumanized and emotionally ostracized. We learn early the process of dealing with that which causes us discomfort or pain by locating it outside ourselves and identifying it as bad, evil or dangerous. Despite an intellectual awareness to the contrary, as acquired in later years, we often still act on the basis of the earlier processes. This frequently occurs in our institutionalized behavior as a society towards those who are different or deviant.

Can society continue to treat children as private possessions?

In an article in the *Saturday Review*,[2] Dr. Judd Marmor makes some comments about the problem of trying to change institutions and institutionalized behavior. He says, "The problems lie not in our individual psychopathologies, but rather in socially sanctioned egosyntonic group values. It is not the 'defectives' among us but we, the 'normal' ones, who constitute the problem." Later, he continues, "There is a deep resistance in most of us against changing of fundamental institutions in our society, because our basic personalities—our needs, expectations, our very language and perceptions—have been so profoundly shaped by those very institutions." Value systems are one aspect of our institutions and society, and we must reflect on the discrepancies between what has been called a child-centered society and the actual behavior of our society towards its children. Can our society continue to tolerate the treatment of children as entirely private possessions based on the traditional models of a free enterprise society, dominated as it is now by a technological capacity which many fear is rapidly moving beyond our control and is no longer in the service of human values? Large numbers of what has been referred to as our most valuable natural resource must receive an increasing degree of our communal, and not only our individualistic, concern. We cannot be more obsessively worried about the pollution of our air and water than we are about the pollution of young lives.

AN ANCIENT LESSON

We cannot continue to behave as if no problem really existed in regard to our concern and care for the rights of children. Society's attitudes towards those who are different or deviant is reflected very well in our literature and goes at least as far back as ancient Greece. In Sophocles' play, "Philoctetes," as the result of an accidental snake bite, Philoctetes develops an unsightly and odorous ulcer on his leg. The Greeks banish him to live alone on an island. The play deals with the process by which they must restore this outcast to society if they themselves are to survive. The people choose Achilles' adolescent son as their emissary; it is youth they must depend upon for their future.

A happy innocent childhood is one of the enduring myths of our culture. Its perpetuation may depend on our collective inclination as a society to banish from our concern the unsightly ulcer of unhappy, disturbed or deprived children.

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TO THE TEACHER

The annotated bibliography which follows is offered as a useful reference list for the course of study. The items noted here are drawn from the larger bibliography utilized in the development of the curriculum document. The selected articles are suggested references for more detailed and in-depth study of various aspects of child maltreatment. The annotations that appear in quotation marks are provided by the publisher.

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THE AMERICAN HUMANE ASSOCIATION, CHILDREN'S DIVISION-----is the disseminator of the 19 pamphlets on Child Maltreatment listed immediately below. Annotations are those provided by the association. Prices and ordering information may be found in Appendix D for those suggested for the Classroom Learning Center.

* A National Symposium on Child Abuse. 1972.

  An interdisciplinary exploration of child abuse and sexual exploitation of children. Papers given at a national symposium which examined the intensity of the problem and discussed the legal, medical, and protective aspects of the problem. 72 pp.

* Child Abuse Legislation in the 1970's. Vincent DeFrancis and Carroll Lucht. rev. ed. 1974.

  Report and analysis of current child abuse laws. Reflects changes; records status of laws in each state; calls attention to novel approaches; discusses problem areas; and challenges some concepts. Highlights selected language. A guideline for legislation. 208 pp.

* Due Process in Child Protective Proceedings. Thomas T. Becker. 1971

  Discusses the implication of the mandate for due process as it applies to the neglect proceeding in juvenile court; defines the elements of due process, and interprets the precarious balance required to protect conflicting rights. 24 pp.

* Emotional Neglect of Children. Robert M. Mulford. 1958.

  A penetrating analysis of the challenge to Child Protection posed by this difficult area of child neglect. 11 pp.

* Fourth National Symposium on Child Abuse. 1975.

  Selected papers delivered at a national symposium which brought together panels of experts in areas of identification and protection of neglected, maltreated, and sexually abused children. Papers deal with multidisciplinary approaches, medical problems, and legal aspects in terms of invoking the authority of the courts. 92 pp.

* Suggested for Classroom Learning Center

* In the Interest of Children, A Century of Progress. Katherine B Oettinger, Rev. Arthur Morton, and Robert M. Mulford. n.d.

Review and assessment of problems and progress in child protection in the United States and England during the 20th Century. Discussion of needs, approaches, trends, and future goals. 28 pp.

* Let's Get Technical: The "Why and What" of Child Protective Services Vincent DeFrancis. n.d.

Explores special skills and their application through the use of a case history. 10 pp.

Neglecting Parents, A Study of Psychosocial Characteristics. Morton Cohen, Robert M. Mulford, and Elizabeth Philbrick. 1967.

Interpretation of the findings in a research project to identify the psychosocial characteristics of neglecting parents in almost 1,000 families. 28 pp.

* Plain Talk About Child Abuse. Herb Stoenner. 1972.

Six articles from The Denver Post which expose the myths and stereotypes popularly accepted about parents who neglect or abuse children. An interpretation for the general public of the nature and dimension of neglect and abuse, its causation and treatment. 24 pp.

* Protecting the Battered Child. Edgar Merrill, Irving Kaufman, Philip R. Dodge, and Arthur E. Schoepfer. 1962.

Report of a statewide study and analysis of child abuse cases, discussion of implications as viewed by experts in psychiatry, medicine, law, and social work. 30 pp.

** Protecting the Child Victim of Sex Crimes. Vincent DeFrancis. 1965.

Examines the impact to child victims of sex crimes and the process used to prosecute the offender; and explores approaches for protecting children from lasting emotional damage. 14 pp.

* Selected for Classroom Learning Center
** See Appendix F.

ERIC

** Protecting the Child Victim of Sex Crimes Committed by Adults. Vincent DeFrancis. 1969.

The final report of an intensive 3-year study of sexual abuse of children. An in-depth analysis of the problem and its implications in terms of an enormous incidence, the severity of impact on the victim, the contribution of parents to the occurrence, and the responsibility for social services. Major findings remove the wraps from a hitherto ignored area of child neglect and abuse. 203 pp.

* Protective Services and Community Expectations. Vincent DeFrancis. n.d.

A discussion of community responsibility for providing protective services -- the legal frame of reference for physical and emotional neglect -- the problems involved in obtaining a legal finding of emotional neglect. 17 pp.

* Protective Services and Emotional Neglect. Max Wald. n.d.

A discussion of emotional neglect; description of skills and attitudes necessary to change destructive parental behavior; illustrations of techniques through case history. 20 pp.

* Second National Symposium on Child Abuse. 1972.

A group of national experts discuss multidisciplinary approaches for protecting victims of neglect and abuse. Roles and responsibilities of professionals involved in the process are interpreted and related to cooperative and coordinated services. 60 pp.

* Speaking out for Child Protection. Vincent DeFrancis. 1973. Highlights of testimony before U.S. Senate Subcommittee on Children and Youth. Strongly points to urgency of implementation of Child Protective Services. Gives perspective on progress in this specialized field. 28 pp.

* The Status of Child Protection. Vincent DeFrancis and Boyd Oviatt. 1971.

Discussion of the general failure to mount Child Protective programs of sufficient magnitude and competency to effectively treat the needs of neglected, abused children; questions are raised and directions for needed changes proposed. 28 pp.

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APPENDICES

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CONTENTS

APPENDIX

A Instructional and Performance Objectives by Unit

B Classroom Instructional Materials by Unit

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D Classroom Learning Center for Child Maltreatme

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APPENDIX A

Instructional and Performance Objectives by Unit

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EVALUATION

In the Policies and Procedures Handbook, the revised MCPS Regulation 355-4, dated October 1, 1975, defines the instructional objective as "a general statement of what the student should attain"; the performance objective as "a specific statement of what the student should be abl   lo."

For each instructional objective in the course of study, sets of performance objectives have been designed with specific classroom activities and procedures developed for each set. The performance objectives are measurable and may be used as indicators of student attainment of the instructional objectives.

Each unit contains an evaluation section with sample assessment measures for each performance objective in the unit, and criteria fo   isfactory attainment of each objective are itemized. For each unit, a class record form has been designed for the teacher to record student attainment of the performance objectives for that unit. For the student, an individual record form has been designed which includes the performance objectives for each of the six units. Sixty percent satisfactory attainment for the total number of performance objectives attempted by the student is suggested as the basis for course credit.

Each performance objective contains a statement of the behavior desired of the learner in demonstrating attainment of the objective. The key word which specifie the behavior is the verb. In order to prevent misunderstanding, both the teac r and the student should have a common understanding of the meaning of the key words. A Key Word List is therefore provided with a description of the behavior the learner should use in demonstrating attainment of the objective.

Teachers should make every effort to clarify the performance objectives for students. The teacher must have a thorough understanding of the intent of each performance objective in relation to the appropriate instructional objective and be able to communicate this intent to the learner. The learner must also know what is expected of him, so that it is essential also for the student to have a clear understanding of the behavior described in each performance objective.

KEY WORD LIST

for

Performance Objectives

CITE	- to quote information from an external source for the purpose of clarifying something (e.g., cite examples, data)
CLASSIFY	- to place into groups according to certain criteria
COMPARE	- to list the similarities and differences of things
DESCRIBE	- to state a verbal picture or /to/list the characteristics of a person, place, thing, or event
DISCRIMINATE AND DISTINGUISH	- to be able to differentiate one type from another -- similar to "classify"
EXPLAIN	- to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship
IDENTIFY	- to select from among several choices the item(s) that meet(s) certain criteria
LIST	- to make a series of words or statements
PREDICT	- to state a possible conclusion before it occurs
RECOMMEND	- to present something as worthy of acceptance
STATE	- to make a declarative word phrase setting forth something

Definitions quoted from
Thomas Evaul. Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO COMPARE THE HISTORICAL AND CONTEMPORARY PHENOMENON OF CHILD MALTREATMENT IN SOCIETY.

Performance Objectives

1. DESCRIBE forms of child maltreatment in the past.
2. LIST possible reasons for child maltreatment in the past.
3. CITE medical and psychological evidence of child maltreatment in society today.
4. CITE statistical evidence of child maltreatment in society today.
5. CITE sociological evidence of child maltreatment in society today.
6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.
7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.
8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child.

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO DISTINGUISH THE NATURE OF CHILD MALTREATMENT FROM ACCEPTABLE OR USUAL CHILD REARING PRACTICES IN SOCIETY TODAY.

Performance Objectives

1. STATE the federal definition of child maltreatment.
2. IDENTIFY the caretaker.
3. DESCRIBE typical acts of physical and psychological abuse.

4. DESCRIBE typical acts of psychological abuse without physical abuse.
5. DESCRIBE typical acts of physical and psychological neglect.
6. DESCRIBE typical manifestations of physical abuse and neglect in the child.
7. DESCRIBE typical manifestations of psychological abuse and neglect in the child.
8. LIST characteristics of acceptable child-rearing practices today.
9. LIST characteristics of child maltreatment today.
10. COMPARE child maltreatment with acceptable child-rearing practices.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO DESCRIBE THE COMPONENTS IN AN EPISODE OF CHILD MALTREATMENT.

Performance Objectives

1. LIST the components of the episode of child maltreatment.
2. EXPLAIN the role of the caretaker.
3. EXPLAIN the role of the child.
4. EXPLAIN the role of stress.
5. EXPLAIN the role of the passive partner.
6. EXPLAIN the role of the sibling on-looker(s).
7. IDENTIFY the potentially abusive or neglectful caretaker.
8. STATE the characteristics of the potentially abusive or neglectful caretaker.
9. IDENTIFY the potentially vulnerable child.

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10. STATE the characteristics of the potentially vulnerable child.

11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.

12. STATE the meaning of the term "stress".

13. LIST the characteristics of stress.

14. CLASSIFY the kinds of stress.

15. DESCRIBE the origins of stress.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO EXPLAIN THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT.

Performance Objectives

1. STATE the meaning of the term psychodynamics.
2. STATE the meaning of the term interaction.
3. EXPLAIN psychodynamic interaction in relation to stress factors within society, the family, and the individual.
4. STATE the meaning of the term conscious (re)actions in relation to the caretaker.
5. STATE the meaning of the term unconscious (re)actions in relation to the caretaker.
6. DESCRIBE typical (re)actions of the caretaker to the child.
7. DISCRIMINATE conscious and unconscious (re)actions of the caretaker to the child.

8. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the caretaker to the child.

9. STATE the meaning of the term conscious (re)actions in relation to the child.

10. STATE the meaning of the term unconscious (re)actions in relation to the child.

11. DESCRIBE typical reactions of the child to the caretaker.

12. DISCRIMINATE conscious and unconscious (re)actions of the child to the caretaker.

13. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the child to the caretaker (i.e., to maltreatment).

14. EXPLAIN the relationship of nurturing experiences in infancy or childhood to the ability to nurture in later life.

15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.

16. RECOMMEND ways to break the recurring cycle of child maltreatment from the standpoint of the child.

17. RECOMMEND ways to break the recurring cycle of child maltreatment from the standpoint of the caretaker.

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One

THE STUDENT WILL BE ABLE TO IDENTIFY THE INDIVIDUAL AND SOCIETAL PROBLEM OF CHILD MALTREATMENT.

Performance Objectives

1. STATE the meaning of the term circumstantial child maltreatment.
2. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within society.
3. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within the family.
4. EXPLAIN the relationship of circumstantial child maltreatment to dysfunctions within the individual.
5. PREDICT the probability of circumstantial child maltreatment in relation to individual ability to cope with stress.
6. STATE the meaning of the term incidental child maltreatment.
7. DESCRIBE incidental child maltreatment in relation to dysfunctions within society.
8. DESCRIBE incidental child maltreatment in relation to dysfunctions within the family.
9. EXPLAIN the relationship of incidental child maltreatment to dysfunctions within the individual.
10. PREDICT the probability of incidental child maltreatment in relation to individual ability to cope with stress.
11. STATE the meaning of the term intentional child maltreatment.
12. DESCRIBE intentional child maltreatment in relation to dysfunctions within society.
13. DESCRIBE intentional child maltreatment in relation to dysfunctions within the family.

14. EXPLAIN the relationship of intentional child maltreatment to dysfunctions within the individual.

15. PREDICT the probability of intentional child maltreatment in relation to individual ability to cope with stress.

Instructional Objective Two

THE STUDENT WILL BE ABLE TO STATE THE PROVISIONS OF FEDERAL, STATE AND LOCAL CHILD MALTREATMENT LAW.

Performance Objectives

1. DESCRIBE briefly the chronology and extent of child maltreatment legislation in the U.S.

2. STATE the provisions of the federal Child Abuse Prevention Act of 1974.

3. STATE the provisions of the state law for a) abuse and b) neglect.

4. COMPARE the state law with the local law for a) abuse and b) neglect.

5. DESCRIBE the local reporting process for a) abuse and b) neglect.

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES TO THE PROBLEM OF CHILD MALTREATMENT WHICH PROVIDE HELP FOR BOTH THE CHILD AND THE CARETAKER.

Performance Objectives

1. IDENTIFY the kinds of responses which help the maltreated child.

2. DESCRIBE the kinds of help available to the maltreated child.

3. IDENTIFY the kinds of responses which help the caretaker.

4. DESCRIBE the kinds of help available to the caretaker.

Instructional Objective Two

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES WHICH PROVIDE HOPE FOR PREVENTION OF CHILD MALTREATMENT IN SOCIETY.

Performance Objectives

1. IDENTIFY those in society who must respond to the problem of child maltreatment.

2. DESCRIBE the kinds of response which provide hope for prevention of child maltreatment in society.

APPENDIX B

Classroom Instructional Materials by Unit

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CLASSROOM INSTRUCTIONAL MATERIAL

for

I. The Phenomenon of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (I.1)
2. "Our Forebears Made Childhood a Nightmare" (I.2)
3. "Who Owns the Child?" (I.3)
4. Questions and Answers About Child Maltreatment (I.4)
5. "Child Abuse and Neglect Programs: A National Overview" (I.5)
6. Dysfunctions of Society, the Family, and the Individual (I.6)
7. "Child Abuse Reports Have Increased Since 1972" (I.7)
8. "Good Children' (Our Own), 'Bad Children' (Other People's), and the Horrible Work Ethic" (I.8)
9. "Is U.S. Becoming Less Child-Oriented?" (I.9)
10. "Imprisoning Our Children" (I.10)
11. "They've No Right To Destroy the Children" (I.11)
12. "Medical Care Lacking for Children of Poor" (I.12)
13. "Shipping Children South" (I.13)
14. "Child-Snatching" (I.14)
15. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

1. Table 1, Mershon Study Center
2. Age Profile 1974-75, Reports of Suspected Child Abuse, MCPS
3. Sex and Mean Age of Children Reported, MCPS
4. Age Profiles Compared, 1973-74 and 1974-75, MCPS

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FILM

Children in Peril. Discusses causes of child abuse and programs developed for treatment of child abusers. S. T 22 min. color 1. Child abuse. EMC 362.7 5684 Media Concepts 1972.

Fragile, Handle with Care. A film of stark realism which tells of the death of an infant brought to the emergency ward time after time by its young parents before finally succumbing to maltreatment. The film delves into the reasons why parents abuse their children, and what happens to the children mentally and physically. It also looks into ways of preventing child abuse, the legal considerations involved, and the professional help that is available for children.

A KTAR TV film produced in cooperation with The Independent Order of Foresters 16mm color 26 min. Available on loan from Independent Order of Foresters, 10215 Reisterstown Road, Owings Mills, Maryland 21117.

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CLASSROOM INSTRUCTIONAL MATERIALS

for

II. The Nature of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (II.1)
2. Federal Definition of Child Maltreatment (II.2)
3. Identity of the Caretaker (II.3)
4. Typical Acts of Physical and Psychological Abuse (II.4)
5. Typical Acts of Psychological Abuse Without Physical Abuse Which May Result in Damage to the Child (II.5)
6. Typical Acts of Physical and Psychological Neglect Which May Result in Damage to the Child (II.6)
7. Characteristics of Child Maltreatment (II.7)
8. Typical Manifestations of Physical Abuse and Neglect in the Child (II.8)
9. Typical Manifestations of Psychological Abuse and Neglect in the Child (II.9)
10. "Signs of Trouble Preceded Death of Boy, 4" (II.10)
11. "Boy Spurned"; Boys Taken from Home After Beating"; "Infant, 2, Dies, Sitter Is Held"; "Child-beating Death Draws Man Ten Years" (II.11)
12. "Mother admits failure to feed son, who died a 'vegetable' of 8 pounds"; "2 Infants Found in Trash Can"; "Newborn Baby Is Found Left in Trashcan" (II.12)

13. "Beaten, they can't fight back" (II.13)

14. "Mother talks of horror, seeking aid" (II.14)

15. "Law broadened to aid battered" (II.15)

16. "Case History"; "Case History" (II.16)

17. "Don't Shake the Baby" (II.17)

18. "Counter-Culture Kids" (II.18)

19. "Child Care in America" (II.19)

20. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

5. Definition of Child Maltreatment

6. Identity of the Caretaker

7. Typical Acts of Physical and Psychological Abuse

8. Typical Acts of Psychological Abuse Without Physical Abuse

9. Typical Acts of Physical and Psychological Neglect

10. Characteristics of Child Maltreatment

11. Typical Manifestations of Physical Abuse and Neglect in the Child (a and b)

12. Typical Manifestations of Psychological Abuse and Neglect in the Child (a and b)

Slides (Series 1 through 10)

A color slide series of photographed examples of child maltreatment is in preparation.

ERIC

Films

Cipher in the Snow This dramatization of psychological abuse is based on the true story of a boy who no one thought was important until his sudden death one snowy morning. The story on which the film was based won first-place award in the N.E.A. Teachers Writing Contest.
Brigham Young University 1973 16mm color 23 min. MCPS Film Library #6571

Growth Failure and Maternal Deprivation This film shows physical and mental retardation in young children which may often result from lack of parental attention, especially from the mother. Two children, one thirteen months old and one almost four years old are shown as examples of failure-to-thrive. The circumstances under which these children lived and those aspects of the mother-child relationship thought to be responsible for their failure to grow and develop normally are discussed.
McGraw Hill 1966 16mm black/white 28 min. MCPS Film Library #4218

CLASSROOM INSTRUCTIONAL MATERIALS

for

III. The Episode of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (III.1a)
2. Interpretations of the Nurturing Experience (III.1b)
3. The Components (III.2)
4. The Potentially Abusive or Neglectful Caretaker (III.3)
5. The Criteria of Emotional Maturity (III.4)
6. Characteristics of the Potentially Vulnerable Child (III.5)
7. Typical On-Going Stress Factors (III.6)
8. Typical Stress Factor Immediately Prior to Maltreatment (III.7)
9. "How A Baby Learns to Love" (III.8)
10. "'Battered' Babies; Birth Without Violence" (III.9)
11. "How To Conquer Stress" (III.10)
12. "Child Care by Adolescent Parents" (III.11)
13. "Mom and Dad" (III.12)
14. "Holiday season filled with child abuse" (III.13)
15. Classroom learning center for child maltreatment

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AUDIOVISUAL MATERIALS

Overhead Transparencies

13. The Episode of Child Maltreatment, The Components
14. The Potentially Abusive or Neglectful Caretaker (a and b)
15. Characteristics of the Potentially Vulnerable Child (a and b)
16. Typical On-Going Stress Factors (a, b, c)
17. Typical Stress Factors Immediately Prior to Maltreatment (a and b)

17c World of Abnormal Rearing

Films

Birth Without Violence A film depicting the birth delivery techniques of Dr. Frederick Leboyer, who has himself delivered more than 10,000 babies. Though considered radical by some, his supremely simple technique seemingly eases the birth trauma and helps the new human being to start life without pain, confusion and fear. Recommended for classroom use, where available.

Second Chance. The treatment of maternal deprivation syndrome is described in this film. A deprived 22-month-old child is seen through the period of hospitalization at the Chicago Children's Memorial Hospital. The profound effects of the lack of emotional care, the child's defensive reactions to maltreatment, and her improvement after therapy are illustrated and explored.

Children's Memorial Hospital 1974, color 12 min. Available through MCPS Film Library

CLASSROOM INSTRUCTIONAL MATERIALS

for

IV. The Psychodynamics of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (IV.1)
2. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series (IV.2)
3. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (IV.3)
4. Typical Conscious and Unconscious (Re)Actions of the Child to the Caretaker, i.e., to Maltreatment (IV.4)
5. The Violence Cycle Illustrated, "World of Abnormal Rearing" (IV.5)
6. "Early Child Abuse and Adolescence, A Literature Review" (IV.6)
7. "Home Called More Violent Than Street" (IV.7)
8. Ann Landers' Column (IV.8)
9. "The Child-Abusing Parent: A Psychological Review" (IV.9)
10. "Violence in Our Society" (IV.10)
11. Selected Instructional Material from Units I, II, and III
12. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIALS

Overhead Transparencies

18. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series 1 through 6
19. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (a, b, c)
20. Typical Conscious and Unconscious (Re)Actions of the Child to the Caretaker; i.e., to Maltreatment (a, b, c)
21. The Violence Cycle Illustrated, "World of Abnormal Rearing"

Films

War of the Eggs. A heart-rending incisive story of a young couple who quarrel and as a result, their young son begins to cry hysterically. The enraged young wife roughly pushes him down the stairs, badly injuring him. At the hospital a psychiatrist gently tries to help them. Painfully, husband and wife open to each other, accept responsibility for what they have done, and turn for help. Written by Michael Crichton, author of Andromeda Strain.

Paulist Productions 1974 16mm color 26½ min. MCPS Film Library

Rockabye Baby. A film which illustrates the effects of parental deprivation upon young animals and children. The importance of physical touching and body movement for normal social and emotional development are effectively dramatized through this film. It presents some of the techniques that psychologists use to measure mothering practices during the importnat infant years.

Time-Life Films, Inc. 1971 16mm color 20 min. MCPS Film Library #6095

CLASSROOM INSTRUCTIONAL MATERIALS

for

V. The Problem of Child Maltreatment

1. Definition of Terms (V.1)
2. "Child Abuse in the United States" (V.2)
3. "Child Abuse Legislation in the 1970's" (V.3)
4. "Child Abuse: Attempts to Solve the Problem by Reporting Laws" (V.4)
5. "The Child Abuse Prevention and Treatment Act of 1974"(V.5)
6. Child Abuse: Maryland State Child Maltreatment Law (V.6)
7. Child Neglect: Maryland State Child Maltreatment Law (V.7)
8. "Defining Emotional Neglect" (V.8)
9. "Preparing for a Neglect Proceeding: A Guide for the Social Worker" (V.9)
10. "The Problem of the Battered Child" (V.10)
11. "Child Abuse Syndrome: A Review" (V.11)
12. Instructional Materials for Units I, II, III, and IV
13. Classroom learning center for child maltreatment

CLASSROOM INSTRUCTIONAL MATERIALS

for

VI. Child Maltreatment: Help and Hope

1. Indicators of Child Maltreatment, Montgomery County Health Department (VI.1)
2. Child Abuse/Neglect Information, Montgomery County Health Department (VI.2)
3. "A Policy Statement on Child Abuse and Child Neglect"; "More About Project PROTECTION" (VI.3)
4. "Protect a Child Help a Parent, Our Community Responsibility" (VI.4)
5. Montgomery County Services for Maltreated Children and Their Families (VI.5)
6. "Even Parents Sometimes Lose Control" (VI.6)
7. "C.A.L.M.--A Timely Experiment in the Prevention of Child Abuse" (VI.7)
8. "Parental Stress Service--How It All Began" (VI.8)
9. "The Extended Family Center" (VI.9)
10. "Working With Abusive Parents, A Social Worker's View" (VI.10)
11. "Working With Abusive Parents, A Psychiatrist's View" (VI.11)
12. "Working With Abusive Parents, A Parent's View" (VI.12)
13. "Child Neglect: Reaching the Parent" (VI.13)
14. "Why Most Physicians Don't Want To Get Involved in Child Abuse Cases and What To Do About It" (VI.14)
15. "Understanding and Helping Child-Abusing Parents" (VI.15)
16. "Project PROTECTION: A School Program to Detect and Prevent Child Abuse and Neglect" (VI.16)

17. "Child Abuse: Detection and Prevention" (VI.17)

18. "Battered Children and Counselor Responsibility" (VI.18)

19. "Preventing Child Abuse" (VI.19)

20. "The Abused Parent of the Abused Child" (VI.20)

21. "The Rights of Children" (VI.21)

22. Instructional Materials for Units I, II, III, IV, and V

23. Classroom learning center for child maltreatment

Film

Don't Give Up On Me Produced for the Metropolitan Area Protective Service and the Illinois Department of Children and Family Services for use in case workers awareness training. This film uses real people in real situations to probe the reasons behind the child abuse pattern. A mother of two small children is in danger of having her daughter taken by the court, and the assigned social worker struggles to have the distraught mother come to grips with her problem.

Motorola Teleprograms, Inc. 1976 16mm color 28½ min.

Available from HELP Resource Project
1123 North Eutaw Street
Baltimore, Maryland 21201

APPENDIX C

Definition of Terms by Unit

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TERMINOLOGY

The definition of terms forms an important part of the curriculum instruction. In the development of this curriculum, special effort has been made in the selection of terminology.

The effort here has been 1) to select the exact term to communicate the intended meaning; 2) to select only those terms found in a widely used dictionary readily available to students; and 3) to make certain that the definition of the term as found in the dictionary and the meaning of the term as used throughout the document are consistent.

The definitions are quoted (with one exception) from Webster's New Collegiate Dictionary (1974 edition); hence, some may be brief; some may be lengthy. Teachers should use the definitions as points of reference to synthesize the intent and meaning of the terms as used.

For each unit, the definitions are listed in the order of instructional use.

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I. THE PHENOMENON OF CHILD MALTREATMENT

*DEFINITION OF TERMS (I.1)

	Term		Definition
1.	Phenomenon	n.	- 3.b. an exceptional, unusual, or abnormal person, thing, or occurence
2.	Maltreat Maltreatment	vt. n.	- to treat cruelly or roughly
3.	Syndrome	n	- a group of signs and symptoms that occur together and characterize a particular abnormality
4.	Radiological	adj.	- of or pertaining to the use of radiology (X-ray)
5.	Pathological Pathology	adj. n	- 2: altered or caused by disease 2 a: anatomic and physiologic deviations from the normal that constitute disease or characterize a particular disease
6.	Dysfunction	n	- impaired or abnormal functioning

* Webster's New Collegiate Dictionary. Springfield, Massachusetts: S & C Merriam Co.

THE NATURE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (II.1)

	Term	Part	Definition
1.	Physical	adj.	- 3: of or relating to the body
2.	Psychological	adj.	- 1: b: MENTAL
3.	Abuse	vt.	- 1: to attack in words 4: to use so as to injure or damage
	Abuse	n.	- 4: abusive language 5: physical maltreatment
4.	Neglect	vt.	- 1: to give little attention or respect to: DISREGARD 2: to leave undone or unattended to especially through carelessness
5.	Damage	n.	- 1: loss or harm resulting from injury to the person SYN: injury
6.	Injure	vt.	- 1a: to inflict bodily harm b: to impair the soundness of
7.	Paramour	n.	- an illicit lover

*Webster's New Collegiate Dictionary, 1974.

THE EPISODE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (III.1a)

1.	Potential	adj.	- 1: existing in possibility: capable of development into actuality
2.	Vulnerable	adj.	- 1: capable of being physically wounded 2: open to attack or damage
3.	Stress	n.	- 1: constraining force or influence: as c: a physical, chemical, or emotional factor that causes bodily or mental tension d: a state resulting from stress
4.	Positive	adj.	- 6a: marked by or indicating acceptance, approval, or affirmation b: affirming the present of that sought or suspected to be present
5.	Negative	adj.	- 1a: marked by denial, prohibition, or refusal 2b: marked by features (as hostility or withdrawal) opposing constructive treatment or development
6.	Passive	adj.	- 3a: receiving or enduring without resistance: SUBMISSIVE
7.	Punitive	adj.	- 1: inflicting, involving, or aiming at punishment
8.	Authoritarian	adj.	- 1: relating to or favoring blind submission to authority
9.	Psychopathic personality	n.	- 1: an emotionally and behaviorally disordered state characterized by clear perception of reality except for the individual's social and moral obligations and often by the pursuit of immediate personal gratification in criminal acts, drug addiction, or sexual perversion

* Webster's New Collegiate Dictionary, 1974.

10.	Psychoneurosis (Psychoneurotic) adj.	n.	- 1: a neurosis based on emotional conflict in which an impulse that has been blocked seeks expression in a disguised response or symptom
11.	Nurturance	n.	- affectionate care and attention
	Nurture	n.	- 1: TRAINING, UPBRINGING 3: the sum of the influence modifying the expression of the genetic potentialities of an organism. (See Interpretations of the Nurturing Experience (III.1b).

* Webster's New Collegiate Dictionary, 1974.

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THE EPISODE OF CHILD MALTREATMENT

INTERPRETATIONS OF THE NURTURING EXPERIENCE (III.1b)

".....the process in which an adult takes care of an infant; that is, a theoretically mature capable, self-sufficient person caring for a helpless, needy, dependent, immature individual...Mothering consists of feeding, holding, clothing, and cleaning the infant...along with the more subtle ingredients of tenderness, of awareness and consideration of the needs and desires of the infant and of appropriate emotional interaction with it."

".....the deep, sensitive, intuitive awareness of and response to the infant's condition and needs, as well as consideration of the infant's capacity to perform according to his age."

From "A Psychiatric Study of Parents Who Abuse Infants and Small Children" by Brandt F. Steele and Carl B. Pollock in The Battered Child, edited by Ray E. Helfer and C. Henry Kempe. Chicago: The University of Chicago Press (1974).

".....intimacy, empathy, trust and 'mothering', used in the generic sense of mother-father parenting. Intimacy as the positive outgrowth of a willingness to risk a sharing of onesself with another is seen as an expression of a bond of affection and closeness between 'parent and child'--Intimacy is the emotional touching that leads to affectional fulfillment in an interpersonal relationship. It is the foundation stone to family harmony."

From "Parent Surrogate Roles: A Dynamic Concept in Understanding and Treating Abusive Parents" by Morris J. Paulson and Anne Chaleff in Journal of Clinical Child Psychology, Vol. II (3) Fall 1973.

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

*Definition of Terms (IV.1)

	Term		Definition
1.	Physical	adj.	- 3a: of or relating to the body b: concerned or preoccupied with the body and its needs
2.	Psychological	adj.	- 2: directed toward the will or toward the mind
**3.	Dynamics	n.	- 2: the driving physical, moral, or intellectual forces of any area or the laws relating to them
4.	Psychodynamics Psychodynamic	n. adj.	- the psychology of mental or emotional forces or processes developing esp. in early childhood and their effects of behavior and mental states 2: explanation or interpretation (as of behavior or mental states) in terms of mental or emotional forces or processes 3: motivational forces acting esp. at the unconscious level
5.	Personality	n.	- 3a) the complex of characteristics that distinguishes an individual b(1): the totality of an individual's behavioral and emotional tendencies (2): the organization of the individual's distinguishing character traits, attitudes, or habits
6.	Interaction	n.	- a mutual or reciprocal action or influence
7.	Psychodynamic interaction	n.	- a (re)action in response to an influence (past or present), an event (past or present), or a person (past or present)
8.	Conscious reaction	n.	- reactions which are marked by thought, will, or design
9.	Unconscious reaction	n.	- reactions which are not known or perceived; unaware

* Webster's New Collegiate Dictionary, 1974

** Webster's Seventh Collegiate Dictionary, 1966

*DEFINITION OF TERMS (V.1)

Circumstantial	adj.	- 1: belonging to, consisting in, or dependent upon circumstances
Incidental	adj.	- occurring merely by chance or without intention or calculation
Intentional	adj.	- 1: done by intention or design

* Webster's New Collegiate Dictionary, 1974.

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APPENDIX D

Classroom Learning Center for Child Maltreatment

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CLASSROOM LEARNING CENTER FOR CHILD MALTREATMENT

In lieu of a suitable textbook, a classroom learning center for child maltreatment is suggested to supplement the classroom instruction. A variety of magazines, pamphlets, and article reprints for such a center may be obtained free or at low cost. Because effort, time, and money are involved in assembling the materials, teachers and students should develop a plan for use of the center which would insure availability of the materials for subsequent classes. All prices quoted were current as of spring, 1976.

Other resources appropriate to the study of child maltreatment which have been approved for classroom use may be added to the center.

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CLASSROOM LEARNING CENTER FOR CHILD MALTREATMENT

• The American Humane Association, Children's Division, P. O. Box 1266, Denver, Colorado 80201. Pamphlets are ordered by number indicated and title.

8. Emotional Neglect of Children (1958) 10¢
9. Let's Get Technical: The Why and What of Child Protective Services (n.d.) 10¢
18. Protective Services and Community Expectations (n.d.) 15¢
20. Protective Services and Emotional Neglect (n.d.) 15¢
21. Protecting the Battered Child (1962) 35¢
34. In the Interest of Children, A Century of Progress (n.d.) 35¢
42. Child Abuse Legislation in the 1970's, rev. ed (1974) $2.50
43. The Status of Child Protection (1971) 35¢
44. Termination of Parental Rights (1971) 35¢
45. Due Process in Child Protective Proceedings (1971) 35¢
46. A National Symposium on Child Abuse (1972) $1.00
47. Plain Talk About Child Abuse (1972) 35¢
48. Second National Symposium on Child Abuse (1972) $1.00
49. Speaking Out for Child Protection (1973) 50¢
50. Fourth National Symposium on Child Abuse (1975) $1.00

• American Psychological Association. Journal of Clinical Child Psychology. 2(Fall 1973). $2.50 Suite 208 Meramec Bldg., 111 S. Meramec Avenue, St. Louis, Missouri 63105

• Blue Cross Association. Stress. Blue Print for Health 25(1974) Free. 840 North Lake Shore Drive, Chicago, Illinois 60611

. Irwin, Theodore. To Combat Child Abuse and Neglect. Public Affairs Pamphlet 381 Park Avenue, South, New York 10016 35¢

. Maryland, State of. Department of Employment and Social Services, Social Services Administration. Incidents of Suspected Child Abuse in Maryland, 1972. Free.

. Maryland, State of. Department of Employment and Social Services, Social Services Administration. Incidents of Suspected Child Abuse in Maryland, 1973. Free.

. Montgomery County Public Schools. Proceedings: Project PROTECTION Child Abuse and Neglect Conference and Workshop, September 1974. Free.

. Montgomery County Services for Maltreated Children and Their Families. Project PROTECTION November 3, 1975.

. Mutch, David. "Rescuing Abused and Neglected Children." A series of five articles. Christian Science Monitor October 21-25, 1974.

. Report of the U.S. Department of Health, Education, and Welfare to the President and Congress of the United States on the Implementation of Public Law 93-247, The Child Abuse Prevention and Treatment Act. August 1975.

. Child Abuse and Neglect: The Problem and Its Management. Vol 1 An Overview of the Problem (OHD) 75-30073 $1.50; Vol 2 The Roles and Responsibilities of Professionals (OHD) 75-30074 $1.90; Vol 3 The Community Team, An Approach to Case Management and Prevention (OHD) 75-30075 $2.60

. The Diagnostic Process and Treatment Programs by Ray E. Helfer (OHD) 75-69.

. Working with Abusive Parents, From a Psychiatric Point of View by Brandt F. Steele (OHD) 75-70.

APPENDIX E

Speakers and Information Resources

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SPEAKERS AND INFORMATION RESOURCES

Montgomery County

Community Coordinated Child Care Council
301 E. Jefferson Street
Rockville, Maryland 20850
279-1773

Department of Social Services
Protective Service Unit
5630 Fishers Lane
Rockville, Maryland 20852
279-1758

Montgomery County Child Protection Team
301 E. Jefferson Street
Rockville, Maryland 20850
279-1512

Office of Human Resources
Child Protection Services
301 E. Jefferson Street
Rockville, Maryland 20850
279-1512

Maryland

Metro Area

Children's Hospital
National Medical Center
2125 13th Street, NW
Washington, D. C. 20009

Georgetown University Speakers Bureau
3800 Reservoir Road, NW
Washington, D. C. 20007
625-4151

National

American Humane Association
Children's Division
P. O. Box 1266
Denver, Colorado 80201

Child Welfare League of America, Inc.
67 Irving Place
New York, New York 10003

National Center for Child Abuse and Neglect
Office of Child Development
P. O. Box 1182
Washington, D. C. 20013

National Center for the Prevention and Treatment of Child Abuse and Neglect

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APPENDIX F

Sexual Molestation of Children

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TO THE TEACHER

Because the psychodynamics are different and more complex, sexual molestation of children is not included in this curriculum. Sexual abuse, however, is a part of the definition of child maltreatment according to State law. (See p.285.) Teachers should therefore be informed. Two references are included here for informational purposes. Teachers are urged to refer to the items noted in the Selected Articles and the Annotated Bibliography for more in-depth understanding of the topic.

SEXUAL MOLESTATION OF CHILDREN

The Last Frontier in Child Abuse

Children Today 5(May-June 1975)

by Suzanne M. Sgroi

Any member of the "helping professions" who is searching for an effective method to make himself unpopular with his peer group can probably achieve that goal by frequent involvement in cases such as those described above. The professional who becomes sufficiently concerned and knowledgeable about sexual abuse of children to be consistently alert to the possibility that sexual molestation *may* have occurred will often face a spectrum of reactions from his colleagues that range from incredulity to frank hostility. For although the pioneering efforts of many distinguished professionals and dedicated lay people over the past decade have made child abuse a national issue, the problem of sexual molestation of children remains a taboo topic in many areas.

This is not to argue that the problem of child abuse has been "solved" any-

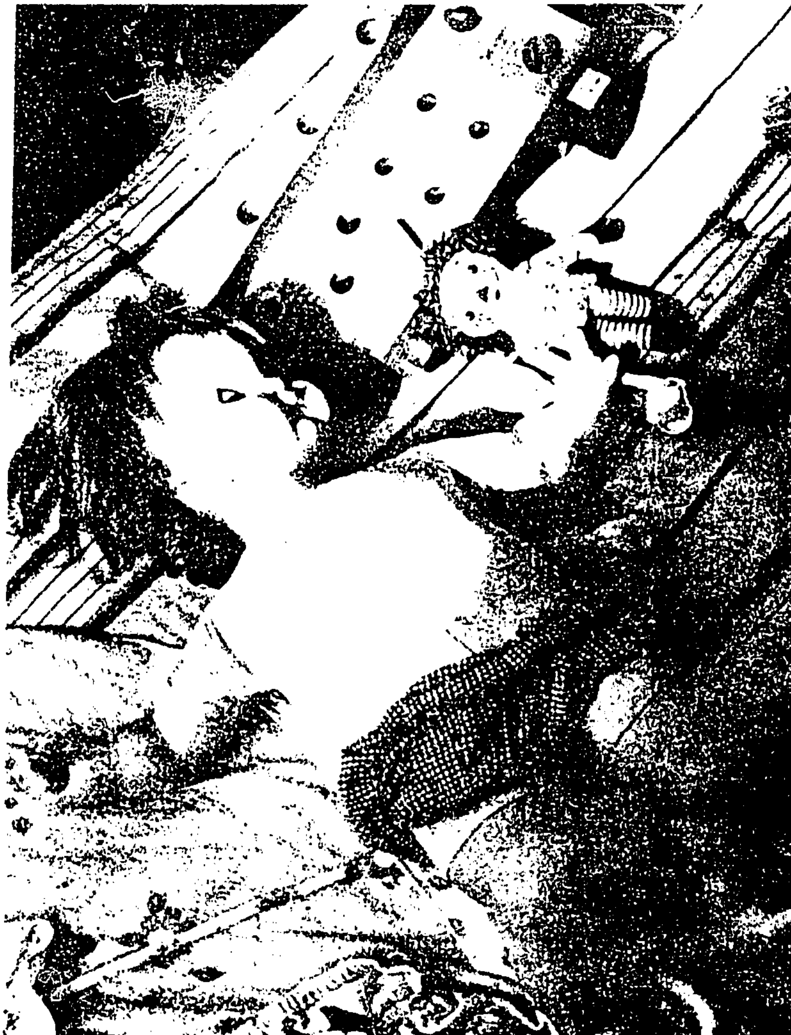
Incidence of Molestation

No one knows the true incidence of child molestation in the United States today. Vincent DeFrancis, director of the Children's Division of the American Humane Association, conducted a comprehensive 3-year study of child molestation in New York City that was reported in 1969.[1] His estimate of approximately 3,000 cases each year in New York City alone is probably conservative. Considering the widespread reluctance to recognize and report this condition, it must be assumed that the reported incidents represent a small fraction of the cases.

Nevertheless, the reporting of suspected sexual abuse of children is encompassed in the child abuse reporting statutes of many states. Recent strengthening of these statutes and the establishment of child abuse hotlines has markedly increased the reporting of all forms of child maltreatment. In

1973), which involves a $500 fine for mandated reporters who fail to report suspected child abuse, resulted in 1,957 reported cases in fiscal year 1974—an increase of nearly 200 percent over the preceding fiscal year. A breakdown of the total by reporting source is shown in Table I below.

The opening of the Care-Line, a 24-hour statewide toll-free child abuse prevention and information line, probably had a significant impact since it facilitated the reporting process for many professionals and private citizens who called to express concern about children. The Connecticut Child Welfare Association (CCWA), a private statewide citizens' organization which operates the Care-Line, has also conducted a continuing education effort aimed at both the general public and the professional groups who have been required to report cases of suspected child abuse since 1971. Connecticut's



nursery school teacher noted that Judy, Jerry's 4-year-old sister, consistently refused to take her turn riding a rocking horse during playtime. When asked why, she replied "It hurts." A careful examination by the school's pediatrician that same day revealed the presence of sperm in Judy's vagina. An immediate joint police-Protective Services investigation of the family revealed that Jerry's and Judy's father had a long history of previous incidents of child-molesting although none had ever been proved. Their mother admitted she was aware that both children had been sexually assaulted by their father on numerous occasions.

Case No. 3: Stephanie, at age 17 months, was brought to a hospital emergency room by her mother who had noticed blood in the baby's diaper after she returned home from work. On examination, the child was found to have a small anal fissure that bled freely when touched. There was no previous history of abnormality or trauma and the mother was reassured that the fissure could be easily corrected surgically if it did not heal by itself. Several weeks later, Stephanie was found dead in her crib—a victim of asphyxiation. An autopsy revealed the presence of semen in her mouth and throat. When apprehended, the babysitter, a 19-year-old boy, freely admitted to sexual abuse of the child but protested "I didn't mean to kill her!"

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into their mandatory training program for all newly-hired police officers in 166 of the state's 169 towns. These child abuse training sessions were initiated in 1972 as part of the CCWA Child Advocacy Project and have been conducted by Association staff at 6-week intervals ever since. In October 1973 the two groups jointly sponsored and taught three one-day seminars on child abuse which were attended by higher ranking police officers from all over the state. It is therefore not surprising that the percentage of reports of suspected child abuse by police officers increased markedly in F.Y. 1974, while reports by hospitals decreased proportionately and those by private physicians remained at the same low level—five percent.

It is noteworthy that during this same reporting period, the total number of reports of suspected sexual abuse of children in Connecticut increased, while the proportion of such reports to total child abuse reporting statistics declined slightly. Table 2, below, shows a breakdown of sexual abuse by type of report.

In fiscal years 1973 and 1974 in Connecticut, the relationship of the perpetrator to the child in all cases of suspected abuse was that of a parent or a parent-substitute in 80 percent of the cases. This complements DeFrancis' finding that parents were involved in the sexual molestation of children in 72 percent of the cases studied—either by perpetration of the offense (25 percent) or else by acts of omission named perpetrator in cases of sexual abuse is the father or a male relative or boyfriend—virtually always someone who has ready access to the child in his or her home. Ages of victims may range from early infancy (one to two months) all the way to 17 or 18 years.

Recognizing Sexual Abuse

Why is sexual molestation of children the last frontier in child abuse? And what are the major obstacles to identifying the sexually abused child?

In practical terms, the answers are lack of recognition of the phenomenon, failure to obtain adequate medical corroboration of the event, and reluctance to report. If one accepts the premise that it is impossible to protect the child victim of sexual molestation unless we know that he exists, these obstacles take on major importance. Each is rooted in ignorance and taboo and must be considered accordingly.

Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist. Unfortunately, willingness to consider the diagnosis of suspected child sexual molestation frequently seems to vary in inverse proportion to the individual's level of training. That is, the more advanced the training of some, the less willing they are to suspect molestation.

The lack of preparation and willingness of many physicians to assist patients with sexual problems in general is a child, these deficiencies are extremely serious.

If the victim of alleged sexual assault is a child, a complete physical examination with careful attention to any other signs of physical abuse or neglect must accompany the routinized perineal examination and laboratory tests. The examination is not complete unless the child is carefully scrutinized for evidence of oral and/or anal penetration as well as genital sexual contact. This includes inspection for trauma as well as laboratory tests for the presence of semen and venereal disease.

Unfortunately, all too few health professionals are trained to look for or to recognize the signs of rectal and urogenital gonorrhea infections in young children. This not only requires a high index of suspicion but again an inherent willingness to entertain the diagnosis of acquired venereal disease in a child. With the exception of congenital syphilis and gonococcal eye infection in newborns, the presence of a gonorrhea or syphilis infection in a child makes it imperative that sexual molestation be suspected unless or until it is ruled out by a careful joint medical and protective services investigation. The U.S. Public Health Service, which operates the National Communicable Disease Center in Atlanta, Georgia, has recently cautioned that "with gonococcal infection in children, the possibility of child abuse must be considered!" [3]

Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist.

and welcomed by a child victim who is old enough to worry that he or she may have been harmed by the assault. For example, the examiner may find numerous opportunities to assure the child that all is well, that no harm has occurred or else that any injury incurred can be alleviated.

It is well to avoid repeated questioning of the child about circumstances relating to the incident of sexual abuse at any time. Such questioning is particularly to be avoided during the physical examination. Since repeated examinations may indeed be traumatic, the first should be comprehensive enough to preclude the necessity for further examinations if the child's condition does not require them.

Preventing a recurrence of sexual abuse should be a twin therapeutic goal along with preventing and alleviating any psychological damage incurred by the sexually molested child. Each of these goals should have equal priority. The therapist who counsels against a comprehensive and compassionate examination of the child in a case of suspected sexual assault (including, of course, a physical examination) effectively circumvents an adequate Protective Services investigation of the case. It is a known fact that

risks must be carefully weighed in selecting what the authors of *Beyond the Best Interest of the Child* term "the least detrimental alternative."[1]

Regardless of the consequences, it would be unusual in any state for a child to be removed permanently from his parents to protect him from sexual abuse if corroborating medical evidence were not presented to verify that sexual molestation of that child had already occurred within the family. To put it another way, the future protection of a child victim of sexual assault is virtually impossible without a carefully recorded examination by a knowledgeable physician.

Reporting Sexual Abuse

Failure to report to the statutory authority is the last major obstacle to identifying the sexually abused child. Sexual abuse of a minor is a reportable condition in every state in the United States. Such a report is the triggering mechanism for a Protective Services investigation of the child and his family—thereby providing a conduit for professional help and community resources to strengthen and improve the home situation or, occasionally, to remove a child from an untenably dangerous environment. Nevertheless, sex-

voluntary compliance (which may cease at any time), such reasoning is fallacious. A far more appropriate course for the private help source who discovers the abuse is to report immediately and request to "service" the case in cooperation with the statutory authority. In most cases, cooperation with the frequently superior resources of the private source of help will be eagerly welcomed by the public agency. The result: a higher level of service available to the family as well as increased protection for the child.

For too long health professionals have skirted the issue of reporting suspected sexual molestation when an unmistakable diagnosis of acquired venereal disease has been made in a child. We have been content to do contact investigation within the family circle and to treat other family members—parents, aunts and uncles, older siblings, etc.—for venereal disease without asking why or how a 6-year-old boy acquired a gonorrheal urethritis or a 3-year-old girl contracted pelvic infection with gonococci. Because of reluctance to entertain the possibility of sexual molestation of a child by an adult, we have often postulated modes of transmission of venereal disease to children within

sharing a report of venereal disease in a child with the statutory agency mandated to investigate suspected child abuse. Connecticut is the first state in the United States to clarify this issue in its child abuse reporting statute. According to the Connecticut law, all reports of acquired venereal disease in children under 13 years of age must be reported to Protective Services as well as to the State Health Department. In this way a simultaneous Protective Services investigation of the family may, if necessary, initiate steps to protect the child from further sexual molestation while public health authorities do contact investigation and treatment to prevent further transmission of the disease.

Identifying Abused Children

Since we cannot help the sexually abused child and his family unless we know they exist, how then can the major obstacles to identification detailed in this article be overcome? The key role of the physician in obtaining adequate medical corroboration of sexual abuse has not been minimized. Nevertheless, any concerned individual, especially when professionally involved with some aspect of child care, can do much to enhance recognition and reporting of this phenomenon.

First, since this is a phenomenon that thrives and proliferates in darkness, we need to open windows and doors and promote open public discussion of the topic. Increased public awareness is best stimulated by people who care enough to snatch every opportunity to arouse society's consciousness of the child victim of sexual abuse. Only then will the public sanction so vital to identifying and assisting these children be forthcoming.

Instead of wasting time during a crisis situation in helpless frustration with medical personnel who are uncooperative or unknowledgeable in this area, those who are concerned should identify and establish a relationship with reliable sources of medical help in advance. Knowledgeable and receptive physicians and health professionals in the community should be sought out so that ways to improve medical services to child victims of sexual assault can be jointly explored. Emergency rooms or private practitioners who do the most effective and sensitive job should be identified, encouraged and patronized. The services of new demonstration programs in this area should also be identified and sought.

Connecticut has recently received funding from the Children's Bureau, OCD to establish a Child Abuse and Neglect Demonstration Center that will enable a multidisciplinary consortium of agencies to work cooperatively toward diagnosis and treatment of families where child abuse, neglect or sexual molestation is a danger. One of the center's charges will be to delineate a workable range of effective services for child protection. As a last resort, it may be necessary to utilize legal and judicial means to identify and enforce the basic minimum standard of medical services that the sexually abused child is entitled to receive.

Lastly, it behooves every professional who deals with children to be aware that sexual molestation exists, to recognize danger signals—especially in high-risk children—and to be knowledgeable about his or her state's reporting laws and sources of help. Sexual abuse of children is certainly not the problem of any single profession or segment of society. A strong united effort is required to push back the last frontier in child abuse and assist the sexually molested child. ■

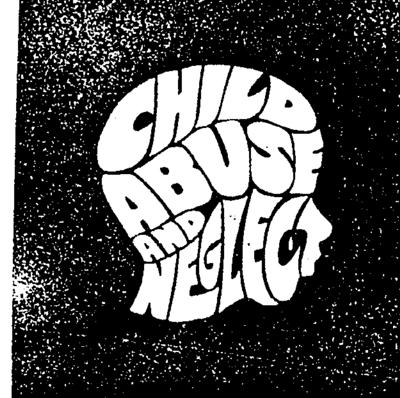
[1] *DeFrancis, Vincent*, "Protecting the Child Victim of Sex Crimes Committed by Adults." *Children's Division, American Humane Association, Denver, 1969.*

[2] *Ibid.*

[3] *"Gonorrhea: The Latest Word,"* Emergency Medicine. *Vol. 7, No. 2, February 1975, pp. 132-138.*

[4] *Goldstein, Joseph et al,* Beyond the Best Interest of the Child. *Macmillan Publishing Co., Inc., New York, 1973.*

A Series of Three Articles on:



April 14, 15, and 16, 1975

Battered Children: Innocent Victims of Recession's Stresses

By Michael Satchell
Washington Star Staff Writer

Cases increase with parents' frustrations

The signs, coast to coast, are ominous.

Case-hardened social workers in recession-wracked Detroit are stunned when five "very severe" cases of child battering, one of them fatal,

First of three articles

occur in the same vestpocket neighborhood on the Lower East Side in less than a month.

In Los Angeles, the number of children under 10 murdered by their parents or guardians suddenly dou-

Washington home. The father is unemployed.

All over the country, reported cases of child abuse and neglect are rising sharply and puzzled officials, searching for reasons why, are beginning to focus on the current economic condition as the culprit behind the upsurge. Children, in a sense, are becoming the innocent victims of the recession.

crease public awareness of the problem and to gather data about these incidents," said Frank Ferro, acting associate chief of the Children's Bureau at the HEW agency. "I have no doubt that there is a relationship between unemployment and the economic crisis and the increased incidence of child abuse and neglect. The question is, how do you deal with it?"

Child abuse and neglect is one of

"About all we can offer is the conventional wisdom," he said. "For every physical abuse case, there are anywhere from one to three neglect cases. For every abuse or neglect case reported, two or three go unreported, which means we are seeing only the tip of the iceberg.

"STUDIES DONE for us have estimated the child abuse and neglect rate at somewhere between 7.6 cases and 13.4 cases per thousand children. About the only firm thing we can say is that we know that two children die each day in America from battering, and even that figure may be low because the cause often is hidden."

Dr. Nina Scribanu, assistant professor of pediatrics at Georgetown University, observed: "This problem crosses economic lines, you find it in the nicest neighborhoods, and it happens as much in middle or upper class homes as in lower social levels. But the better-off families are better able to hide it, they take their children to private physicians for example, who often don't recognize cases of abuse. And even if they do, they don't report them for investigation."

Just as police departments around the country have tagged sharp increases in economic crimes

"For example, in Florida in 1970-71, there were just 17 reported cases of abuse. They conducted a massive public education campaign and the next year, there were over 19,000 cases reported, with 60 percent of them valid. Now they are up to 30,000 cases a year. Florida is a perfect example of how notoriously underreported this crime is."

In Wayne County, Mich. where Detroit is located, Sam Manzo, the supervisor of children and family services, listened to the predictions of massive layoffs in the auto industry and began preparing for the anticipated rise in child abuse cases. His caseload last year was 1,114, up from 932 in 1973.

"The recession hit particularly hard here," Manzo said. "And we've seen a corresponding rise in our incidents. Our social agencies involved in marriage and family counseling have been busier than ever trying to keep marriages hanging together. But marriages are beginning to disintegrate along with increases in child cruelty."

Washington is one of the few areas of the nation that has been largely shielded from the recession, feeling only the tremors of the massive unemployment afflicting other areas but suffering nevertheless from the inflationary squeeze.

476 cases of neglect but our abuse cases rose to 21. I can see no other social factors at work in society except tougher economic times. The children are simply becoming the victims of this recession.

"A lot of the cases we see are at the lower end of the social scale and the greater stress caused by the economic situation causes them to turn to increased use of alcohol and drugs. And when the money runs out more quickly and they can't pay for these things, they come home and frequently hit the kids.

"It is a very serious problem. When I first came into this field I didn't believe there could be so many cases. Now I feel we see only the tip of the iceberg."

MARYLAND'S total of reported cases of abuse and neglect leapt from 931 in 1973 to 1,251 last year. Virginia recently released a detailed breakdown of its total for 1974, which was up 61 percent over the previous year.

The state health department logged 426 cases, up from 264 in 1973, with 11 cases resulting in death. In 246 or 58 percent of the cases, the child had been physically or sexually abused. Neglect accounted for 158 cases and 25 more were logged as having un-

Parents Anonymous, a Los Angeles-based organization of parents who have abused their children, but who are making an attempt to break out of the cycle, much like members of Alcoholics Anonymous. Mrs. K. uses only the initial of her surname to preserve her own anonymity and as an example to parents who wish to join the organization.

Based on information from many of her chapters located to date in 33 states, Mrs. K. thinks the current child abuse situation is "explosive."

"There's been a noticeable increase that we feel is tied directly to the economic situation," she said. "Joblessness means there are more people staying at home all day because they are out of work.

"The cost of living goes up, inflation soars, the issue becomes more loaded, and stress mounts within the family. Maybe the man loses his job and he feels that he no longer fulfills his breadwinner role. It's a great blow to his ego. He becomes tense, the whole thing builds and builds and suddenly he strikes out — at the children. It's just like striking a match to an explosive situation."

Mrs. K. noted that in Los Angeles, the doubled murder rate of children had been accompanied by a sharp increase in child abuse and neglect cases, from 1,897 incidents investigated by the L.A. Police Department in 1973 to 2,183 last year.

Georgetown's Dr. Scribanu, in analyzing the trend, stressed that the current state of the economy was not, in itself, the cause of escalating child abuse.

"You can't say that people beat their children because they are out of work," the Romanian-born pediatrician said. "Hard economic times won't themselves produce child beaters. We know that there are specific components that come into play in child abuse cases and one of the main ones is stress.

"You can see then how the economic situation will have quite a bearing on this element. People who are out of work, who are on the brink of bankruptcy, are in crisis and if the potential is there, it is often the last drop in the bucket."

One of the frustrations in dealing with child abuse is trying to identify potential child beaters and prevent the incidents. While some progress has been made toward this end, it still isn't known what drives one mother to hold her infant's head underwater or burn its tender flesh with a cigarette when the baby cries, and another mother to respond with tenderness and soothing words.

What is clear in every case is that the offending parent needs psychiatric help. The nation's courts generally respond in this way when parents are brought up on neglect or abuse charges. Only in the most severe cases of child battering are parents sent to jail.

IF AN INCIDENT isn't too severe, say a simple neglect case, a judge at the preliminary hearing often will allow the child to be returned home under close supervision by a social worker.

But in more serious neglect cases, and invariably in those in which a youngster has been hurt in any way, judges immediately whisk the children out of the homes and into foster care setting. Parents are often ordered to undergo intense psychiatric counseling, sometimes in tandem with group therapy involving other battering parents.

If good progress is made, a child victim will be eased slowly back into the home under close supervision, although there is no guarantee that the child won't be back in the emergency room a week later because psychiatrists and social workers aren't infallible.

That a child will be returned to the home and be beaten again is the kind of mistake that keeps those in the child abuse field awake nights. Experts say such recurrances happen with some regularity.

Another tragedy of the whole unfortunate syndrome is the fact that child abuse is a crime that breeds within itself. One of the few common threads running through many child abuse cases is that the parent who beats his or her child half to death was the victim of similar treatment as a child. And that may be the most tragic aspect of all to this extraordinarily common but little-understood problem.

Tomorrow's Portfolio section: Child molesting.

Taboo: Sexual Abuse of Children

Second of three articles

By Michael Satchell
Washington Star Staff Writer

It has been characterized as the unspeakable subject, the unthinkable thought, the ultimate taboo. Sexual abuse of children remains one of the least understood, most ignored and universally feared warps in the social fabric.

Authorities stress that the problem pervades society at every social, professional and economic level. Recent offenders brought before local courts include a pastor, a fire captain, a professional boxer and even a policeman. Wide publicity was given to the case of singer Peter Yarrow who admitted guilt in a sex case involving a 14-year-old girl in a District hotel. Star football flanker Lance Rentzel is still on probation after pleading guilty in Texas to a charge of exposing himself to a 10-year-old girl.

LAST YEAR, District police investigated 371 cases of sexual abuse, molesting or exposing involving girls and boys under the age of 15 and they are confident that hundreds more cases were never reported. Suburban police departments, while not maintaining the same detailed statistical breakdowns on juvenile sex crimes as the District, report that the problem appears to be equally as common in their jurisdictions and recently there has been no better illustration than the search for the two missing Lyon girls in Montgomery County.

Captain Gabriel LaMastra, who is heading the search for the 11 and 13 year old daughters of a WMAL radio announcer missing since March 25, has virtually ruled out the possibility they ran away and has voiced strong suspicions that they may be the victims of a sex crime.

FAIRFAX COUNTY'S chief social work supervisor Julia Barton confirmed that the problem of juvenile sexual abuse occurs in "even the best" of families. Said Mrs. Barton: "We have had enough referrals from the courts and police to indicate that the incidence of incest is much higher than we realize. I couldn't give you a detailed breakdown but it occurs a lot more often than most us would like to admit. And it's an occurrence that strikes across all economic levels."

Because society abhors the subject, it also tends to ignore it. But it won't go away and those who have been fighting this head-in-the-sand attitude — sex squad officers, social workers, psychiatrists, physicians and other professionals — insist that the problem is far more widespread than people believe, or want to believe. The number of reported cases, they say, is but the tip of the iceberg.

THE LEGACY of this ostrich logic is that society is poorly equipped to both deal with the overall problem, and try to prevent it.

Research into curing or preventing pedophiles from violating children is skimpy. Because of rigid legal requirements, the crime usually goes unpunished.

And the extent of the problem nationwide simply isn't known. The FBI compiles annual crime totals of such things as stolen cars, burglaries, rapes or bank robberies, but has no idea how many children were victims of sexual attacks.

"We are in the stone age in this area," said Nan Huhn, an assistant D.C. corporation counsel in charge of the juvenile division. "You would be amazed at how much of this goes on, and at the cases we see. People just have no idea."

ONE OF THE FEW comprehensive attempts to study the problem was completed in 1969 by the Children's Division of the Denver-based American Humane Association. Among the major findings of the three-year, 250-case study were the following:

- The problem is one of unknown national dimensions but findings "strongly point to the probability of an enormous national incidence many times larger than the reported incidence of physical abuse of children."
- It happens in families of every race and at every social and economic level. In the majority of cases, there were serious inter-family problems such as drugs or alcohol, child neglect or abuse, a deteriorating marriage or relationship, or some combination of these.
- Victims have been subjected to every conceivable type of sexual attack or activity.
- Offenders were predominantly males between 17 and 68 years of

age who tended to victimize children of their own race. Victims ranged from infants on up with the median age being 11 years and at the ratio of 10 females to one male.

- In three out of four cases, the offender was known to the child or to the child's family.

Sexual abuse of their children is the crime that parent's fear most, and it's a rare mother or father who doesn't worry about some "dirty old man" dressed in a shabby raincoat and skulking in the bushes when the youngsters head for the park. But the finding that 75 percent of the offenders are known to the child or family belies this fear to an extent.

"It's a popular misconception, but the vast majority of our cases involve the paramour — the live-in boyfriend — or the stepfather, occasionally an uncle, a male babysitter or the natural father," said the District's Nan Huhn whose sense of outrage at the offenders is matched only by her zeal in getting the children out of the home and trying to prosecute their abusers.

SHE DETESTS sexual abusers of children and has a special contempt for what he calls "these strange, passive women" who conceal assaults on their children for various reasons.

"My hangup is with the mothers who often know, or should know what is going on," she said. " But they don't report it. I had one case recently where the mother had to know. She had seen semen on the child's bed, blood on her underwear and she had seen her daughter and her paramour in bed together.

"Then she claims she didn't know what was going on. We find this in many cases and I still have trouble understanding these mothers who allow it to continue or who won't do anything about it. I mean, they actually know it's happening."

Mrs. Huhn's experience was echoed by Lt. Robert Caldwell, head of the D.C. Police Department's sex squad, a cop who sees perhaps the seamiest side of the lowlife and who forces himself to forget it at 4 p.m. sharp.

Said Caldwell: "We often find the mother is more concerned about what will happen to her boyfriend or her husband when we arrest him than what effect it will have on her child. Now how do you come to grips with that?"

Sexual activity involving children runs a broad gamut from the stranger who simply exposes himself in front of youngsters (relatively harmless, say the experts), to the individual who uses a child for sexual gratification and accompanies the assault with a beating, often if the child resists or threatens to tell.

"The children rarely resist," said Frank Mussell, an assistant corporation counsel who works in Mrs. Huhn's office."They are either too young to know what is happening, or too frightened if they do. Occasionally though, we do get a case where a child fights back although it's rare."

Mussell related with thinly disguised pleasure the case of one 13-year-old girl who took revenge on her mother's boyfriend after he had forced her into bed and was attempting to have intercourse. The girl managed to get away and returned with a butcher knife and stabbed the man in the genitals.

"After they stitched him up at the hospital, he was arrested and charged but was out on bail and back in the home the next day," Mussell recalled. "The mother was supposed to bring the child in to us but the kid ran away."

THOSE WHO DEAL with sex crime cases involving children see victims as young as 6 months, the infants incredibly subjected to attempted intercourse. Older victims, those approaching or reaching puberty, often have been used by their abusers for months or years without anyone finding out.

"The kid usually breaks when she decides she can't take it any longer," said Mrs. Huhn. "After two or three years of having to sleep with pappa, something snaps, and the kid often just runs away from home and the story comes out when she's picked up by the police.

"Sometimes, an older sister who has been used will finally blow the whistle when she sees a younger sister about to become a victim. And very often, the kids are simply too scared to tell their mother. They feel that momma won't believe them, so they keep quiet and take it."

A CIVIL HEARING is held within 24 hours of a reported offense and with only minimal proof of assault required, the judge usually orders the child into foster care. If the mother kicks her man out of the house, the child may be allowed home under close protective supervision.

Protecting the child by removing her — or him — from the home is legally easy. But criminal prosecutions are very difficult.

Frank Mussell explained: "First, the trauma of having to repeat what happened to police, to case workers, to prosecutors, to a grand jury and then in open court may be worse

than the effect of the assault itself," he said. "Then there's the problem of corroboration.The child is usually assaulted when there are no witnesses around.

"A 5-year-old girl may have a perforated hymen, for example, but how do you prove that it was through intercourse unless you get the child to the hospital immediately after it happened? How does a youngster that young explain what happened?

"Often, older kid[illegible] terribly embarrassed and ashamed of what happened that they won't talk about it and especially in open court. And sometimes, say in an oral sodomy case, there's no physical evidence, no bruises, no perforated hymen, nothing to prove the child was assaulted., How do you prosecute then?

"The result is that the crime goes unpunished."

Aware of this problem, a D.C. Medical Society group studying sexual assaults on children recommended last year that closed circuit television cameras be allowed in court so the victim could present testimony without the ordeal of facing the accused in open court, as the 6th Amendment to the Constitution requires.

So far, D.C. Courts have not acted on the Medical Society's recommendation.

Tommorow: a medical and psychiatric view.

The Veil Cloaking Child Abuse

Victims Treated, Not the Causes

By Michael Satchell
Washington Star Staff Writer

(Last of three articles)

Three years ago, a 42-year-old man charged with 14 counts of child molesting sat in the dock of a Denver, Colo. courtroom and sobbed to the judge: "Please help me. If you release me, I'll tell you I'll go right out and do it again because I can't help it."

He also testified that during his adult years he had molested somewhere between 400 and 500 little girls under the age of 12. The judge went ahead and agreed to the man's plea — not for mercy, but for permission to be castrated in the hopes of curbing his overwhelming compulsion.

THE DENVER castration case did not attract much public attention because it wasn't widely reported. But it created a furor among some psychiatrists and civil liberties groups who regarded the drastic and irreversible surgery as something akin to a barbaric leap backward into the Middle Ages.

To others it was one more example of the woeful lack of knowledge about what causes men, and occasionally women, to become sexual abusers or molesters of children, and of the dearth of methods to treat them. Most offenders end up behind bars which is about as effective a cure or deterrent as jailing drunks.

Reliable nationwide statistics aren't available. Many molestation incidents are not reported to the police because often, a child will not tell a parent. Parents who do learn that their child has been a victim often hush it up for fear of causing further emotional damage. In some homes, it's kept quiet because a relative or a live-in boyfriend may be involved.

Despite the absence of reliable statistics, most experts concerned with the problem feel that sexual abuse and molestation of children is far more deeply rooted and pervasive than most people realize, with anyone's child a potential victim and offenders coming from every walk of life or social and economic level.

PEDOPHILIA can be the compulsion of rich and poor, black and white, yet because of the distasteful nature of the problem, medical and psychiatric research into its prevention and cure have been minimal with most of the [illegible] ust aimed at treating the victims rather than preventing the crime in the first place.

"It's incredibly difficult to get research funds because everybody shies away from it," said Dr. John Money, a medical psychologist at Johns Hopkins

Hospital in Baltimore. "Everyone's afraid of burning their fingers and even the government is extremely reluctant to give money for this kind of research. The result is that treatment programs are negligible."

A spokesman for the U.S. Department of Health, Education and Welfare was unable to provide a list of federal grants for research into the problem because of statistical limitations, but a survey by The Washington Star indicates that only a handful of research programs are currently underway nationwide, one of them being conducted by Dr. Money, a noted specialist on sex hormones.

Money's subjects, all volunteer referrals and most of them men who either expose themselves to children or non-violently molest them, are given weekly doses of an androgen-depleting hormone. The result is a sort of chemical castration, or in Money's view: "It gives the person a vacation from his sex drive."

The treatments are combined with intensive counseling sessions aimed at giving the off[illegible]der a "psychic realignment", channeling his sex drive into more acceptable behavior. So far, results have been promising, Money says, with about half his subjects being able to settle down to "normal" sex lives.

Because of the recent controversy over the use of prisoner-patients in medical experiments, particularly at the Patuxent Institution in Maryland, Money is forbidden to recruit inmate offenders for his research, a fact that annoys him intensely.

"THESE FANATICAL crackpots have made such a fuss of the ability of prisoners to give informed consent to participate in these research programs that I cannot use anyone who has been arrested or is in jail," Money c[illegible]ed. "With something [illegible]astic as brain surgery, you can understand the concern for a prisoner's civil rights but the pendulum has swung too far with the result that progress into understanding this, and many other problems, is severely hampered."

Researchers in other states do not share Money's handicap. At the Connecticut State prison in Somers, doctors are experimenting with a controversial type of aversion therapy similar to the treatment that the violence-loving Alex was forced to undergo in the movie "Clockwork Orange."

Hypnosis and electric shock punishments are employed as tools t[illegible] try and redirect the volunteer offender's sex drive. Simply stated, a homosexual child molester, for example, will be shown slides of nude young boys, along with slides of naked women in provocative poses. The boy pictures will be accompanied by a slight electric shock, the adult women pictures with encouragement to enjoy and remember them.

In Rahway, N.J., inmates at the state prison there go through intensive group therapy. About half of the offenders in the program were themselves victims of molesters and they are encouraged to relive their childhood sexual experiences in a sort of drastic emotional catharsis.

Doctors at California's Atascadero State Hospital, operating under the theory that most child molesters have led highly inadequate social and sexual lives, teach offenders how to talk to and relate to adults, even to the point of volunteer counselors from local gay organizations teaching homosexual offenders how to pick up adult partners.

And that, they say, is about it as far as research elsewhere goes.

At St. Elizabeth's Hospital here, Dr Eugene Stammeyer is studying 2[illegible]0 [illegible]ffender case histories, trying to p[illegible] the psychology of child molesters. He wants to learn the differences between them and adult rapists, between the molester who simply exposes himself or fondles a child to the more violent offender who attempts rape or other sexual acts with children.

"I can say from clinicial observation, that people who molest chidren tend to be older and they are basically a very passive group," Dr. Stammeyer said. "Those that commit any real brutality tend to be younger although those that accompany the act with brutality is very limited.

"Child mol[illegible]ers appear to be much more deviant psychologically and behaviorally than do adult rapists. One of the outstanding characteristics is that they tend to be very timid socially, to be very shy and withdrawn.

"Fondlers and exhibitionists may lead otherwise perfectly normal lives. But those who become more assaultive, who attempt intercourse with a child, tend to be very impulsive people. For them, it often doesn't make any difference whether their partner is an adult or a child and alcohol is often a factor in these assaults. They get drunk, their impulse control is taxed and they act out."

JOHNS HOPKINS' Dr. Money agrees with Dr. Stammeyer and he feels that the simple exhibitionist or the non-violent child molester really isn't the kind of monster that society fears him to be, although he will doubtless get a strong argument on that conclusion from many parents.

"Molesters and exhibitionists are really very ordinary human beings struggling with a compulsive problem," Money argued." Most of these people are very affectionate. They are

kind to kids and there's no cruelty involved.

"The exhibitionists get into trouble because they take their pants off, and there is no evidence that it harms children to see a man's penis. I'm not saying that there should be child molesters in the world, everybody would be much better off if there weren't any. But society has produced these stigmatized people by over-reacting."

While this "over-reaction" is understandable in a society that venerates the young and is often overly protective of childen in many ways, those who deal with the victims of sexual abuse say the psychic harm that results can be extremely damaging depending on the type and severity of the offense.

Dr. Annette Ficker is the staff pediatrician to the D.C. Children's Hospital child abuse team, and she sees the victims of pedophilia when they generally are at their worst — scared, dazed, confused and often physically injured when they are brought into the emergency room. It is, she said simply, a "very bad experience" for all concerned.

"Molesting or sexual abuse can be a very traumatic experience both physically and psychologically," Dr. Ficker said. "Physically it can be both [illegible]ing and very pain[illegible] boys as well as gi[illegible] But the physical w[illegible]s usually heal. I be[illegible] the worst damage is [illegible]ional."

[illegible] infant too young to [illegible]alize what is happening probably will not have lasting mental scars, Dr. Ficker and several other experts agree. But the older child faces a host of potential problems in trying to overcome the memory and heal the psychic wounds.

SOME CHILDREN sink into an abyss of depression. Some grow to fear and hate men and as they reach adulthood are unable to enjoy a satisfactory sexual relationship. For others the result is the opposite and the frigidity that gradually atrophies one victim's sexuality may become driven promiscuity in another.

The young victims often undergo behavioral changes. School grades may suffer. Relationships with other members of the family may change. Psychosomatic complaints sometimes result with the child being unable to sleep, or complaining constantly of headaches, abdominal pains or such problems.

"I think kids experience the same kind of stigma that a rape victim feels, but they are totally unable to handle it," said Jim Shannon, a Children's Hospital social worker who specializes in these cases. "And it's the exceptional family that can bring the kid out of this themselves. They need good psychiatric help to overcome the trauma."

Until the researchers come up with some sort of therapy or cure for those who molest or otherwise sexually abuse children, prevention will continue to be a strictly hit or miss proposition for it is the kind of crime that police can do little to prevent bearing in mind that studies show three out of four offenders are known to the child or the victim's family.

"You could put a thousand officers on each block and not prevent it," said Lt. Robert Caldwell, head of the D.C. Police Department sex squad. "Maybe if society doesn't keep ignoring this problem, we may start to make some progress toward solving it."

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