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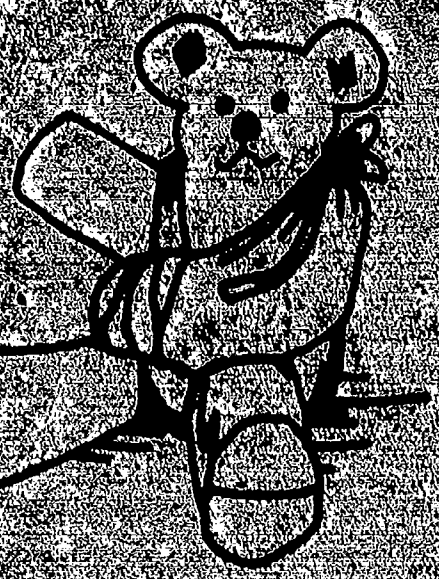
ABSTRACT

Proceedings of a workshop on the need to establish a close working relationship between the medical, legal, and social work professions in the management of child abuse is presented. An introduction by Frank Beal is followed by welcoming remarks by Pennsylvania Governor Milton Shapp. Speeches by Elizabeth Davoren, Eli Newberger, and Vincent DeFrancis address the role of the protective services worker, the physician, and the lawyer respectively. A workshop on the legal aspects of child abuse and neglect led by Judge Gilfert Mihalich discusses such issues as time constraints and cooperation with other agencies. The medical aspects of child abuse and neglect are considered by Dr. Joan Adler and Dr. John Reinhart. Criteria for suspecting child abuse and reasons for failure of reporting from private offices as well as an outline of the procedures followed at one children's hospital are among subjects considered. The workshop on the social services aspects of child abuse and neglect, led by James Delsordo, focuses on the Bucks County Model for assessing and managing situations of child abuse. A list of the participants is included. (PHR)

Child Abuse and Neglect



The Proceedings of AN INTERDISCIPLINARY WORKSHOP ON CHILD ABUSE

Sponsored by

Department of Public Welfare
Commonwealth of Pennsylvania

College of Medicine
The Pennsylvania State University

Young Lawyers Section
Pennsylvania Bar Association

U.S. Department of Health, Education and Welfare

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG, PENNSYLVANIA 17120

Dear Friend:

In April of 1977, the Bureau of Child Welfare in the Pennsylvania Department of Public Welfare, The Milton S. Hershey Medical Center, the Young Lawyers Section of the Pennsylvania Bar Association and Region III of the U. S. Department of Health, Education, and Welfare cosponsored a seminar on the need for establishing close working relationships among the medical, legal and social work professions in managing cases of child abuse. The featured speakers and workshop leaders, recognized as experts in their respective fields, provided valuable insight regarding the interdependence of these three professions in providing services to abused children and their parents.

Realizing the value of the material that was presented, the Bureau of Child Welfare made arrangements for the publication of the workshop proceedings so that others might benefit from the presentations. The attached publication contains the highlights of the workshops -- the major concerns, definition of problems and suggested solutions.

I wish to extend my sincere appreciation to all those who helped to make the conference a success and to the Public Welfare Department's Bureau of Public Education for editing this material and making all the arrangements for its publication. Additional copies are available from:

Publications Division
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313 Health & Welfare Bldg.
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Harrisburg, PA 17120

Sincerely yours,

Gordon Johnson, Director
Bureau of Child Welfare
Office of Children and Youth

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PREFACE

On April 12 and 13, 1977, an Interdisciplinary Workshop on Child Abuse and Neglect was held in Hershey, Pennsylvania. The workshop was made possible through the combined efforts of the Pennsylvania Department of Public Welfare, the Milton S. Hershey Medical Center of the Pennsylvania State University and the Young Lawyers Section of the Pennsylvania Bar Association. Partial financial support of the program was provided by the Regional Office of Child Development, U.S. Department of Health, Education, and Welfare.

The purpose of the workshop was to provide a forum through which physicians, lawyers and social workers involved in child abuse and neglect could exchange information, share progress and problems, and suggest more effective ways of carrying out their responsibilities under the Pennsylvania Child Protective Services Law (Act 124 of 1975). An essential aspect involved in effective implementation is interdisciplinary cooperation and communication.

The one-and-a-half day workshop combined presentations from representatives of the three professions and participant involvement in small group workshops.

This report is a compilation of the presentations and the workshop summaries.

AGENDA

Tuesday, April 12

7:30 a.m.	Registration
9:00 a.m.	Introduction Secretary of Welfare Frank S. Beal Welcoming Remarks Governor Milton J. Shapp
9:30 a.m.	Child Abuse & Neglect Role of Protective Services Worker Elizabeth Davoren, A.M., ACSW Role of the Physician Eli H. Newberger, M.D. Role of the Lawyer Vincent DeFrancis, J.D.
12:30 p.m.	Lunch
1:30 p.m.	Topic Workshop Session I Child Protective Services Law, Act 124 Medical Aspects of Child Abuse and Neglect Legal Aspects of Child Abuse and Neglect Social Service Aspects of Child Abuse and Neglect
3:00 p.m.	Break
3:30 p.m.	Topic Workshop Session II Same as Session I
5:00 p.m.	Reception for Invited Speakers

Wednesday, April 13

8:30 a.m.	Topic Workshop Session III Same as Session I
10:00 a.m.	Break
10:30 a.m.	Topic Workshop Session IV Same as Session I
NOON	Concluding Remarks Joseph E. Gallagher, Esq.
1:00 p.m.	Adjournment

INTRODUCTION

Frank S. Beal

I want to welcome each and every one of you, on behalf of the Department of Public Welfare, to this Child Abuse and Neglect Workshop. I want to thank formally the Bureau of Child Welfare of the Department, the Milton S. Hershey Medical Center of the Pennsylvania State University, and the Young Lawyers Section of the Pennsylvania Bar Association for being co-sponsors of this workshop. I want to also extend a welcome and thanks to the speakers, workshop leaders and all people participating in the workshops that will be meeting today.

A little over three years ago in October 1973 Governor Shapp convened Pennsylvania's first statewide Governor's Conference on the Rights of Children. Many of you who are here today participated in that event and helped to shape the recommendations for action.

One of the major issues explored at that conference was child abuse and neglect. Concern was expressed by featured speakers, panelists and participants about the ineffectiveness of the existing reporting system and the lack of resources to help eliminate abusive behavior on the part of parents and guardians.

Two specific recommendations were made as part of the plan of action resulting from the 1973 conference:

1) The establishment of a central registry for child abuse complaints in Pennsylvania and participation in the development of a National Clearinghouse on Child Abuse and Neglect.
2) The development of a special poster for display in hospital emergency rooms to alert medical personnel to the signs of child abuse and to whom it should be reported.

Conferences are often criticized for their rhetorical emphasis. We all know of reports and recommendations made as the result of such meetings which lead to no action beyond taking up space on some agency's bookshelves.

So it is with special pride that I believe we can point to the actions that have taken place since the 1973 conference.

Not only have the two specific recommendations I just cited been implemented, but a comprehensive statewide reporting system is now in place, an intensive public education campaign has been implemented over the past year, and an array of special programs and services have been developed at the local level through child welfare agencies, hospitals, community groups and other concerned organizations.

I think Pennsylvania can be proud of the programs and services that are now in place and to those that are in process of being developed to insure that children are protected from abuse and to help eliminate abusive behavior.

The success of our program is due to many people, some of whom have devoted their entire lives to creating a nurturing and protective environment for children.

We have been fortunate in this state to have leadership in the General Assembly. Through the dedicated efforts of Senator Michael O'Pake and members of the Committee on Aging and Youth and the interest of many other senators and representatives, the Child Protective Service Act of 1975 provided legislative authority for Pennsylvania programs.

And we have been fortunate to have the support of a person who has steadfastly fought for the rights of all people in this Commonwealth.

At the 1973 conference, as keynote speaker, Governor Shapp said: "I do not see these sessions as an end in themselves, but rather the genesis of a healthy rebirth of interest in the development of programs so that each child may be able to develop his or her maximum potential."

It is largely due to his support, commitment and concern for Pennsylvania's children that that rebirth has become a reality.

It is my pleasure to introduce to you Governor Milton J. Shapp.

WELCOMING REMARKS – GOVERNOR MILTON J. SHAPP

"Ladies and gentlemen, welcome to this workshop on child abuse. In the next day and a half you will be hearing from physicians, attorneys and social workers – all experts in the field of child abuse, a sad topic that is finally receiving effective action.

"This topic deals with the relationship between the basic social unit of our society - the family - and the state. In 1973, I sponsored a statewide Conference on the Rights of Children. This was considered to be a "first", and I am pleased to say it led to some changes.

"On November 26, 1975, I signed the Child Protective Services Law which provided a uniform definition of child abuse and required that suspected cases be reported by physicians, law enforcement officials and other persons whose jobs bring them into contact with children.

"This bill required the appointment of a guardian for the child, provided new rules for taking a child into protective custody, and modified the rules of evidence for child abuse hearings.

"As to be expected, the passage of legislation in this area touched off a good deal of controversy. I vetoed an earlier bill because it did not satisfy the needs of both children and families. The bill I finally signed was revised five times before it passed.

"The law most likely requires further change. We have received reports of children being taken from their parents without justifiable cause. This was not the intent of the law. The intent was to protect the rights of children, but without denying parents their rights.

"One of the purposes of this workshop is to get your comments on the apparent weaknesses of the law and your suggestions and recommendations for possible amendments.

"This legislation was followed in March, 1976, by the opening of a 24-hour, toll-free, child abuse prevention hotline, operated by the Department of Public Welfare's Office of Children and Youth. This ChildLine also serves as a central register for compiling annual statistics and research data on child abuse for state and national use.

"Reporting of child abuse alone is not enough. We must have in place a system of services able to protect the child and to rehabilitate the family. The counties, with assistance from the department, are in the final stages of developing child protective service units within their child welfare agencies. We expect to spend $16 million a year on providing these services once the county programs are fully operational.

"From these efforts, you may be sure that prevention of child abuse has been and continues to be a high priority item in my administration. I hope that the training sessions arranged today and tomorrow by our Bureau of Child Welfare will carefully evaluate what we have done so far in this field and what remains to be done.

"Child abuse is an ugly topic. Beating and spurning our children goes against the natural order of things – the natural love, affection and care of parents for their children. It takes no unusual stretch of the imagination to understand that a society that turns on its children is a society that will not last.

"I am not suggesting that American society has been reduced to this. On the contrary, the strength of our nation continues to endure because, for the most part, we are historically a people willing to work and sacrifice so that our children can achieve the best in life. But we are a complex, modern society, in which individuals are subjected to varying emotional strains. These strains, whether they originate from the loss of a job, the inability of parents to get along, a feeling of alienation or whatever; too often are manifested in physical or mental brutality towards those least likely to defend themselves – children.

"This is a fact of life. We cannot ignore it. We cannot pretend child abuse does not exist. Children are human beings with very definable rights. When they are abused through some failure in their family's abilities to raise them, they are entitled to some form of recourse. Government and the various social agencies must step into the breach of a family's distress to provide aid, comfort and protection to those in need.

"I think it important to note that pinpointing cases of child abuse and resolving adverse situations benefit not only the children, but often their parents or guardians. Our ChildLine, for example, has at least a double use. A neighbor or bystander can use it to report a potential or actual abuse case. Or a parent or guardian, torn by urges to lash out at his or her child, can use the phone and be cooled down by a professional on the other end of the line.

"When we initiated the ChildLine, we also launched a statewide campaign to encourage the reporting of suspected child abuse cases. The result has been a substantial increase in cases reported. In 1974, more than 2,000 cases were reported. From November 26, 1975, through December 31, 1976, nearly 6,500 instances of child abuse were reported.

"This increase substantiated what we have suspected for a number of years, which is, unfortunately, that child abuse is a common occurrence. In fact, child abuse ranks number two as the cause of death of children under two. We certainly face an extremely grave situation.

"I suspect that the number of cases will continue to increase as our reporting techniques improve. This means we will have a true appraisal of the extent of the problem. The next stage – and here much work remains to be done – is to improve the speed of investigating alleged cases of child abuse and our effectiveness in dealing with these cases.

"Child abuse is widespread. All of us involved in its prevention are aware of that. Many Pennsylvania citizens are also aware of the problem through our recent efforts at publicizing child abuse. Yet, I am sure the great majority of our citizens still regard child abuse as a remote problem that has little or no bearing on their lives.

"If this is so, then people are under a misapprehension which we should remove. It is a fact that more than 80 percent of all crimes are committed by persons under 25 years of age. Further, if we look into the backgrounds of these young offenders, we will find that many of them were deprived or suffered some sort of abuse, neglect or health-retardation problem.

"Therefore pinpointing a case of child abuse, defending that child and providing protection are actions that benefit not only that particular child, but society at large.

"Child abuse is everybody's problem. The sooner we get that message across, the better.

"As I said at the beginning of my remarks, we have made progress in recent years in focusing on the problems of child abuse and formulating courses of action. We have a new Child Protective Services Law, a toll-free ChildLine and we are funding legal representation for the victims of child abuse through the Governor's Justice Commission.

"But we have only uncovered the tip of the iceberg. Much remains to be done and I would hope in these two days of training sessions we are able to improve upon and devise further methods to deal successfully with child abuse.

"In particular, I would like to see some concrete recommendations on strengthening our current child protective services law.

"Thank you."

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THE ROLE OF THE PROTECTIVE SERVICES WORKER

Elizabeth Davoren, AM, ACSW

HISTORY

The first battered children of record in America were children who had been indentured either by their parents, so that they could learn a trade, or by officials when their parents could not care for them because of death or other reasons.

These children were considered servants when they were old enough to work, but their masters were also their caretakers and had parental responsibilities.

Children and Youth in America (Volume 1), published by the Harvard University Press, contains a number of documents detailing the abuse that some indentured children suffered. For example, a 12-year-old boy named John Walker died in Plymouth in 1655. The description of the damage to his body, which rivals the worst physical abuse cases coming to our attention today, leaves no doubt that John died of inflicted injury. The master, found guilty of manslaughter by a jury of 12 men, was "burned in the hand" and his possessions were taken away.

Richard Parker of Salem, Mass. fared somewhat better. In 1680 it is recorded that although the court supported the right of Richard's master, Phillip Fowler, to correct Richard, they cautioned Mr. Fowler not to hang the boy up by his heels like a beast of slaughter.

The much mentioned Mary Ellen Wilson was also an indentured child. In 1866, at 1½ years of age, she was indentured to a couple named Connolly. Eight years later a neighbor on her death bed said she could not die happy without telling someone about the cruel treatment of the child by Mrs. Connolly.

The situation was brought to the attention of Henry Bergh, founder of the Society of Prevention of Cruelty to Animals. As a private citizen he petitioned the court for Mary Ellen's protection from the extreme neglect and abuse she was experiencing. Mrs. Connolly, whom Mary Ellen had called "mama" according to her testimony, was sent to prison for a year at hard labor, and Mary Ellen was sent to an institution called, "The Sheltering Arms."

On April 14, 1874, a full account of the trial appeared in the New York Times. The attention to this case resulted in the formation of the Society for the Prevention of Cruelty to Children (SPCC) in New York in 1875.

Earlier child rescue seemed more concerned with protecting adults from children than protecting children from adults. The Orphan Society of Philadelphia was founded in 1814 "to rescue from ignorance, idleness and vice unprotected and helpless children."

Roaming bands of boys in the streets of Boston and other major cities, orphaned during the Civil War and thought to be dangerous, prompted institutions such as the New England Home for Little Wanderers to find homes for them, usually in the midwest, where labor was needed on farms.

With the founding of the SPCC, the focus changed to protecting children from physical abuse, sexual exploitation, economic exploitation and various forms of neglect. There was concern with punishment of the responsible adult as well. About 250 SPCC's were formed over a period of 25 years, based on the New York model. Some societies were devoted exclusively to children, and some were linked with the SPCA.

Periodic concern about combining animal and child protection was noted such as the following, written in 1924:

"The state bureaus in Colorado, Minnesota, Montana, Washington, Wyoming and the Wisconsin State Agent combined child protection with that of animals. In most cases the emphasis was on animal protection. From 1920 to 1922, the Colorado Bureau, which had stated as its policy not to expand either branch of work to the detriment of the other, handled cases involving 1,118 children and 5,183 animals."

At the turn of the century, reluctance to remove children from their own homes was expressed. In a 1910 report, the Pennsylvania SPCC was quoted as sharing "the modern economic thought that the normal condition of the child is in the home, even though the home be a poor one; the children often help their parents to reform, and the father and mother can in many cases be made to realize and feel . . . that upon them is the burden of responsibility to see that their children do not become in any sense a charge upon the community."

In addition to wanting to leave children in their own homes, the protection societies began to question the police powers they had been given to remove children from their families and place them in reformatories or charitable institutions. In 1914 the Secretary of the Pennsylvania SPCC, at a conference of the American Humane Association (AHA) said, "This thing we are doing is, after all, the job of the public authorities. **The public ought to protect all citizens, including children, from cruelty and improper care.** As speedily as conditions permit, we should turn over to the public the things we are at present doing."

The advantages of state administration were considered to be many, including such specifics as: the state would have more money, more prestige and power, would be able to develop more uniform practice statewide and would cover children in rural areas, as well as in large cities. Pennsylvania, along with such other states as Minnesota, Alabama, and New York, began organizing child protection along county lines.

I have focused on earlier history because it is interesting to see how much progress has been made in child care and the continuity of such ideas as keeping children in the home. The Social Security Act of 1935 had a profound effect on child care, but the depression years were not years for the advancement of child protective services. There simply wasn't any money.

In 1939 the following standards were suggested for Child Protective Service workers: they should have good judgment, tact, diplomacy, tolerance, sympathy, and a good education. In addition they should be able to command respect from official authorities, have personal integrity, and be specialists, i.e., not go out on animal protection calls.

In 1951 standards wers set for members of the American Humane Association Children's Division, which are still applicable today.

In 1960 protective services were defined as a function of welfare departments, no longer a service split between public and private agencies. Special emphasis was placed on the

non-punitive nature of this work with parents, but, at the same time, the need for agencies to have authority to remove children was stressed.

About this time, hospital social workers and physicians became more involved in the act of protecting children.

The American Humane Association Children's Division published the results of a two-year study of Child Protective Services. Considerable expansion of Child Protective Services had taken place since their former study ten years earlier, but it was concluded there was still a long way to go to establish a protective service program adequate in size and quality to meet the needs of abused and neglected children. Gaps in services were being met, the study said, by law enforcement agencies such as police and juvenile court. If law enforcement agencies take over child protective services functions they would negate the philosophy of a helping, non-punitive approach and create an unnecessary, drain on the judicial setting.

TREATMENT PROBLEMS AND SOLUTIONS

Public awareness is at an all time high, and there has been a dramatic increase in reports to child protective services. There is also a need for more protective service workers. If the number of workers does not increase, some reports will be ignored or, as the AHA study indicated, such reports will be diverted to other sources.

Joseph Garvin, executive director of the New York Council of Voluntary Child Care Agencies, at a public hearing in New York City, in early 1973, suggested that investigation of child abuse and neglect be switched to the District Attorney, his investigative staff and the police department. He said that increased reports and decreased staff of Child Protective Services had made them less available and perhaps less competent to do investigations.

Routine investigations of reports by law enforcement personnel has a price tag. We know that if we and the parents we identify believe that we are out to punish them, we are right back where we were 100 years ago, with outdated concepts of morality. If we see ourselves as agents of worthwhile change in family interaction, and families can see us that way, too, half the battle for good child protection has been won.

Treatment starts with the first contact — the first phone call, the first knock on the door of a reported family. It is my dream to have the Child Protective Service worker who sees the family first continue with the family until the case is closed. Most, if not all, of the parents we deal with in child abuse and neglect are fearful. They don't trust most other people. They are more leary than most of us of strangers. And they cannot relate to a complicated agency system. Yet most of the time we fail to respect their fears.

While we are building up a system to encourage identification and reporting and setting up a structure to deal with investigations and what follows, we easily overlook what this does to the people we are supposed to serve.

Setting up a system that forces parents being helped to make adaptations they are poorly equipped to make victimizes them even further than they already have been victimized by their own lives. The worker and the family alike are being set up for failure. Workers are frequently frantic to find treatment techniques to deal with clients they regard as unreachable without realizing that they are trying to work with their clients in a counter-therapeutic system. This is something the administrators need to take care of; they need to know what they can expect from their clients and what they cannot expect.

The major approach in this field is, and always will be, finding ways to safeguard the dignity of the parent we call child abuser or child neglecter.

There are many ways we should protect parents from the assault of our own held on their lives. I should like to address four of these assaults. One I have already described — our expectation that these parents can made adaptations which they are not capable of making.

The second involves the negative effect of name calling. I refer to not only the names "abuser" and "neglecter", which I believe we have to get rid of, but also to the diagnostic labels we use. Even the word 'neurotic' — in common usage — has turned into something unflattering to say about someone you don't like. Diagnostic terms such as "inadequate personality" and "impulse-ridden character", used by very competent caseworkers, describe clients in ways that make worker identification with the client most difficult. Some of these terms express thinly veiled hostility to our clients. They are also dead ends; they don't tell us where to go.

For example, rather than describing the client as "an inadequate personality" or "infantile", we can use for their distressing condition the term "overwhelmed." This word leads to questions to which we can find answers — overwhelmed by what? If we say to a client "you're overwhelmed", they are likely to say "you bet." If we call them infantile, they would probably like to punch us in the nose. When what we have to say about clients behind their backs can be written in their records for them to read and understand, more than half the battle is won — maybe the whole battle.

The third point has to do with anonymous calls. Most communities respect anonymous calls, which, although a valuable source of referral, do have built-in hazards.

1) The first hazard is that anonymity can induce in clients the feeling that they are surrounded by unknown enemies who are out to get them.
2) The second is that a lot of energy is used up by the client trying to figure out "who told" and by the worker in explaining they can't divulge the informant's identity.
3) The third and most important hazard is that if people who report don't want themselves identified, it seems logical to assume that they feel they are doing something "bad" to the client; in other words, such a beginning helps to set the tone that "something awful is happening here" rather than "we're out to do something that will benefit you."

The fourth and final point about how we can understand the parents with whom we work and protect their dignity has to do with the issue of power or control. Our clients frequently have very little control over their own lives. When we intervene, we threaten the little control they may have, specifically the control they have over their own children. If we are to help them change, we need to encourage them to take charge whenever possible, so that they will eventually be able to take better charge of their own lives. This may mean allowing them, or even helping them, to direct us. Such behavior can be threatening to the worker, who may end up feeling manipulated, overextended, and unimportant. "I'm just running errands; I want to do therapy" is the cry.

Workers need an understanding support system that lets them know they are not belittled when they serve their clients. The attitudes of administration and supervisory personnel are important here. We had a unique treatment agency in San Francisco for parents and their abused children, where the parents were on the agency board and had staff hiring and firing responsibilities. They read their own case records, or had them read to them if they couldn't read. They wrote in their own records, too. Fathers, who would not have dreamed of showing up for therapy groups, attended policy meetings and ended up discussing their personal problems with each other and staff in attendance. As patients or clients receiving treatment they would be helpless and too humiliated to discuss personal affairs. As policy makers they were important and could talk about anything.

MULTI-DISCIPLINARY TEAMS

Our professional decisions tend to be highly ego-invested. We put ourselves on the line, along with our decisions, and feel rejected when our recommendations are questioned or reversed without our agreement. I believe that this accounts for the difficulties that exist in many communities throughout the United States between protective service workers and multi-disciplinary teams established to evaluate cases. Workers, sometimes backed by their agencies, are reluctant to use teams, and teams are frustrated by the lack of request for their services or angered when their advice is ignored. Workers sometimes say it is impossible for them to use advice that runs counter to their own; mostly, they say the team is not helpful. I believe that team decisions should be binding, with the proviso that the entire team is responsible to help carry out decisions.

Structures for multi-disciplinary interaction are relatively easy to set up, but the capacity of the professionals to use the structures is limited. There are not enough who come in as learners -- with a genuine desire to understand and find out about other disciplines and their area of knowledge. We need to be sure enough of ourselves to be able to learn from others.

We need each others' skills and we need to learn how to trust each other just as our patients or clients are expected to learn to trust us.

TREATMENT APPROACHES

There are no short cuts or gimmicks for treatment in this field. But there are differing methods of approach. Here are some of my thoughts about the most frequently-used approaches.

1. **Groups** have become an extremely important method of working with parents -- as savers of professional time, for one, and as providers of a support system for parents, for another. Groups are most likely to continue when transportation is provided, at least at the beginning, and when there is much encouragement for each member to attend. Individual treatment, which often needs to precede any group attendance, should always be available.
2. **Transactional analysis** is popular with paraprofessional and untrained workers. It is a tool for understanding work with parents. However, the vocabulary to TA can serve as a barrier, rather than assist communication, if it is overused.
3. **Behavior Modification** has many facets that we don't have time to go into here. The reservations about this form of treatment stem from the fact that parents have often been overmanipulated and tend to overmanipulate their children, (See The Battered Child, Helfer and Kempe, eds, University of Chicago Press - 2nd edition, pp. 137-138). Although behavior modifiers would be unhappy to have their techniques described as manipulation, that's what they can become.
4. **Gestaldt Techniques** have intriguing possibilities but could impress the clients we serve as rather kooky if not very skillfully used.
5. **Meditation** has proven a useful adjunct to treatment because it is something the client controls. But it takes time to develop client use of meditation for the "kooky" reason mentioned above. Considerable help is needed if meditation is to become more than a superficial bit of behavior.
6. As for **social casework** skills, I think it would be helpful if supervisors could give ongoing classes on some of the crucial interactions; e.g.:
   a. The meaning of termination to workers and clients;
   b. Friendliness and decorum -- when to socialize and how;
   c. The use of authority as an adjunct to treatment -- avoidance of power abuse.
7. When we were working with extremely damaged children and their parents in Denver, before child abuse reporting laws had been enacted, the only approach that worked was one which would engage the parents voluntarily. We had to reach out aggressively with a service that would give parents something they wanted. We called it a **nurturing approach**. It can be called "modeling" or "reparenting." It is the basis for much of the treatment that is done now and I know works.

ISSUES NEEDING ATTENTION

The issues needing attention from the social work point of view are:

1. We need a sufficient number of able child protective service workers with:
   a. High degree of tolerance for ambiguity;
   b. Curiosity about how other people function;
   c. Flexibility and open-mindedness in dealing with others;
   d. Self-understanding, and a willingness to increase self-understanding;
   e. Self-acceptance that allows for sensitivity toward others;
   f. Capacity to make wise judgments and use appropriate help in doing so;
   g. A rewarding life apart from the job;
   h. Dedication;
   i. Imagination;

   There is more you could add to this list, but if we look for too much we might end up with no workers. Furthermore we need to think in terms of developing some of these characteristics and attitudes on the job.
2. Worker burnout is something about which a lot has been said and a lot more will be written. There are two things particularly pertinent to what we have been discussing today. First, we tend to expect ourselves to do the

impossible. Making decisions about the adequacy of parents and the safety of children is extremely taxing; we need the support not only of other professions but also the community in setting standards. Second, although worker burnout is a very real and rapid phenomenon in this field and preventive measures are needed, too much expectation of burnout will bring it about.

3. Human interaction is so complex that most theorists who want to accomplish something definitive in a lifetime end up studying little bits of behavior. In our field we must deal with the complex whole and try to theorize about it as we go along. This is a humbling experience. We need to take account of the difference between emotional intelligence and cognitive intelligence in more specific ways.
4. We need to be sure that we develop the kind of treatment that will not only provide ways of protecting children but also make those families identified as needing protection feel pleased that the identification was made.

THE MEDICAL ROLE IN THE MANAGEMENT OF CHILD ABUSE AND NEGLECT: REALITIES AND DILEMMAS

Eli H. Newberger, M.D.

The abuse and neglect of children is complex and disturbing. Many physicians and nurses find it difficult to approach this problem with the same logic and order with which they approach other complex child developmental and familial problems. The distress associated with thinking about child abuse can be expressed in denial; we may fail to consider the possibility of maltreatment and limit our activities to treating the child's injuries. And when we suspect child abuse or neglect, our uncertainty and worry about how to handle the family may lead us to ignore our legal responsibility to report the case findings to the mandated protective agency. If we report, we may assume that the buck is passed, and we are rid of continuing obligation to the child and his family.

In excellent child health practice, child abuse can be seen as a problem of distressed parenting behavior and as a symptom of family crisis. This view leads to a pediatric approach of continuing involvement and support of parents and child. Even after the diagnosis of suspected child abuse or neglect is made, there is no simple solution. Successful case management requires the coordinated efforts of professionals from several disciplines. Prevention of child abuse and neglect involves addressing cultural traditions, social values and economic realities which may exert a deleterious impact on a family's ability to protect its offspring.

What is Child Abuse?

In 1961, Kempe and his colleagues coined the term, the "battered child syndrome". They drew attention to the most severe form of child abuse. The physical injuries most frequently include fractures, soft tissue injuries, burns, hematomas, welts, internal injuries, bruises and contusions. One should be particularly alert to multiple injuries, a history of repeated injuries, and untreated old injuries. Physical abuse is felt by many authorities to be the most severe manifestation in a spectrum of disturbances involving a family's ability to nurture and protect a child, the special qualities of that child, and an environment which stresses the parent-child relationship.

In 1974, Congress passed the Child Abuse Prevention and Treatment Act, Public Law 93-247, which defines child abuse and neglect as "the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health and welfare is harmed or threatened thereby". The definition suggests that child abuse and neglect can take many forms.

Physical neglect defies exact definition but may include the failure to provide the child with the essentials of life, such as food, clothing, shelter, care and supervision, and protection from harm. Its manifestations may be seen in children with symptoms of malnutrition, "failure to thrive", and medical and dental neglect.

The maltreatment need not be willful, but this is not to say that a parent's anger, expressed actively or passively toward a child, is not primary in many child abuse and neglect cases. Abusing and neglecting parents may have excessive and premature expectations of their children and believe in the value of physical punishment to correct undesirable behavior. Often the angry feelings, of which the child's condition is a symptomatic expression, appear to derive from the violent circumstances or deprivation of the parent's own upbringing, and they may reflect a deep disappointment that the child has not been able to meet the parent's own dependency needs.

The goals in the diagnosis and management of child abuse and neglect include exploring possible causal factors, assessing the family's capacity to protect and nurture the child(ren), and identifying the appropriate helping services to strengthen the family's functioning.

In child abuse and neglect, the diagnostic assessment involves the taking of an adequate medical-social history and completing a physical examination, including an assessment of the child's development. If the physical findings are found to be at variance with the given history, a more comprehensive medical workup, including a skeletal survey and laboratory tests, may be deemed appropriate. If child abuse is suspected, photographs are often taken of the child's injuries. This is not always necessary, however, and may be contradicted if it will appear to the family as part of an interrogatory and alienating approach to their problems with their child.

The physician has the dual responsibility to give the necessary emergency treatment and protection to the child and to attend to the parent's distress. It is important to emphasize to the parent the child's need for treatment and protection, which may include his admission to a hospital, and to demonstrate a concern and ability to help the parent through the crisis. No direct or indirect attempt should be made to elicit a confession from the parent. Such maneuvers hamper the gathering of vital information and the fostering of a helpful professional relationship. Interviewing the parent can be a difficult and vexing task for medical personnel, who may be overwhelmed with angry feelings toward abusing and neglectful parents. It is important to keep in mind that these parents may themselves have been abused or neglected as children and may be following much the same pattern in rearing their own offspring.

Because of the complexity of abuse and neglect, and the need to address causal factors, professionals in several disciplines must work together to give the family services appropriate to their needs. Social workers and nurses play vital roles in evaluating the family's functioning, the parent-child interactions, the child's physical and psychological development, the parent's expectations of the child, the parent's own experiences in childhood, and the home environment. A psychiatric consultation may offer a clearer understanding of family dynamics.

This information is vital to answering the question: Is the home safe for the child? If the child is believed to be "at risk", protection through hospitalization may be vital for diagnostic assessment as well as for protective shelter; or temporary foster home placement may be arranged through a child protective agency.

In explaining his legal obligation to report suspected child abuse under the state law, the physician's compassion and

honesty will help to allay the parent's anxiety. The parent needs to know what specific actions will result from the physician's report to the child protective agency.

An accepted tenet of child abuse management tells professionals to be compassionate and to convey to parents their interest in helping to maintain the integrity of the family unit. On the other hand, child abuse reporting laws force us to make judgments about families which we and the family may feel are onerous and heavily value-laden. Additionally, the perceived effect of reporting is to bring to bear a quasi-legal mechanism which, while nonpunitive in theory, may be the opposite in practice. In some states, parents may be jailed as a result of the mandated case report.

Professionals may thus be torn between their legal responsibility to report and their clinical judgment which may suggest that reporting itself may jeopardize the opportunity to develop a satisfactory treatment program for the family. Often this conflict is expressed in reticence to inform families that they are being reported, or reluctance and even frank refusal to report cases of abuse and neglect.

While there are no clear-cut rules which resolve this conflict definitively, two simple guidelines make it easier for the mandated professional to come to terms with legal responsibility and clinical judgment:

1. The family must be told that a report is being filed. Much of the apprehension which may surround the receipt of this information can be alleviated by explaining to the family what the reporting process is and is not; it does not necessarily mean that the child will be taken away or that a court hearing will be held. The reporting process can best be presented to the family as a referral of the family for services, and an explicit acknowledgment that they have a serious problem in protecting their child, which others, including the reporting practitioner, can help to solve.
2. The mandated professional can explain to the family that the report represents an obligation that the practitioner is bound by law to fulfill.

Often, rather than reacting in a hostile manner, families will greet the news with relief. The reporting process may procure help which they have been seeking for a long time. They may be relieved that the concerns about their parenting abilities are finally out in the open where they can be dealt with in a straightforward manner.

While such an approach to child abuse reporting may palliate the anxiety of the professional and the family, it does not remove the real, inherent labeling and stigmatizing aspects of the reporting process as it exists in most of the states today. Unfortunately, this is a problem that cannot be alleviated simply by a revision of reporting itself; it is rather an aspect of our society's perception of child abuse and the abusing parent. So long as child abuse is viewed as a form of radically deviant behavior, and as a symptom of pathology and sickness in others, the stigmatizing process will continue.

All who are concerned with the prevention and treatment of child abuse have, therefore, a responsibility to demythologize the problem: to recognize that the potential to act in ways which we identify as deviant is in all of us. Until attitudes and policies change toward troubled families, whose children may bear physical signs of their distress, we shall have to work within the prevailing legal framework and to assure to the extent possible that children and families are helped not harmed by it.

All state statutes abrogate privileged communication when it involves a case of known or suspected child abuse. In reporting to mandated state agencies, the reporter should identify the facts as they are known; hearsay and secondary source information can be labeled as such. Most states have provisions in their statutes for central registers, which may become repositories for information both founded and unfounded, depending on the expungement provisions of the individual statutes. Who has access to this information is left up to the individual states, and it is well to remember that information that is submitted in such reports may be used at some later date to raise the issue of competency of a family or the risk to a child.

The principle on which most prevailing statutes are built is that services should be made available to families in which child abuse has been reported as a problem. It is incumbent upon the professional reporting a suspected case to continue involvement in the case to assure that appropriate help will be given and that the family will not "fall between the cracks" of the service structure.

A report of suspected child abuse or neglect is assigned to a protective agency worker for an investigation of the allegations, determination of the family's needs, and provision of appropriate services. The first issue to be settled is whether the child can safely remain in the parental home. The decision making involves answering the following questions: Are the child and family in need of protective services? Is there a need for immediate action? Should the child be placed in protective custody? Should the child be removed from the parental home? Is court involvement necessary?

If the initial investigation indicates a need for protecting the child, the investigating worker has three immediate alternatives, depending upon the severity of the case: the child can be hospitalized; the child can remain at home under protective supervision and with supportive services to the parents; or the child can be removed to an emergency shelter or other temporary facility. If the child's safety is in question and the parents refuse voluntary placement of the child, the case is frequently referred to the juvenile court.

In the past, the protective agency's activities often involved removing the child-victim from the hazardous home situation. The book, *Beyond The Best Interests Of The Child*, emphasizes the need for choosing the "least detrimental alternative" in decision making in child protection: this concept suggests that the impact on the child's development must be considered in any decision affecting his family. Studies have shown that foster home and institutional placements often result in long-term damaging effects on the children and their families. Therefore, a child should be separated from his family only after the evaluation of the family situation reveals the child's risk of reinjury is great and time is needed to activate the necessary supportive services for the troubled family.

There are divergent opinions regarding the hospitalizing of children whose conditions do not medically indicate admission. The American Academy of Pediatrics Committee on the Infant and Preschool Child advocates hospitalization as a means for providing the necessary time and resources for complete diagnostic evaluation; in addition, until a more thorough evaluation is made, the hospitalized child is protected. Every hospital should formulate a policy concerning the admission of suspected abuse or neglected children. Whatever policy is adopted, it should be coordinated

with the local child protective agency. Some state statutes allow physicians or hospital administrators to admit a child to a hospital without the parent's consent; this action requires a court order which may be obtained by telephone and justified on the next court day. However, if the parents are treated with sensitivity and honesty, most physicians should not find it difficult to convince the parents of the need to hospitalize their child.

Helping the abused or neglected child and his family requires the coordinated efforts of many professionals. A single situation may involve protective agency and hospital social workers, pediatricians, psychiatrist, psychologist, public health nurses, juvenile court judge, lawyers, and a number of other professionals. It is vitally important that medical personnel invest the necessary time and energy to assist the protective agency worker in working out a disposition plan for the child and his family.

The physician's responsibilities may involve attending several multi-disciplinary conferences; making requests for supportive services, e.g. day care, counseling, and homemaker services, and working with the parents to engender a relationship of confidence and trust, which will enable them to accept the recommended professional services. This takes time, patience, persistence and a capacity to deal with ambiguous data in situations of conflict and crisis. It is never easy.

The help and advice of consultants from various disciplines can be an invaluable asset to decision making. Nevertheless, the ultimate responsibility for the protection of the child and the rehabilitation of the family rests with the protective agency, or in some jurisdictions with the juvenile court. The medical professional must acknowledge that he or she must work with, but cannot control, the decisions or professional actions of child welfare colleagues. A supportive and gracious demeanor and responsive attitude can foster communication in the individual case and sustain relationships for future interdisciplinary work.

After investigating and evaluating the family, the protective agency worker's role is often that of facilitator. Once the needs of the family have been determined, the worker must locate the appropriate community resources (such as day care and mental health services) and prepare the family for referral to them. In order to help strengthen family life and prevent further maltreatment, the worker must have access to various counseling and concrete services designed to modify the specific psychological and environmental conditions that lead parents to abuse and neglect their children.

In handling abusive and neglectful situations, intervention is more effective if the dynamics of the abusive pattern are understood. It has been found that the parents themselves have experienced very traumatic experiences, frequently involving abuse or neglect, in childhood. In essence they may be rearing their own children in a similar fashion. Abusive parents often demand performance from their children that is clearly beyond the ability of the children and ignore the children's own needs, limited abilities and helplessness.

The children are often perceived as being different than siblings and other children; the abused children fail to respond in the expected manner or possibly are different, e.g., retarded or hyperactive. Crises, stemming from personal, social, economic and environmental stresses, play a crucial role in the life of the family and are often the precipitators of an abusive act.

There probably is no universal pattern underlying neglectful actions involving children. However, neglectful behavior appears to be a parental response to internal and external stresses; the parents are themselves often victims of misfortune.

Because of the parents' personality traits — immaturity, excessive dependence, distrustfulness, social isolation and poor self-esteem which are seen frequently in practice — and their failure to seek out or respond appropriately to offers of help, many professionals conclude that the abusive and neglectful parents are unmotivated and untreatable. Despite their initial resistance to professional intervention, it is recognized that a majority of the parents genuinely want assistance and can be helped to modify destructive child-rearing practices.

The sequelae of abusive and neglectful actions may result in immediate and long-term effects on the children's physical, neurological, cognitive and emotional functioning. Brandt Steele, Harold Martin, Henry Kempe and others have emphasized that abnormal child rearing experiences may predispose these children to act out their angry feelings in becoming abusive parents, or by committing anti-social acts, e.g., delinquency and adult crime, later in life. In the interest of helping these children in their subsequent growth and development, professionals can break the generational cycle of abuse and neglect.

Family rehabilitative services may include: medical and dental care; 24-hour comprehensive emergency services; public health nurse visitations; psychiatric care; individual or family counseling; group therapy; self-help group support; day care, crisis nursery or baby-sitting; family planning; homemaker service; parent aides; short- or long-term placement; financial assistance; job counseling and training; employment; advocacy for more adequate housing; and transportation.

Providing and coordinating the necessary services specific to each family is a function beyond the capability of any one professional, discipline or agency. However, the interdisciplinary nature of case management frequently proves to be a problem because of the lack of effective communication among the professionals. It is well to keep in mind Abraham Maslow's warning to the effect that if the only tool you have is a hammer, you treat every problem as if it were a nail.

Primary professionals involved in the management of child abuse and neglect are physicians and nurses, social workers, lawyers and judges.

All of the states have passed legislation requiring the reporting of suspected child abuse to public authorities. In the early statutes, physicians were given the primary responsibility to report suspected physical abuse to the protective service agency. The focus has since been broadened to include other child-caring professionals, but physicians in hospital and private practice settings continue to play the central role in identifying, diagnosing and reporting child abuse.

Early state child abuse legislation was viewed as a casefinding tool to identify abuse at the earliest possible time and as a means of strengthening child protective services. But if laws requiring protective services are to be effective, appropriations to support the expansion of these services are essential. Many services to children and families depend upon a combination of federal, state, and local appropriations. These appropriations currently lag far behind the level needed to create good service programs and staff them with the number and quality of personnel required to make the services effective.

If protective service agencies and workers are unable to respond adequately to reports of suspected abuse or neglect, they lose the confidence of physicians and other reporting professionals and of the troubled families. Families stop asking for help. Professionals stop filing reports except in the most blatant abuse cases. Early identification and intervention are lost.

The problem does not lie principally in the way protective services are conceived in the legislation. The gap is between what the programs are authorized by law to do and the appropriation of funds to carry out the programs. At each level — federal, state and local — appropriations fall short of recognized service needs. Until there is a commitment to a social policy that assumes responsibility for assuring every community adequate protective services, the needs of abused and neglected children and their families will not be met.

Frequently physicians have not had training and clinical experience in prevention and treatment of child abuse and neglect, in evaluating non-medical family problems and in planning appropriate long-range family rehabilitation with multi-disciplinary professionals. Not understanding the orientation and practice of social workers, lawyers, judges and members of other non-medical professions, physicians may be uncomfortable working in interdisciplinary management of abuse cases.

Child abuse imposes many stresses and strains upon medical personnel. Decision making is enhanced in hospital settings by written policy and procedural steps in handling suspected child abuse and neglect cases and by available consultative services.

Physicians in private practice may be at a disadvantage in working with these troubled families if they do not have easy access to consultants and to colleagues for emotional support. Physicians are reluctant to report abuse based on suspicions and may delay reporting until more substantial evidence is available. When reporting leads to court involvement, physicians often lack the skill and experience to present testimony in the best interests of the child and family.

When physicians do become involved in child abuse and neglect cases, they may become discouraged by the gaps in community resources. However, few physicians see themselves as agents for bringing about social change and avoid becoming involved in solving community problems.

By tradition, training and experience, child protection has been the responsibility of the social work profession. This specialized child welfare service is delegated by law to offer help to any child considered or found to be neglected, abused, or exploited. The protective agency has an obligation to explore, study and evaluate the facts of suspected abuse and neglect cases and to provide appropriate services until the family situation has been stabilized and the potential hazard to the physical or emotional well-being of the child is lessened or eliminated.

Too often the agency is prevented from fulfilling its role by ineffective programs, inadequately trained and limited staff, insufficient funding and a lack of essential community resources. It is a startling fact that no state has developed community child protective programs adequate in size to meet the service needs of all reported cases of abuse and neglect.

To cope with the acute and complex problems presented in child abuse and neglect cases, an effective child protective program must recognize the necessity for comprehensive staff development and sufficient staff to allow each worker a manageable caseload of approximately 20 to 25 active cases.

Although an important aspect of protective services involves the application of basic social work knowledge and skills, an interdisciplinary approach to case management is imperative. Cooperation and coordination between social work, medical and legal/judicial resources is vital.

Judicial proceedings may be necessary to provide care and protection for the child and modify parental behavior or circumstances affecting the welfare of the child. Too few provisions have been made to protect the legal and constitutional rights of the child and his parents.

Parents have the right to counsel in a suspected abuse or neglect proceeding. Of special concern is counsel for the child. Recently, provision for the appointment of a "guardian ad litem" to protect the child's interests have been made statutorily possible in some jurisdictions.

When court action is planned, the protective agency worker and other professionals qualifying as expert witnesses should have legal counsel readily available for advice and assistance in preparation of the facts and in presentation of testimony to the court. Unfortunately, because legal assistance is often lacking, professionals are reluctant to use the authority of the court as a community resource to rehabilitate the family. Instead, they reserve court involvement for family situations deemed hopeless after social service intervention and expect separation of the child from the family and punishment for the parents.

Identification, diagnosis and reporting of child abuse are critically important, but they cannot, by themselves, assure that children will be protected. These initial activities must be correlated with effective services to abused children and their families. Physicians should be aware that the protective service system has as its major function the coordination of acute care services.

When the roles of the professionals involved from the several disciplines are defined, a serious gap in services may be found: no professional or agency has assumed the responsibility for the provision and coordination of long-term therapeutic intervention. Health workers can become child advocates and prime movers for the development of multi-disciplinary child abuse and neglect programs within their communities.

While much of recent literature on child abuse and neglect has focused on clinical aspects of diagnosis, intervention and treatment, little attention has been given to the impact of the orientation of institutions, and the professionals who staff them, on clinical practice.

The actual incidence of child abuse and neglect continues to be debated with annual estimates cited from 200,000 to 4.5 million cases. A great number of the reported cases originate from hospital settings. However, pediatricians and other child health providers are aware of many cases of suspected abuse and neglect, which they do not report to the child protective agency.

The evolution of child health practice has contributed to the persistent denial of child abuse and neglect. Social and behavioral determinants of illness are still frequently ignored, and treatment modalities are often unknown or lacking. The result has been that children who present physical consequences of these complex causal processes are treated symptomatically.

Although it is quite unlikely that the conceptual and philosophical orientation of the practice of medicine will change dramatically overnight, there are, nonetheless, several

important and abiding realities of child abuse and neglect cases that are particularly noteworthy for health care professionals to consider during the diagnostic and treatment process.

First, **child abuse is a symptom of family dysfunction resulting from complex causal processes.** Frequently, physicians view child abuse and neglect cases in terms of the presenting symptomatology (e.g., fractures, bruises, burns, and failure to thrive) and give little attention to the underlying causes of family dysfunction.

Traditionally, the training of physicians and other health personnel has focused rather narrowly on the biological aspects of the etiology of disease and only recently has begun to acknowledge the importance of the environmental and social determinants of illness. The complexities of managing child abuse and neglect cases overwhelm many physicians. Access to a competent, multi-disciplinary team can both expedite getting help for the victims and their families and provide valuable support and consultation to the physicians.

Second, **child abuse and neglect occur in all cultural, social and economic strata of society.** When the professional staff is socially, culturally and economically discrepant from the patient population, there is the danger that behavior may be interpreted in a culturally biased fashion; that strengths in families may be seen as weaknesses, or that a child's illness may be characterized by a more value-laden diagnostic label than would happen in a similar situation involving a child from the same social background as the professional staff (e.g., "child abuse" vs. "accident" or "neglect" vs. "failure to thrive").

Third, **child abuse cases arouse overwhelming emotional reactions which may interfere with the objectivity and sound judgment of the involved professionals.** Often the professionals are not consciously aware of these aroused feelings. The accessibility for consultation of others who are not directly involved in the management of a particular case but who are sensitive and competent to deal with both technical and human aspects of case management provides the professionals with a mechanism for dealing with these feelings and not permitting them to surface in a way which might be detrimental to the management of the case.

Fourth, **the initial assessment in child abuse and neglect cases frequently is oriented toward the diagnosis of adult psychopathology.** The physician's orientation to abuse and neglect situations is to search for psychopathology in the suspected perpetrators. Several studies demonstrate a small percentage of abusive adults to be seriously mentally ill. A more productive approach would be to concentrate on the family's potential to respond to helpful services. Successful intervention builds on the family's strengths and uses community resources to enhance the family's functioning.

Fifth, **child abuse and neglect are not monolithic entities.** Child abuse and neglect are complex problems with medical, social, psychological and legal components. After the diagnostic assessment is completed, there are no simple solutions or cures. Therefore, the outcome in case management cannot be predicted with certainty. However, it is recognized that many abusive and neglectful parents genuinely want professional help to become more nurturing, protecting parents and to stabilize their family situations. A compassionate and understanding response from the helping professionals is essential to the parents' coming to terms with their problems and responsibilities in protecting their offspring.

Sixth, **in child abuse and neglect situations, family rehabilitation usually requires prolonged involvement.** These situations can be especially distressing for professionals who are accustomed to an efficient diagnostic and treatment process: defining the etiology of the illness; operating on its causes, either with drug therapy or surgical intervention; and finally waiting a short period of time for the therapeutic outcome. Child abuse and neglect cases almost never follow this pattern, although the rewards of successful treatment can be no less gratifying.

Seventh, **the door to the physician's office, or to the entrance to the hospital emergency room, is perceived by many people as the only portal of entry into the human service system.** At a time when the availability of services and resources to assist families with life crises is diminishing, and as social and economic stresses seem ever more to be threatening the integrity of the family unit, it is little wonder that medical personnel are hearing cries for help from patients and their parents. Isolated families may have nowhere else to turn.

If we are not sufficiently cognizant to this new role which has been thrust upon us, we may force parents to package their problems in ways that they know will demand attention. All too frequently, we can look retrospectively in the medical chart of a child who has been identified as abused or neglected only to find that his parents have brought him in frequently in the past complaining of vague or undetectable symptoms. One can only speculate about the number of such cases that might have been prevented had time been taken to find out why the family sought help at that time.

Eighth, **the severity of a child's presenting symptoms may bear no relationship to the prospect for the successful management of his family's problems.** The symptoms with which the child presents are not always an accurate reflection of the nature and extent of family dysfunction. In fact, chronicity may be a more important factor in estimating prognosis: long-term patterns of behavior may have lasting and profound implications for both the child and the family. Here again, the importance of the early recognition of family distress is underscored.

Lastly, **child abuse and neglect cases necessarily bring health professionals in contact with other disciplines whose professional orientation, training and skills, and methods of practice may be unfamiliar.** Medical personnel must respect and acknowledge any opinions and orientations of those in other professions whose actions and recommendations are formed by different underlying principles and assumptions. Coordinated interdisciplinary management is essential to successful intervention in child abuse.

It is unlikely that child abuse and neglect can be eradicated without changes in attitudes and priorities in society. The acceptance of violence in our culture is undoubtedly a factor in the complex causality of child abuse. Poverty and unemployment play important primary roles.

There are definite actions that physicians and other health professionals can take toward the goal of prevention. The identification of abusive or neglectful families generally occurs when the child is brought for treatment of an injury or condition. Awareness of the indicators of maltreatment, e.g., the differential diagnoses between childhood accidents and physical abuse, should lead not only to reporting of suspected abuse, but to "reaching out" to the troubled families to prevent repeated incidents of abuse or neglect.

Any professional who has contact with parents and

parents-to-be must be sensitive to their knowledge of child growth and development, preparedness to cope with the role and responsibility of parenthood, and problems that may influence their ability to handle their children. Personality factors that may influence the parents' ability to nurture and protect their children may include immaturity, excessive dependence, aggressiveness, alcohol and other drug abuse, emotional instability and mental disturbance.

Several studies indicate a significant number of maltreated children were low-birth weight infants. The traditional hospital practice which separates mothers and infants can thwart the parents' development of positive feelings for the children. The "special" children — premature, handicapped, multiple-birth, unhealthy, unplanned and unwanted — seem from available data to run a higher risk of maltreatment than "normal" children. Preventive efforts can include the provision of educational and supportive services to the families who have "special" children.

In many abusive and neglecting families, crises are frequent, and isolation limits parents' ways of coping with stress. Services and facilities to "reach out" and help vulnerable families should be available in the community. If parents are aware that such services — 24-hour hotlines, self-help groups, crisis nurseries/day-care, emergency shelters, and family crisis centers — are available to any family in need, they may refer themselves before their children become the unwitting victims of their frustration and anger.

Poverty is recognized as an aggravating influence to families with the potential to maltreat their children. The environmental and social stresses are more serious and the opportunities for occasional relief from child caring responsibilities are fewer. It is possible for a concerned professional community to make the delivery of services to the victims of poverty less chaotic, more reliable, more supportive to personal dignity and self-esteem, and thus, more protective to children. We can work, furthermore, for the development of social policies which make for more equitable access to the goods and resources of society.

Prevention of abuse and neglect requires the support of family life. During regular office or clinic visits, the physician can ask the parents gently probing questions: Are you having any particular problems with your children? When there are problems, do you have someone to help you? Do you share the responsibility of child care? How do you feel about your children? What were your experiences in childhood. Is there something which I or someone else can do to help? Sympathetic questioning will show concern for the parents and help detect problems that the parents might not otherwise reveal. With knowledge of the family's problems and needs, and with the basis of an excellent professional relationship, an effective referral can be made for appropriate community services.

Parents' abilities to nurture and protect their children can be fostered by an effective health care system and by other services and programs which support family life and help people manage personal crises more effectively. Health professionals can, by stimulating coordinated action, help make the community a more favorable environment for supporting child health and growth.

THE ROLE OF THE LAWYER

Vincent DeFrancis, J.D.

My subject today is the role of a lawyer. I am wearing a lawyer's hat at this point, though I like to talk as a social worker. What I want to relate is the fact that the lawyer's role is a complicated one, particularly the lawyer in private practice who finds himself appearing in Juvenile Court in any one of a number of different capacities. They are capacities which present problems for him because of adjustments he needs to make in his philosophy of child neglect and abuse, his emotional outlook, where his strengths should be placed. This stems from the fact that on some occasions he is there to represent the parent; on others he may be a legal guardian for the child; and occasionally, on a contract with the Department of Social Services, he may be serving as counsel for the petitioner. Each of these takes a different stand; each requires a different philosophical approach. He must resolve this conflict and adjust accordingly.

There are some lawyers who have a very specialized approach which reduces this conflict. A public defender appears for only one of the litigants. The role varies depending upon the locality or community. In some communities, the public defender appears only on behalf of the parents. In many communities, the public defender serves as guardian ad litem for the child. A county solicitor is the public attorney who often appears on behalf of the petitioner. Also there is the legal aid attorney who frequently appears on behalf of the parents. For legal representatives who are so channeled, conflict is reduced. They deal solely with one or another of the litigants and appear as advocates on behalf of one or the other of the litigants.

Intervention by the legal profession in the process of protecting the neglected and abused child is rather recent. It has become more commonplace since the Gault decision of the U.S. Supreme Court in 1967. This decision stated that the juvenile courts of this country had been riding roughshod over the constitutional rights of children. They had ignored the basic concepts and principals of due process. As a consequence of the Gault decision, most juvenile court proceedings have become more legalistic. Due process is being observed. With the concepts of due process being exercised to a high degree, one of the necessary ingredients is the matter of legal representation for the litigants. What we are finding now as a consequence of the Gault decision is that parents are entitled to legal representation and are so advised. If they are able to afford counsel on their own, they are advised to obtain it. If they cannot, then counsel will be made available to them.

Because the child's interest and the parent's interest are in conflict, a guardian ad litem is appointed for the child. I am distressed by that concept because, all too frequently, a lawyer is appointed as guardian ad litem. The role of a legal representative for the child and the role of a guardian ad litem are not compatible. In many instances, they may be in conflict. Recent Pennsylvania legislation (Act 124) speaks of a guardian ad litem being appointed by the court. I think that should read, "Legal representation should be made available for the child." The role of the lawyer, then, would be more clearly defined, because the role of the lawyer in representing the child would be to represent the child's interests. If the child is of an age where he can express his interests, the lawyer should advocate for the expressed desires of the client, in this case, the child.

The role of guardian ad litem is entirely different. A guardian ad litem acts on behalf of the child instead of the parents acting on behalf of the child. He makes decisions for the child whether he likes them or not. A guardian ad litem makes decisions in terms of what he believes to be the best decision for the child. The lawyer serving in both capacities may tend to be schizophrenic because he cannot serve both roles simultaneously.

The next role I wish to discuss is the counsel representing the petitioner. Here I want to speak as a social worker, as well as a lawyer. Part of the precept of child protective services is that when we deal with these cases we rehabilitate. Services are poured into the home to determine whether or not there is neglect or abuse and an assessment is made of the injury or damage which the child may have sustained. We inquire into the causative factors, then examine:

A) the risk. Should the child remain in the home? and

B) the treatability of the situation.

Is there potential for rehabilitation and, if so, is the risk too high for the child to remain in the home? Treatment and services are then provided to stabilize the home situation and to correct the conditions that led to the abuse or neglect.

In some cases, by far the minority, it is necessary to invoke the authority of the court. In a good child protective setting, not more than 10 percent of the cases ever wind up in court. These are the cases where the child is at great risk should he remain in the home. We have to put our best foot forward in order to present a case so that the court can truly act on behalf of the child. The court may do this only if we have prepared the content which needs to be presented to the court in terms of evidence and hard facts. The court may then say, "I find this child to be deprived; I find the child to be a neglected child." The child then comes within the jurisdiction of the court, which may make a disposition in the child's best interest.

What I have found, traveling around the nation, is that in most instances only lip service is given to the concept of adequately preparing the difficult case that needs to be presented in court. In many communities, the legal representation given to the protective services worker comes from a county solicitor. They are very qualified people, but also very busy people. They do not have the time to give to a neglect case that it deserves. What I have seen happen is that just before the case is called to trial, after all the "preparation" has been handled by the caseworker, the county attorney rushes in and says, "Here I am, what is this case all about?" In two minutes he prepares the case. This is not doing justice to the situation.

I am not derogating the obligation or responsibility of the persons or their dedication to their work. They are busy people and are unable to allocate the time to a responsibility, which, in the minds of many county attorneys, is not as great a responsibility as other litigation they are engaged in. What is needed and should be provided is a staff counsel.

Perhaps if there is a rich enough county attorneys department, one member of that staff could be assigned full-time to the Department of Social Services to give advice and counsel in these cases. Whichever way it is done, there should be time allocated to the Department so that when a worker makes a decision to take a case to court — that is, a social work decision, not a legal one — the worker then will be given the advice, counsel and consultation needed in the preparation of the case.

One of the things that needs to be done is a review of the data with the worker, in terms of the worker's knowledge of the situation. This review is needed so that a determination may be made of the caliber, quality and quantity of the evidence available for sustaining the petition. Part of the responsibility of the legal consultant would be to advise the worker whether there is a enough evidence. If there is not, the advice should be in terms of what else is needed and how that additional evidence may be acquired to support the case. The expert in terms of evidence is the lawyer, who should be available to give that consultation to the worker.

The second element in terms of preparation is the matter of interviewing the witnesses. This involves determining which witnesses you have and what they are going to say. There is nothing more disconcerting to a lawyer than to have a witness take the stand and have him testify about something when the lawyer does not know what the full content of the evidence will be. There is nothing more disconcerting to a witness than not knowing what questions will be asked. That preparation on both sides should occur before the matter is taken to court.

The third element should be the preparation of the petition. The petition is a legal document, not a social work document. In too many communities it is prepared and drafted by social workers. This is a highly technical document which needs to be prepared by someone competent in the law. This is a responsibility that social workers should not have to take.

Finally comes the presentation. How the case is presented in court will determine the outcome of that case. How it is presented in court depends upon who is trying the case. If the county attorney or county solicitor is unprepared, except for the little interpretation given prior to the trial, he does not know what to ask or how to present the case. He does not know what to expect from the social worker or what to expect from the witnesses. He does not know what kind of expert testimony the caseworker is bringing into court, what the nature of it is, and what he will have to face in terms of knowing what cross examination will be made of his witnesses. The preparation of the case would involve knowing how to present it, what to present, and when and in what sequence to present the witnesses.

Am I talking about a utopian situation or what should be here and now? In view of the fact that you have a new mandate in Pennsylvania law, in which so many areas are so closely defined, I cannot help but wonder why there is no provision for legal representation or staff counsel, or assignment of a full-time representative of the county solicitor's office to your agency so this kind of relationship could be established.

This is a cooperative relationship, and the lawyer who is representing the petition advances your cause. The lawyer who is presenting evidence on behalf of the agency is advocating the cause for the child as interpreted and seen by the caseworker and the agency. In a process which frequently occurs this lawyer and the parent's lawyer may get together for compromise and adjustment of action. His representation of the Department should carry with it an understanding that no determination or decision in terms of adjustment should occur without consulting the caseworker. This definitely is a step that needs to occur.

When a case is tried in court under Pennsylvania law, similar to the law in most states, we have what is called a bifurcated hearing. There are two parts to the hearing — the first part is the adjudicatory or fact-finding hearing. In that hearing, the court is solely concerned with the hard facts of the matter - what happened, how did it happen, where did it happen and what was the impact on the child. On the basis of the examination of the hard evidence, the court makes a decision whether or not this is a deprived child.

Once the judge decides that the evidence presented is of sufficient weight in that this was a true case of deprivation, the court then moves to the second phase of its responsibility, the dispositional hearing. The court may do this immediately after the finding in the adjudicatory hearing or, if he has any real concern for getting sound dispositional advice, hold it at a later date. This would allow for the gathering of the kind of information necessary to help him decide what would be the best order. He, as a judge, could make the decision truly meet the best interest of the child.

In this aspect of the hearing, there is a relaxation of the court process. In the disposition hearing, the juvenile court becomes a socialized court. The legalism which must be present during the adjudication hearing is not apparent and is not required during the dispositional hearing. The court may hear anyone who has any information to offer which will guide the judge in making a better disposition. The caseworker, with the advice of counsel, can now offer his or her opinion of what would be the best way to handle the situation after the finding of deprivation. Usually the dispositions available to the court include the following:

1) Protective supervision, which means leaving the custody of the child with the parents under conditions prescribed by the court and under supervision by the agency;
2) Temporary placement with someone other than the parents, such as a relative or another social agency within the community;
3) Placement of the child, ostensibly temporary but with a longer range view in mind, with the offer of necessary service implied in terms of helping the parents readjust their lives so that the child can be returned to the home.

One important element social workers need to be aware of is that in an adjudicatory hearing you are testifying to the conditions as you have identified them - conditions of neglect or abuse, the circumstances, the impact on the child, and all other knowledge you may have about the case. The role which the attorney for the parents will play in seeking out the truth that may be helpful to his clients is to determine what efforts, if any, they have made to rehabilitate prior to taking the case to court. This is the philosophy expressed in the law.

The intent of the law is to provide a vehicle for protective social services so that children may be protected, neglect and abuse may be prevented, the family stabilized and the intactness of the family maintained wherever possible. This is an area where you will be examined and the question is, what have you done to seek to live up to the requirements of the law which says this is an obligation we have towards the family, parents and child. Part of the preparation which I would hope the counsel would make is to review what we, as an agency and community, have done to help those parents.

LEGAL ASPECTS OF CHILD ABUSE AND NEGLECT

Judge Gilfert M. Mihalich

It is my intent and objective to present a judicial perspective in child abuse and neglect cases. As custody judge, I handle all cases involving problems relating to the custody of children in Westmoreland County. I would like to review some recent and profound changes that have occurred in our judicial process dealing with abuse and neglect cases. The courts play a vital role in the success or failure of the welfare and protective services provided to the children of our Commonwealth.

Many times law enforcement officers, social workers and the general public have difficulty in understanding the role of a judge in child abuse and neglect cases. A judge's function is complicated by mixed emotions in that he is caught between the objectives of the social worker in his/her effort to rehabilitate the family unit and the law enforcement officer's efforts to convict and punish the individuals who abuse and neglect their children. The conflict of these mixed emotions makes the judge's role more difficult.

A judge must consciously fight against his instinctive and spontaneous sympathy for the neglected and abused, lovable and defenseless children. He must appreciate the importance of a judicial posture untainted with sympathy, bias or prejudice. This, many times, lies between the good and dedicated efforts of the social worker to rehabilitate and maintain the family unit and the prosecution which seeks to avenge the abused and convict the abuser. The "just decision" often makes the judge unpopular to all parties involved.

I am greatly concerned about the court's role in the overall picture of child welfare and protection in Westmoreland County. Up until the time I became custody judge, our courts had conducted short and informal hearings in child custody matters even when they related to child abuse and neglect. Rarely were full hearings conducted or a transcript made of the proceedings. The adverse parties were practically mandated to arrive at a compromise which would be incorporated into a consent order.

The compromise was a bilateral bargaining away of the children's rights and welfare; however, the child was rarely represented in the bargaining process. No record was made of the testimony which supposedly substantiated and justified the consent decree.

The expeditious handling of judicial matters is a realistic factor in our judicial process; however, the informal and cursory treatment of custody cases – including neglect and abuse, custody change and/or visitation rights – bothered my sense of priorities.

In addition to my function as custody judge, I carry a full load of court cases and handle every type of case except those dealt with in the Orphan's Court. To convey the idea of the size and time consumed by this caseload, consider the following:

In July, 1976, out of maximum court time of 110 hours, I spent 97 hours, 55 minutes actually on the bench in court. In my first year as a custody judge, I handled 146 custody cases, 61 from the children's bureau and 85 dealing with custody and/or visitation. The actual "in court" time devoted to these cases took 245 hours or 45 days of court time. This does not include informal meetings with the Children's Bureau discussing problems which are resolved without "in court" time, or discussion with attorneys about custody and visitation problems. The most difficult task is finding time to hold hearings within reasonable or prescribed times and still continue other judicial activities.

From this broad exposure to many types of judicial proceedings, I was convinced that we were mixed up in our sense of priorities. We are giving more attention to criminal cases and other civil cases than we are to those involving custody. These are the cases that seriously affect the lives of children and the lives of their families. Which type of case is more important and deserves the expenditure of more court time and judicial expense? We still spend more judicial time and attention on other types of civil and criminal cases; however, I now have no difficulty in emphatically stating that a child's life and well being are more important than a smashed fender, broken arm, or the rights of an accused adult criminal.

I fully realize that expediting cases is a practical and essential factor in judicial process, however, I became determined to treat custody cases with greater formality in that I would, in every case involving abuse, neglect or even a change of custody, make a judicial determination based upon evidentiary input. This evidence in all cases would be recorded for appellate evaluation. Even voluntary placements and consent decrees would be effectuated by at least a petition setting forth the evidentiary facts under affidavit.

All cases involving abuse, neglect or compulsory involvement of the Children's Bureau would be judicially determined after full hearing where testimony would be presented under oath and subject to direct and cross-examination. According to our prior practice, most cases were resolved by consent decrees after the attorneys and the Children's Bureau supervisor presented their respective positions to the judge, informally.

I noticed that in this procedure, it was the skill and personality of the attorney, rather than the merits of a particular side that were the influencing factors. It is surprising how the picture changes and resolutions become more definite after the judge has had an opportunity to personally observe sworn testimony from the parties actually involved in the problem.

Some of the basic guidelines I implemented are:

1. All cases of child abuse and/or neglect would be resolved by full and formal hearing wherein testimony would be presented under oath and subject to cross-examination;
2. Before there is a change of custody to or from the Children's Bureau, I would be notified by the caseworker or his supervisor, personally or by petitioner. All changes in custody would be effectuated by court order after evidentiary input;
3. In all hearings, caseworkers and supervisors would testify formally and under oath relative to their involvement, investigation and recommendations;
4. There would be no rubber stamp orders;
5. I effectuated a personal and closer relationship between personnel of the Children's Bureau and the court. There would be easier accessibility to the courts;

6. A conscious effort on my part to exercise understanding and patience with parents and the problems which bring them to the Children's Bureau and/or my court;
7. In cooperation with our new county commissioners, we created a new position of assistant county solicitor whose primary responsibility would be to advise and represent the Children's Bureau. In fact, he is attending this seminar. In my opinion, this is one of the greatest improvements to our judicial process involving all types of cases in our Children's Bureau, especially child abuse and neglect cases.

Child abuse and neglect cases are generally the toughest cases that the Bureau has to deal with from a legal point of view. Because of the criminal implications, competent evidence is generally hard to come by and is often difficult to segregate from inadmissible evidence. With the advent of the new Child Protective Services Act, the function of the Children's Bureau is definitely legally complex, especially in the area of child abuse and neglect. Adequate and capable legal representation is an indispensable factor to a successful operation.

The new relationship between the judge and Children's Bureau personnel had a definite effect on improving morale and the incentive to do a thorough and good job. The caseworkers and supervisors became a visible and effective wheel in the ultimate determination that beneficially changed the future lives of children.

I firmly believe that the Children's Bureau must have a solicitor who is readily available for opinions and presentation of cases to the courts; I firmly believe that the courts must be readily available to the Children's Bureau to make those decisions that only a judge can make.

A judge's role in cases involving child abuse and neglect is a difficult one, and he or she plays a reflective role in such cases. The doctors, nurses, school officials, social workers and Children's Bureau personnel must realize that the judge's decision can only reflect the work they contribute to the judicial proceedings. Insufficient evidence or erroneous evidence will produce a wrong and unjust judicial decision. Be patient, understanding and cooperative when asked to formally present evidence. Judicial hearings are governed by rules of evidence and in many situations your personal testimony is required and indispensable.

Much of our efforts will not produce monetary rewards. Because we are dealing with the well-being of our youth, the reward we receive will be bountiful and gratifying. We are truly the bridge builders for our youth.

MEDICAL ASPECTS OF CHILD ABUSE AND NEGLECT: PHILOSOPHY OF PRACTICE

Joan Adler, M.D.

Physicians or nurses cannot see themselves as purely academic providers of medical services. We must be able to see the family and the medical situation in perspective of the social context. Medical personnel often try to avoid social or psychological aspects of the medical problem and treat it as purely as scientific illness, but child abuse is one "disease" in which one cannot ignore the social and psychological aspects. There is a need to expand the understanding of a social context which causes increased violence toward children and among people in society.

The medical-legal aspects in child abuse also cannot be ignored. There is a legal, as well as a moral, responsibility to report suspected child abuse, so that the child can be protected and further abuse avoided. There must be an understanding that child abuse is found in all socio-economic and racial groups. An attempt must be made not to let personal prejudices or personal identification stand in the way of appropriate identification and treatment of child abuse.

There must also be an understanding that, although economic factors play a very important role in contributing to the stress within the family that results in child abuse, there are also many forms of stress within a family that is not economically disadvantaged which will lead to the same type of behavior.

SUSPECTING AND RECOGNITION OF CHILD ABUSE OR NEGLECT

First, I would like to talk about the demography of child abuse. This is a listing of facts:

- Child abuse is seen throughout all socio-economic and racial groups.
- The average age of an abused child is under the age of four, with most being under the age of two years (this is frequently because older children have a better ability to defend themselves, or run away from child abuse).
- The incidence of abused male children is equal to that of abused female children, although the fatality rate of abused girls is higher than that of boys. Whites have a higher percentage rate than non-whites of child abuse in studies where controls have been used.
- Parents of abused children are in general younger than controls.
- Families where child abuse is occurring are frequently more mobile than non-abusive families (they are found to change address more often).
- Families frequently have a prior record of child abuse.
- The abused child often has a sibling who has been abused.
- The abusing parent has often been abused as a child.
- The death rate of an incident of child abuse ranges anywhere from four to 25 percent, depending on the study.

In order to suspect and recognize child abuse, one must have a high index of suspicion. The nursing profession has defined what is called the high-risk family in terms of child abuse. These high-risk families can frequently be picked up in prenatal or pediatric clinics. They consist of: families where the child is unwanted; the parents have unrealistic expectations of their children in terms of asking the child to support them, or expecting the child to have age-inappropriate physical or psychological ability. These families may come to the doctor with many complaints for which no "cause" can be found, but which are ways of asking for help.

In terms of a medical history in a case of child abuse, these are some things to look for:

- The history that is given about the injury does not go along with the physical findings. It seems in some way to be an unlikely or unusual story.
- Frequently, the interviewer gets the feeling that the parent is holding back information.
- There may be a record of multiple visits to various hospitals.
- There may be a history of family stress, either marital problems, money problems, unemployment, drugs or housing.
- Often the family will come in with a complaint that is quite minor compared to the extent of the actual physical injuries, or the complaint may be totally unrelated to the degree of injury or neglect.
- Often there is an inordinate delay from the time of stated injury to the time that the family seeks help.
- Very often the parents give an inappropriate reaction to the severity of the injury; they may seem distant, detached, unconcerned, or in some way not in touch with the seriousness of the problem.

In the physical examination, these are some things to look for:

- There is often an inappropriate response of the child to the parents or vice versa. For instance the child may not turn to the parent for support during a painful examination. The parent might be observed to be asking support from a child.
- You may see generalized neglect – a dirty, malnourished, irritable, withdrawn child.
- The injuries that are seen in chronic abuse are usually of a minor, but numerous nature, such as bruises, abrasions, burns, soft tissue swelling, head trauma, old scars or healed wounds.
- There may be evidence of old or new fractures or dislocations.
- There may be symptoms of drug ingestions, drug overdose or drug withdrawal.
- The child may be comatose or in a severely ill state, with a history that doesn't give any reason for this.
- The child may have seizures, which may actually be secondary to head trauma.
- The child may show radiological evidence of old or recent fractures or trauma that are unrelated to the problem for which the x-rays were taken. In other words, there may be incidental findings of old or new fractures when this was not previously suspected.
- The child may have an unexplainable surgical situation, such as internal bleeding, for which there is no appropriate story or reason given in the history.

These are examples of what might be seen by physicians or a nurse who first encounters such a child, which should alert the doctor or the nurse to the question of child abuse or neglect.

THE HOSPITAL REPORTING CHILD ABUSE

It is a fact that most cases of child abuse are reported by large medical facilities. There are reasons for this, some of which have to do with the reporting agencies and some with the patients themselves. I am going to discuss the factors that cause the large medical facilities to become the reporters.

First, there is a lack of reports coming from private offices. This will, of course, cause a much higher percentage of reports of child abuse to be generated by hospitals. This deficiency of reports from private offices stems from the following factors:

A. A failure by the private physician to recognize the problem of a child abuse. Many times if a physician is not geared to think about the possibility of child abuse, he or she may examine a child with many signs of physical abuse, but not make the connection that this is a case of potential child abuse. Only by alerting the private physicians and nurses to the problem of child abuse can their index of suspicion be raised to the point where they will be on the lookout for recognition of potential cases.

B. Often a private physician will use the defense of denial to avoid recognizing the problem of child abuse, because of a lack of desire to deal with this problem. Often the question of child abuse evokes many unpleasant emotions in the physician and makes her or him hesitant to initiate a process that will be emotionally trying, both for her/himself and for the parents.

C. There is frequently an ignorance by the private physician of the mandate to report child abuse. This is due to the rapidly changing laws. An attempt must be made to educate the medical community concerning the mandate to report **suspicion** of abuse or neglect.

D. There is often a reluctance on the part of the private doctor or nurse to report a private patient out of concern about jeopardizing their relationship with the patient. This is a very valid concern, because the filing of the report often alienates the patient from the physician. However, priorities must be kept in mind and the physician must be willing to risk the loss of the patient because of the priority to protect the child from further abuse and possible death. Often, if the reporting is handled well by the physician and the primary point stressed is concern for the safety of the child, the parents will work through their anger towards the doctor and the eventual outcome will be one of a continuing relationship between the physician and the parents. Often the families are seeking help and will be grateful that their private physician, with whom they already have a relationship, is recognizing the problem and offering them help.

E. There is a fear of legal reprisals. In all states with child abuse legislation, the physician is not only given legal immunity in these cases, but is required to report a suspicion of abuse or neglect by law. A failure to report this suspicion leaves the physician legally at risk.

F. There is concern about patient-physician confidentiality. In general, child abuse cases are handled with the utmost possible confidentiality. After the investigation takes place, if no abuse or neglect is found there are provisions for expunging the report from the records after a period of time has elapsed.

G. Frequently there is a feeling of futility on the part of the private doctor that nothing will be done, if a report is filed. This is especially true in parts of the country where there are no specialized child abuse services.

It is often true that filing the report will not result in any positive action for the family. However, once again, the priority must be the removal of the abused child from further danger. In such areas where no specialized programs are available, the role of the medical community should be to push for funding such services.

H. There is a reluctance to become involved in the legal process. This is also a very valid concern because the time spent in court is often a burden on the private physician. In areas with active child abuse programs, arrangements can often be made to minimize the amount of time a physician has to spend in court.

I. There is an inadequacy in medical education about the problem of child abuse, and many private practitioners are not fully aware of the problem itself, or of the sociological aspects. In order to deal with this, medical schools and continuing education programs should provide ongoing information on the problem of child abuse, its causes, and its treatment.

J. Often the private practitioner, in a suburban location, feels an identification with his or her patients and, because of this, that these parents cannot be child abusers. The problem is seen as one which affects people of low socio-economic status or racial minorities exclusively. Often the physician's identification with his patients will blind him to the problems that he sees. This is a very difficult problem to overcome, and can only be dealt with through extensive education in the medical community.

Separate from the reporter factors are the patient factors:

The cases of ma[redacted] trauma usually are taken to large city hospitals.

The abusive family frequently tends to seek anonymity in the services from a large city hospital.

Many families become hospital shoppers, going from one hospital to another in an attempt to seek help. Often they are disappointed when one hospital fails to recognize the problem of child abuse and fails to give them any assistance; therefore, they go looking to another and yet another hospital.

The untrained eye frequently will suspect more child abuse than is really going on in a large hospital, where much trauma is seen. Frequently prejudices about low socio-economic status patients who get their primary care at large hospitals causes them to be the victims of this over-interpretation of child abuse.

RESULTS OF UNREPORTED ABUSE

The average death rate of any particular incident of child abuse ranges between four and 25 percent, depending on the study. The average age of a child abuse victim at death is less than three. A study has shown that 44 percent of abused children had been previously abused. 53 percent have siblings who have been abused. 16 percent of abused children had to

undergo serious surgery or other procedures. There is a very high recidivism rate with serious outcome, including deaths and permanent brain damage, in incidents of repeated abuse. These are all things to consider in failing to report your suspicions of child abuse.

The outcome of **reporting** a suspected abuse is frequently and unfortunately quite variable and depends on whether or not there is a program in your area that is equipped to deal with this as a specialized problem. There have been studies showing a recidivism rate of only about 5 percent in families who were somehow hooked into a specialized child abuse rehabilitation program.

The goals for the future should be early recognition and prevention of child abuse. At the present time, however, because of the scarcity of programs, the priority must be to address services towards the family where actual abuse is occurring. In the future, if services and education are expanded, it should be possible to recognize the potential abuse cases and offer services to the family before the abuse becomes a sad reality.

MEDICAL ASPECTS OF CHILD ABUSE AND NEGLECT

John B. Reinhart, M.D.

PROCEDURE FOR SEXUAL ABUSE CASES IN CHILDREN'S HOSPITAL
Pittsburgh, PA

When children are brought to the Emergency Room with a chief complaint of sexual abuse or when, in the process of examining a child, sexual abuse is suspected, the following should be implemented:

1. The Emergency Room doctor should dispassionately and matter-of-factly obtain the history from the parents alone, and from the child alone. If the ER doctor needs help with such a problem, he can contact the outpatient chief resident, one of the ambulatory senior staff, or the senior resident on-call at night.
2. In recording the history, include details relating to date, time, place and circumstances of the incident, as well as the name and description of the alleged abuser (if known). If any witnesses were present, these names should be taken also.
3. **Physical Exam**. Complete general physical should be performed, as well as an external exam of the genitalia. A diagram of any gential injuries should be included in the description of the physical findings. Usually in small children no further exam is necessary unless an external exam suggests evidence of a significant intravaginal laceration. In such cases, the child should be admitted for exam under anesthesia. In pubescent patients a full pelvic exam may be done if the external exam indicates that this is necessary.
4. **Lab Specimens**. If the patient is pubescent and has been raped, within 24 to 72 hours of the examination, an aspirate of vaginal secretions may be obtained using a small syringe, and can be sent to the lab to check for the presence of sperm. There is no indication for culturing for venereal disease following an alleged assault unless a purulent vaginal discharge is present. This complication is not likely to occur for several days following the incident.

   In small children there is no indication for obtaining specimens unless there is a purulent discharge. Any prepubescent child with a vaginal discharge which grows neisseria gonorrhea on culture must be "SCANned" and reported to the Department of Public Health. These children usually do not mention sexual contact in the history, but such an infection in a preadolescent is almost invariably contracted by sexual contact.
5. **Risk of Pregnancy**. If the child is post-menarchael, it is important to determine when in her menstrual cycle the incident occurred. If she is seen within 72 hours of the alleged rape and it appears that she is at any risk of pregnancy, then the resident in the Emergency Room should be notified and he/she will have the necessary medication to prevent implanation available for the family to obtain, if they so desire.
6. **Hospitalization**. This is not necessary, as a rule, unless the injuries are extensive, or the physician and social worker involved in the case feel that the child is at significant risk of further abuse if he or she should return home.
7. **Counseling**. Social Service should be consulted on all cases. During the daytime social workers are available to see all such cases; at night the social worker on call may elect to come in or follow up on the case the next day, depending on the circumstances. The social worker will be responsible for all non-medical follow up, and will also arrange for psychiatric consultation for the child and family if necessary.
8. **Scan Reporting**. All prepubescent children should be viewed and treated as potential scan cases, and scan procedures should be followed accordingly. Reports to the police should be at the discretion of the parents, and they should be advised of their legal rights to do so. Social workers can help parents with this procedure.
9. Under all circumstances parents should be informed, in a matter-of-fact manner, of the presence and extent of any injury or of the absence of injury. If there is no likelihood of any long-term sequelae, this should be explained clearly, in order to reassure the parents and the child.

   These parents will often need an opportunity to discuss their feelings outside of the child's presence. They usually also need some short-term counseling to help them work through their feelings and avoid superimposing their own anxieties on the child. Supportiveness and understanding on the part of the examining physicians are invaluable.

SOCIAL SERVICE ASPECTS OF CHILD ABUSE AND NEGLECT

James Delsordo, A.C.S.W.

Most child welfare agencies responsible for managing parental abuse of children are experiencing a dramatic increase in the demand for their services. Child abuse is becoming a household word, and it seems that everyone in the helping profession is seeking ways to become involved. Information relative to child abuse is coming from all sources, lay and professional, and clear-cut schools of thought are taking shape.

Some "experts" insist that parents can be "educated" out of their abusive patterns with gentle, understanding, "re-mothering". Others insist that the cycle of abuse can only be broken by removing abused children and permanently placing them in a more wholesome environment.

We child welfare workers, who have lived with the problems of child abuse for a decade or more, know that this complex phenomenon is not going to be contained by any extreme or simplistic approach. We, therefore, keep striving to convert our on-the-job experience into strategies which will enable us to deal more effectively with the very delicate task of protecting vulnerable children.

One such strategy in use at the Bucks County Department of Child Welfare is a model, classifying various types of child abuse so that an appropriate plan of service may be formulated. The classification model is based on three major considerations:

1) The degree of injury inflicted.
2) The probability of the abuse recurring.
3) The physical and psychological availability of the parents to help.

Key formulations underpinning this model are:

1) There is a child abuse spectrum which ranges all the way from spanking to homicide. We, therefore, must differentiate the nature of abuse referrals.
2) Child abuse referrals must be assigned a time priority depending on the nature and circumstances of the abuse. We must, therefore, respond with the appropriate degree of authority and speed, depending on the assessed gravity of the child abuse incident.
3) Some abuse situations can be controlled and reversed, and some situations cannot be controlled, even with massive doses of help from all existing resources. We, therefore, must be realistic in our goals by not allowing children to remain in danger while we develop fancy treatment plans.

The Bucks County Model for assessing and managing situations of child abuse contains the following categories:

1) **Abuse by mentally ill parents** – When a child is abused by a mentally ill parent, separation of the abusive parent and the abused child is imperative. The concern is not: how do we manage this problem? The concern is how can we best effect a separation which is least traumatic to all parties concerned? The abused and the abuser need help quickly and decisively. The long-range prognosis for the abuser is bleak indeed.
2) **Abuse by psychopathic parents** – When a child is being abused by a psychopathic parent, it may take a longer period of time for the extent of the destructive pattern to unfold, but before long it will become apparent that there is no potential for this type of parent to be salvaged. Parents in this category make promises easily – to stop drinking – to stop using drugs – to stop sexually molesting their children. But they cannot produce. They cannot control their destructive behavior.

   Once again, it soon boils down to the question of how can we best effect a separation which is least traumatic to all parties concerned. The prognosis for this type of abuser is bleaker than for the psychotic abuser.
3) **Abuse by inadequate personalities** – In this type of abuse we have the baffling syndrome known as the battered child. Time and time again practitioners have been optimistic in thinking that child-battering parents could be successfully treated. Overwhelmingly, their calculations have been proven wrong by the reappearance at the hospital of the previously injured child.

   In this type of child abuse, the abuser and the abused must be separated. If there can ever be a reunion of the two parties, it is so far into the future that it is not part of immediate treatment strategy. Even when the non-abusing parent separates from the abusing parent, there always exists the danger of parental reunion before any of the problems which provoked the abuse have been significantly resolved.
4) **Abuse by stern, disciplinary parents** – In this type of situation we have the cold, rigid, dictatorial kind of parent, who will tolerate no deviation from the "rules". This type of parent is uncomfortable to be near, and may become enraged by behavior which other parents would find only mildly offensive.

   This type of child abuse can be interrupted, and change frequently takes place. Here we have families which often are stalwarts in the church and community, never having run afoul of the law. They are so embarrassed and angered by the intrusion of an official outsider, that they do almost anything requested of them just to get rid of the social worker from the child welfare agency.

   As protective service workers we, of course, prefer deep, lasting behavioral and attitudinal change. But we can accept superficial behavioral change as the next best thing from some people. Some schools of thought claim that a modification of behavior sometimes is shortly followed by a shift toward a more positively oriented attitude. We are not sure about that. We do know that many clients of ours do change considerably; yet they will never acknowledge it.
5) **Abuse by displacement of parental aggression** – In this type of abuse we have situations in which some clear-cut problem is being projected onto the child, who has become the target of parental frustrations and hostility. This type of abusive behavior often mimics the battered child category in that there is usually severe marital conflict, an "unplanned for" child, a badly-handled union or separation, etc.

   However, in displaced aggression situations, the children are older, and are rarely in danger of a fatal

beating. The parents involved usually manifest extensive feelings of guilt, are able to control their behavior, and demonstrate the greatest capacity to use professional help toward reversing their abusive behavior. The prognosis in this type of abuse situation is good.

In the initial research which produced this typology, 80 cases of gross physical abuse were studied. Twenty-five fell into the first three categories and were classified as uncontrollable. Fifty-five of the abuse cases resulted from harsh disciplinary parents, and displaced parental aggression. These 55 situations were classified as controllable, for in each instance the objective of the protective intervention was achieved, that is, the abusive pattern was controlled, and it did not recur, as far as we know. The Bucks County model was developed in 1963[1]. It was refined by different researchers in 1967[2] and 1972[3].

We recognize that there may be some overlap in the types of child abuse documented in this presentation. We also concede that, like it or not, the skill of the practitioner does play a part in how effectively service is provided and used. This is particularly true when functioning from an authoritative base to enter the lives of involuntary clientele.

In this model, the primary helping modality employed is the casework method. This simply means that the abusing parents were engaged in a professional relationship geared to: helping them understand that there was a significant problem in their lives; holding them sufficiently in focus to recognize their part in the problem; and enabling them to develop more acceptable and satisfying strategies to manage their problems if it was within their capacity.

This material is meant to be a summary of one system designed to manage incidents of severe child abuse. It is **not** meant to demonstrate how casework skills are applied to resolve relationship problems.

1 James Delsordo, Protective Caseworker for Abused Children, CHILDREN, November - December, 1963.

2 Serapio Zalba, The Abused Child: A Typology for Treatment, Social Work, January, 1967.

3 Maurice J. Boisvert, The Battered Child Syndrome, Social Casework, October, 1972.

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