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CHILD ABUSE AND NEGLECT: A PRIMER

BY

JUDITH KARTT SCHWARTZ
B.S.H.E., University of North Carolina
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SPECIALTY PAPER

Submitted in partial fulfillment of the requirements
for the Master of Science degree in Clinical Psychology
in the Graduate Studies Program of the College of Social Sciences
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Abstract

The purpose of this speciality paper is to present an overview of child abuse and neglect in the United States. This was accomplished by researching previously published literature. Topics investigated include the epidemiological factors, personality characteristics of children and adults, etiology, diagnosis and assessment procedures, intervention and treatment options and early identification and prevention. Sexual abuse, foster care and the legal problems associated with a diagnosis of child abuse/neglect are treated, briefly, as separate topics. In addition, critical comments in research methodology and findings and suggestions for further research can be found throughout the body of the paper.

Acknowledgement

As I sit here trying to collect my thoughts and feelings, I find I am experiencing a "let-down," rather than an "up-lift." I cannot believe that, after struggling for six years, the end is in sight-- that I will finally reach my goal of a Master's Degree. I know I am ready to move forward to other things, that I want to close this phase of my life; yet I also know that I will miss those at UCF who have so patiently worked with and "understood" my trials and tribulations. They even managed to teach me a few things along the way! I only hope that I will be a credit to them in the future and that I have managed to return at least some of the strength and insight they have given to me.

To my husband, Michael, who said, "Sure you can go back to school. It will give you something to do," I love you.

To my children, Bobby, Dara, Philip and Laurie, who had no choice in the matter: You won't have to share me with school any more.

To my mom and dad who gave me their support and admiration: I am glad I can share this moment with you.

To Burt and Jack, who said, "What you're pregnant again!" I hope the person who takes my place finishes when they should.

And to all my friends who listened to my complaints, carpooled my children and provided encouragement when I needed it,

I GIVE YOU MY HEARTFELT THANKS.

THE WHIPPING*

Robert Hayden

The old woman across the way
 is whipping the boy again
and shouting to the neighborhood
 her goodness and his wrongs.

Wildly he crashes through elephant ears,
 pleads in dusty zinnias,
while she in spite of crippling fat
 pursues and corners him.

She strikes and strikes the shrilling circling
 boy till the stick breaks
in her hand. His tears are rainy weather
 to woundlike memories:

My head gripped in bony vise
 of knees, the writhing struggle
to wrench free, the blows, the fear
 worse than blows that hateful

Words could bring, the face that I
 no longer knew or loved...

Well, it is over now, it is over,
 and the boy sobs in his room,

And the woman leans muttering against
 a tree, exhausted, purged---
avenged in part for lifelong hidings
 she has had to bear.

*Taken from: I Am the Darker Brother, Arnold Adoff, ed.,
The Macmillian company (1968).

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1 EPIDEMIOLOGICAL CONSIDERATIONS OF CHILD ABUSE AND NEGLECT.

Introduction and History

Child abuse and neglect is a multi-generational, social and psychological phenomena which occurs in all stratas of society and in all life styles. Less than 20 years ago, Mother Loretto Bernard claimed that "the most common cause of childhood deaths . . . is physical abuse of children by their own parents" (in ^{*}Fontana, The, Maltreated Child, 1964 , p. iii). It is regretful that she could probably say the same thing in 1981.

[If child abuse was a problem unique to modern times, it might be easier to solve. Unfortunately, this is not the case. This mistreatment of children has been justified throughout history by the belief that severe physical punishment is necessary to maintain discipline, to transmit educational ideas, to please gods, and to expel evil spirits.] (Except, as otherwise noted, the factual information in this section is from Radbill,^{*}1974). [Parents, without condemnation by society, have been permitted to sell their children into slavery, commit infanticide, and mutilate them for personal gain or religious beliefs. Children have been killed as a means of population control, because they are illegitimate or deformed, and for ritual sacrifices.] Many nursery rhymes such as Humpty Dumpty or Rock-A-Bye-Baby carry the theme of danger and violence. Stories such as "Hansel and Gretel," Mowgli, the Jungle Boy, the myth of Romulus and Remeus, and the biblical story of Moses all have

abandonment as part of their themes. The common quotation, "Spare the rod and spoil the child," which is rooted in the bible, was first expressed in 1633 in the Bibliotheca Scholastica. During the Industrial Revolution in England, children as young as five, worked as long as sixteen hours a day in deplorable conditions. The Reform Act of 1802 reduced their hours, but that was only if the parents gave permission for their child to work the shorter time.

It should be noted that there have always been attempts to stop the abuses and to change society's attitudes about the care and upkeep of children. For example, in 1838, the Supreme Court of Pennsylvania expressed the opinion that parental control is a natural, but not an inalienable right. By 1871, New York had a Society for the Prevention of Cruelty to Children; Philadelphia had one by 1877. And in 1909, the first White House Conference to discuss the problem of infant mortality was convened.

Unfortunately, these attempts have not made much of a dent in society's attitude that children are the personal property of parents. A current example of this archaic thinking is the June, 1979 ruling by the Supreme Court which denied children the right to a legal hearing before commitment to mental institutions (Tampa Tribune, July 1, 1979). The court declared, in effect, that parents should be free to do whatever they want with their children.

[Child abuse as a recognizable syndrome is a relatively recent phenomenon.] Even though Tardieu, in 1860, had documented and written about child abuse, it was not until 1946 that Caffee, by using radiologic observations, was able to substantiate and legitimize a diagnosis of child abuse/neglect (in Silverman, 1974). The complex

psycho-social background of child abuse and neglect was largely ignored until the 1920's. It was at that time that Dr. Janet E. Lane-Clayton urged further study into the matter.

The current interest in child abuse and neglect can be traced to Dr. C. Henry Kempe. It was he who, in the 1950's coined the term, "the battered child syndrome" (Kempe, 1961). This, in turn, has evolved into the more comprehensive terminology, child abuse and neglect. As the 1980's are entered, child abuse and neglect should be viewed as a multi-faceted psycho-social system, based upon medical and epidemiological considerations, which involves not only the individual, but also the family, the community, and ultimately, society at large.

Statistics

The National Center on Child Abuse and Neglect (1979) estimates that 100,000-200,000 children are physically abused; 60,000-100,000 are sexually abused, and the rest neglected to the point that they suffer physical and/or emotional deprivation. More than 30,000 of these children live in Florida. Each year, at least 2,000 of these million children are expected to die as a direct result of the trauma of child abuse and neglect. This estimate is based on comparisons of National Estimates of Abuse/Neglect from 1962 to 1975.

Schmitt (1978) in his work with abused children found that approximately 1/3 of physical abuse cases occur in children less than six months old, 1/3 between six months and three years, and the rest in children over three. This has been refuted in other studies (Gil, 1970; National Analysis, 1979) which seem to suggest that children of all ages are equally involved. According to the National Analysis

(1979), overall (birth to age seventeen), child abuse and neglect is divided equally between males and females. Boys are more likely to be abused until age eleven. By the fifteen to seventeen year old age group, the abuse/neglect of girls out-numbers boys. Sexual abuse occurs almost totally in girls, half of whom are under twelve. Failure to thrive (i.e., a marked retardation or cessation of growth) occurs most frequently in the first year of life.

Children younger than two are in the greatest danger of being killed. The 1977 National Analysis (1979) estimates that 60% of this age group, when compared to the other age groups, will die. Almost half of the ones who do not die will sustain some type of permanent disability. Other siblings are also being abused in 20% of reported cases and there is a 50% chance that the reported case is not the first abusive episode. Abuse and/or neglect will continue in half of the cases if there is no intervention (Fontana, 1964). When abuse and neglect figures are combined, over 80% of the perpetrators were natural parents. The figure rises to 90% in neglect only and lowers to 72% for abuse only (National Analysis, 1979). The most important factors as to who becomes the abuser appear to be access to the child and primary caretaking responsibility.

The statistics mentioned above, and the others which follow should be used only as an overview and guideline for realizing the scope of child abuse and neglect. It is this writer's view that the important concept is not the actual number of children who are abused/neglected, but that there are a significant number of children and parents who are suffering and in need of help.

A number of factors interfere with accurate reporting of child abuse and neglect statistics. They include biased sources of information such as not separating abuse from neglect or substantiated from unsubstantiated reports; differences in definitions among the states; ongoing changes in professional and public awareness; bonafide cases of abuse or neglect not being recognized; and a discrepancy between reported and substantiated incidents. It appears to be common knowledge among experts in child abuse and neglect that many cases of maltreatment are undetected (Fontana, 1964; Kempe & Helfer, 1976; Schmitt, 1978; Walters, 1975). Consequently, the reader should keep in mind that these factors tend to cause an underrepresentation of the problem. This, in turn, serves to highlight the seriousness of child abuse and neglect.

The very nature of child abuse and neglect seems to cause a bias in reporting. It depends on another person, after suspecting or recognizing the problem, to call a central registry or child protection agency to report the family. The National Analysis (1979) found friends, neighbors and relatives to be the source of 40% of the initial reports. Schools, law enforcement agencies and medical personnel were responsible for 36% of the referrals. Only 2% of the incidents were reported by the victims. It is interesting to note that of the reports studied in the Analysis, over 50% of those presented by professionals were substantiated, whereas only 34% of the non-professional reports were substantiated. While it is important to investigate all reports of mistreatment, it should be remembered that non-professional sources can be motivated by anger,

a desire for revenge or other unsuitable emotions. Professionals are usually more adept at screening cases and making objective decisions and judgments.

Definitional differences have led to discrepancies as to what constitutes abuse or neglect; who must report and how these reports should be made; and legal and penal sanctions. These differences can lead to confusion not only among states, but within them. For example, Texas has a Family Code designed to protect children from abuse. But another law, which went into effect in January, 1974 states, "The use of force, but not deadly force, against a child younger than 18 years is justified; (1) if the actor is the child's parent or stepparent . . . (2) When and to the degree the actor reasonably believes the force is necessary to discipline the child . . ." Under this law, a parent, as long as the child is not killed, can use whatever force or method he wishes to punish the child (Justice & Justice, 1976). The 1978 Annual Review (1979) reports that as definitions of abuse and neglect are broadened, as more classes of people are required to report with increased confidentiality of records and more central registries open, greater standardization is occurring. This should lead to greater statistical accuracy when comparing data on the incidence and prevalence of child abuse and neglect. It is expected that conflicting statutes such as the one cited above and ambiguities in other ordinances will be reduced as this standardization happens.

Public and professional awareness of child abuse and neglect appears to be in a state of flux. The National Analysis (1979) speculated that as more kinds and numbers of professionals were

educated as to the symptoms of abuse/neglect, and as the public becomes aware of both the scope and sources of reporting, more abuse/neglect would be recognized and reported. They did find a 23% overall increase in the number of reports from 1976 to 1977. Yet, a wide variation in the percentage of change in the number of reports (decrease of 24% in Florida to an increase of 498% for Montana) and in the reporting per 1000 population (low of .2/1000 to a high of 7.1/1000 with a national average of 2.3/1000) suggests that factors other than increased awareness are operating. The most likely causes of these variations are inherent defects in the reporting systems themselves. Additional work is needed to refine and standardize these reporting systems in order to increase their reliability as indicators of child abuse/neglect. It is also important to follow these variations in order to find those places where a true increase/decrease exists. They, in turn, could be analyzed to further increase knowledge in the causes and prevention of child mistreatment.

One constant does seem to be a similiarity in types of incidences being reported. This suggests that while not all abuse/neglect is being reported, a statistical inference can be made as to the types that exist. The National Analysis (1979) reported 33% of the substantiated cases were for abuse only, 51.8% for neglect only, and 15.2% as combined abuse and neglect. Of these reports, the majority were for lack of supervision (31%), physical neglect (29%), emotional neglect (24%), and cuts/bruises/welts (19%). Sexual abuse accounted for almost 6% of the reports. Since a child could experience more than one type of abuse/neglect, the total percentages add up to more

than 100%.

The National Center for Child Abuse and Neglect estimates a 4:1 or 5:1 ratio of neglect to abuse. This differs from Schmitt's (1978) findings that 85% of the child abuse and neglect cases are physical neglect, 10% sexual abuse, and 5% failure to thrive secondary to nutritional deprivation. These differences are probably caused by changes in categories and definitions over the years rather than to an actual change in neglect/abuse ratios. For example, Schmitt (1978) admits to not listing emotional abuse as a separate category, while the National Analysis (1979) does. Caution should be exercised when comparing abuse versus neglect statistics from year to year or study to study. It is important to make sure that comparable categories are being analyzed before reaching any conclusions.

Many abused or neglected children simply escape detection (Fontana, 1964; 1978 Annual Review). The reasons include: believable parental stories; children who are too young or too frightened to tell; physicians who refuse to believe that parents are capable of such acts or who fear the legal complications; the early return of children to parents by children's court judges; no medical attention sought; using a different doctor/hospital; and misdiagnosis by medical personnel. As society becomes more aware of child abuse and neglect, it can be expected that fewer children will remain undetected. This should result in greater statistical reliability and validity of such analyses.

The last factor which interferes with accurate statistical inferences is the problem of substantiated versus unsubstantiated

reports. While it is realistic to assume that not all investigations will yield a bonafide case of abuse/neglect, this area is in need of a standardized definition of what constitutes a provable episode. According to the National Analysis (1979), definitions of a "substantiated case" range from just making sure the incident really took place, to those cases for which services were provided, to only those which could be adjudicated. The National Study uses as their definition, "any case where protective services have been provided or deemed appropriate." (p. 29). It is obvious that the closer the reports are to this definition, the greater the substantiation rate, but that still does not preclude the fact that an actual incident did not take place.

Definitions

As stated earlier, the concept of mistreatment has evolved from the battered child syndrome of Kempe (1962) to the currently used terminology of child abuse and neglect. Just what, then, is child abuse and neglect?

First, child abuse and neglect is a heading which encompasses four main categories: physical violence or abuse; physical and emotional neglect; emotional abuse; and sexual abuse or exploitation. Secondly, what is needed are workable, operational definitions with objective standards instead of subjective norms. Such definitions should protect both children's and parent's rights, set standards and objectives, and spell out the necessary and sufficient conditions of abuse and neglect. They should provide the framework within which prevention, diagnosis, intervention and amelioration can function. This would enable children's health and welfare to be protected,

even if the parents refuse assistance, without fear or arbitrary or inappropriate actions on the part of social service agencies or the judicial system.

Current definitions can be so broad that they include all acts that interfere with the optimal development of children or so narrow that they confine abuse and neglect to only those instances that result in observable injuries (1978 Annual Review). The first is entirely too subjective, while the latter is too constricted and limited.

There appear to be two main obstacles to formulating definitions which are specific enough to prevent misapplication while remaining useful to all those agencies involved in child abuse and neglect. One is that the specific needs of the different institutions involved in the amelioration of child abuse/neglect differ; the other is that the value systems of the people charged with the responsibility may differ. As it stands today, a protective services case worker may have to deal with a criminal law definition which specifies which forms of abuse/neglect are criminally punishable; a juvenile court act which authorized the use of protective services and/or removal from the home; a reporting law definition by which the child first came to the attention of the authorities; whatever definition that caseworker's particular agency may favor; and his/her own, internal definition. It is no wonder that children "fall through the cracks."

Since what looks good in theory may not be applicable in practice, the only way to establish a good definition is by

continually revising the old ones. Personal bias and attitudes are harder to overcome. It has already been historically established that society has yet to develop absolute cultural taboos and legal sanctions against the use of physical force by adults toward children. There are even fewer limitations on neglect, especially emotional neglect. For example, Boehm (1964) found that while there is a strong consensus for protective action in abuse cases, a majority of those queried opposed the same action in emotional neglect cases. This author believes that what is needed is an awakening by society to the fact that emotional abuse and neglect can be even more damaging and long lasting than the consequences of physical attacks. A bone heals in a far shorter time than a bruised psyche.

Kempe's (1962) definition, "a battered child is any child who received non-accidental physical injury (or injuries) as a result of acts (or omissions) on the part of his parents or guardian," (p. 18) is a broad definition that covers physical and sexual abuse and neglect, but does not mention emotional abuse and neglect. Gil (1970) on the other hand, prefers a definition for child abuse based on the motivational and behavioral dynamics of the perpetrator. He feels that child abuse is intentional, non-accidental use of physical force, and that neglect is the intentional, non-accidental acts of omission, on the part of a parent or other caretaker, which is aimed at hurting, injuring or destroying that child. He does not include sexual abuse, unless it is accompanied by physical harm, or emotional neglect/abuse. Also, the emphasis on intent precludes those instances when a child is hurt accidentally, e.g., when a

simple spanking escalates into a beating which results in bruises and welts.

Kempe (1978) later sought to define child abuse/neglect according to the different types. He defined physical abuse in terms of whether the injury or injuries required medical attention, even if it was not given. Physical and emotional neglect was defined in terms of not safeguarding the health, safety and well being of the child(ren). Inadequate clothing and nutrition, no medical care, and failure to protect from physical or social danger are examples of this type of neglect. A diagnosis of emotional abuse was considered if the child is constantly terrorized, berated, and/or rejected by parents and/or guardians. Sexual abuse or exploitation was considered if dependent, developing, immature children and adolescents were involved in sexual acts that they did not fully comprehend, were unable to give formal consent to and that violated the social taboos of family roles (Helfer & Kempe, 1976). This includes sexual abuse due to rape, incest and molestation. Of all Kempe's definitions, this one appears to be the most concise and workable. The definition on physical abuse is too limited in scope, the one on neglect is too easy to misuse, and the one on emotional abuse, while a good beginning, is not comprehensive enough.

The Model Child Protective Services Act (Lauer, Laurie, Salus, & Broadhurst, 1979) is the definition of choice for use in this paper. It spells out clearly and concisely the parameters upon which child abuse/neglect can be judged and appears to be objectively applicable to the different situations common to abuse and neglect.

It is, as follows:

1. "Child" means a person under the age of 18.
2. An "abused or neglected child" means a child whose physical or mental health or welfare is harmed or threatened with harm by the acts or omissions of his/her parent or other person responsible for his/her welfare.
3. "Harm" to child's health or welfare can occur when the parent or other person responsible for his/her welfare:
 - (a) Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or
 - (b) Commits, or allows to be committed, against the child, a sexual offense, as defined by state law; or
 - (c) Fails to supply the child with adequate food, clothing, shelter, education (as defined by state law), or health care, though financially able to do so or offered financial or other reasonable means to do so; for the purposes of this Act, "adequate health care" includes any medical or non-medical health care permitted or authorized under state law; or
 - (d) Abandons the child, as defined by state law; or
 - (e) Fails to provide the child with adequate care, supervision, or guardianship by specific acts or omissions of a similarly serious nature requiring the intervention of the child protective service or a court.
4. "Threatened harm" means a substantial risk of harm.
5. "A person responsible for a child's welfare" includes the child's parent; guardian; foster parent; an employee of a public

or private residential home, institution or agency; or other person responsible for the child's welfare.

6. "Physical injury" means death, disfigurement, or the impairment of any bodily organ.

7. "Mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within a normal range of performance and behavior, with due regard to his culture. (pp. 1-2).

Demographics

The following is a brief summary of child abuse and neglect demographics. For more detailed descriptions, evaluations and critiques of this and other areas of child abuse and neglect, the reader is referred to S.M. Smith's books, The Battered Child Syndrome (1975) and The Maltreatment of Children (1978). Bourne and Newberger's book, Critical Perspectives on Child Abuse (1979) is another book which is both thorough and enlightening. When percentages are used, they are from the 1977 National Analysis of Official Child Abuse and Neglect Reporting (1979). Any other source will be so stated.

Income: While all socio-economic levels are represented, the lower levels are overrepresented (Gil, 1970; National Analysis, 1979; Pelton, 1978; Smith, 1975). Gil found 60% of the families in his study were receiving some type of public assistance. Over 90% of the families involved in the National Study had incomes below the 1977 median of \$16,009, with 43% receiving some type of public

assistance such as Aid to Families with Dependent Children or Food Stamps. The median income for neglect only families was \$4,633, while abuse only families earned \$7,017. It has still not been established if this difference is due to the vagaries of reporting (i.g. greater use of emergency rooms and social services) or to a true incidence of abuse and neglect in the lower incomes. The amount and consistency of available data suggest it is a reflection of a greater incident of abuse/neglect in the lower socio-economic group rather than a reporting or sampling bias.

Parental Figures in the House: (Adams, 1976; National Analysis, 1979; Smith, 1975). There is a greater likelihood of neglect over abuse in a single parent home, with single mothers being 2 times more likely to neglect or abuse than single fathers. When compared to single parent homes, two-parent homes are more likely to abuse (75%) than to neglect (53%). It is also in two-parent homes, rather than single-parent homes, that abuse and neglect occur together. Single-parent homes (38%) are over represented when compared to data on U.S. children as a whole (15.7%). Overall, males and females appear to be equally involved, with the most important factor being access to the child (Schmitt, 1978).

Other Factors Present: Lack of tolerance, less knowledge about developmental states and children in general, decreased ability to provide medical and health care, (National Analysis, 1979); increased levels of environmental stress (Gregg & Elmer, 1969; Bennie & Sclare, 1969); alcoholism (Glazier, 1971; Virkkunen, 1974); prior involvement with law enforcement (Virkkunen, 1974);

Smith, Hanson & Nobel, 1973) social isolation (Steele & Pollack, 1974; Elmer, 1967; Gil, 1970) and family discord (National Analysis, 1979) are all factors which appear to be common familial characteristics in Abusive/Neglectful families.

The data reviewed suggest that neglecting households differ substantially from abusing households. Delineating factors for abuse appear to be lack of tolerance (40%) and loss of control during disciplining (38%). Neglect appears to be linked to insufficient income (38%) and broken family structure (56%). The data reviewed suggest that environmental stress factors seem to be more important in neglect cases; personal characteristics or inability to cope in abuse cases.

Household size: The National Analysis (1979) found no overall significant difference between the number of children in abuse/neglect families (2.4) when compared to the national average (2.2). In fact, 41% of the abused children were only children. This differs with the findings of other researchers such as Elmer (1967) who found abusive families to be larger than average, with neglectful families slightly larger than abusive. It is unknown what factors are operating to cause this discrepancy. One possible explanation is the overall reduction in the birth rate between 1965 and 1977. More current data were unavailable to support this opinion.

Age of Perpetrator: Discrepancies were also evident in the age of the perpetrator. Whereas, some research reported most abusers as under 30 (Gil, 1970; Elmer, 1967; Smith, 1965) the National Study

found 55% of the alleged perpetrators to be over 30 and only 7.6% under 20. The majority (70%) did fall in the 20-40 year old range. The National Study did support the finding that perpetrators younger than 30 were twice as likely to be female. Females of all ages are more likely to neglect; males to abuse.

In this writer's opinion, the age of the perpetrator, upon analysis, means nothing, especially when the following observations are made:

1. Most child rearing takes place during the adult years 20-40.
2. If more young children are abused/neglected (approximately 60% are under 8) then, given that people have children in their 20's, the parents themselves will be young.
3. Valid conclusions cannot be inferred about the age discrepancies between the earlier studies and the National Study unless the age or family placement (1st, 2nd born) of the abused/neglected child is known.
4. While 55% of the parents were indeed over 30, only 22% were over 40. (This is a good example of how statistics can be manipulated to reach a conclusion). This means that the majority of child abuse/neglect perpetrators are still within the major child rearing time span.
5. Women are still considered to be the primary caretakers of young children and are left at home with them more often than males.
6. The fact that less than 10% were under 20 suggests that

emotional immaturity is not a big factor in abuse and neglect. An important, but missing piece of data is the percentage of people under 20 with children who do not abuse. For example, if 20% of the general population fits into this category then an abuse figure of 10% would be very significant.

7. This data suggest the necessity of further research into why females are more likely to neglect than to abuse.

Ethnicity: There is general agreement that whites make up a majority of the cases (66%), but blacks (17%) and people with Spanish surnames (9%) are over represented when compared to the general population, blacks (11%) and Spanish (5%). Religion and nationality do not seem to be statistically relevant.

Educational Level and Intelligence: All educational levels are represented, with an over representation of those not finishing high school. This would be consistent with lower income levels. The IQ range (70-130) follows a bell curve. Steele and Pollack (1974) found no significant relationship between intelligence test scores and the likelihood to abuse, yet Elmer's (1976) data suggest that child abusers have lower intelligence than non abusers. Therefore, additional research is recommended before an objective conclusion as to the role of intelligence as a function of child abuse/neglect can be reached.

Relationship to Child: 80% of all abuse and neglect is executed by the natural parents. In neglect only, the figure raises to 90%, and it lowers to 72% for abuse only (1977 National Analysis, 1979).

Research Problems: The data collection methods used to reach these

conclusions consist mainly of reviewing and analyzing surveys, case studies, case records of hospitals, emergency rooms and HRS workers, interviews, observations and psychological testing. Sample size, characteristics of study populations and the data collection methods vary to such an extent that it is hard to compare results among them. And yet, this very variety, lends credibility to a finding when it appears again and again.

The studies included in this section were those which appeared to be based upon acceptable research foundations. For example, the 1977 National Analysis (1979) is based on reports submitted from all 50 states, the District of Columbia and the Virgin Islands as mandated by the Children's Bureau of the Department of Health, Education and Welfare in 1973. These reports use a standardized form which the caseworker completes.

Elmer's (1967) study is based on a group of 50 children who were previously admitted to the hospital with symptoms of physical abuse. It involved extensive record reviews and case studies from which evolved a structured interview and home observation sheet. She did not use a control group since she felt that she did not know enough about abused children to select a "contrast." After data analysis, her original group separated into an abuse group, a non-abuse group and an unclassified group, which she then compared. She herself cautions about the use of her findings as conclusive rather than suggestive of results.

Gil (1970) attempted a Nationwide Survey which predated the National Study described above. He used legal reporting channels

to obtain as large and as broad a base of information as possible. Some of the study's short-comings include the exclusion of sexual abuse unless accompanied by physical abuse, definitional differences among the states as discussed earlier and the inability to draw reliable inferences from reported to unreported cases.

Neither the National Study, nor Gil's study, used a control group or a random selection process, but attempted to include all reports during a given time. Elmer's study also included all reports during a given time frame. This appears to be the method of choice for most demographic research in child abuse/neglect: (a) decide on a time frame and the location; (b) find everyone involved during that time; and (c) analyze the results.

As stated earlier, these demographic and statistical findings should not be taken as conclusive but rather as guidelines to be used to create viable prevention and treatment programs. If these statistics are interpreted too often as unshakable truths, there is a great chance that many people will be overlooked. While it may be that most abusers come from the lower socio-economic classes, not all of them do. What happens to those who are not low income if the only helping programs are available through public health clinics or welfare agencies? This would be a classic case of reverse discrimination. To label child abuse/neglect as another outgrowth of poverty is also an injustice because it precludes the investigation of other reasons for abuse. A poor environment may be a contributory factor in child abuse/neglect, but it does not fully explain why the majority of poor people do not choose to abuse,

nor does it explain why people who are not poor choose to abuse. Lastly, correlational data has not proven that poverty alone causes abuse.

Discrepancies between studies should be used as keys for further research. Part of the discrepancies are functions of the studies themselves. As Steele & Pollack (1974) put so well, "Different reports reflect the inevitable result of using skewed samples, social agencies, welfare organizations, and municipal hospitals will . . . draw . . . from lower socio-economic states, whereas private doctor's clinics and hospitals will attract a different sample which is also skewed." (p. 93).

Some of the discrepancies between the studies are a function of increased knowledge. Others are due to changing life styles and differences in population growth. As a nation we are growing older, having fewer children at later age, and experiencing more broken families. Another type of family with multiple parents (through divorce and remarriage) is emerging.

Since the implication is that child abuse is a function of family dynamics, then as the family changes, the demographics of the abusive/neglectful family will change and the programs offered will have to change to meet those new needs. What is valid today may not have been valid a decade ago nor may it be valid in the future.

On the whole, current research is continuing to support, rather than refute earlier demographic information. Discrepancies, when they arise, appear to be more a function of the methodology rather

than a restructuring of basic information. While it is necessary to continually update and improve the kind of information, it is even more important to develop studies which can empirically evaluate the efficiency of treatment and prevention procedures.

2 PERSONALITY VARIABLES AND CHARACTERISTICS

Before beginning this chapter, it is important to say something about the information that will be presented. Chapter 1 dealt with statistical facts derived by analyzing reams of demographic information. This chapter presents theoretical, subjective conclusions based more upon professional bias, years of working with abusive people and abused children, studies of case histories, assessment procedures common to psychiatric diagnosis and observations both in clinical and home settings and therapeutic interviews rather than upon random sampling and statistical analysis methods. Consequently, the reader may find information about design specifics scanty. In those cases, it is safe to assume that the study was not developed by using a "true experimental research design." It is also this writer's opinion, that studies which are not "true experimental designs" do not necessarily produce "bad" results and "good" studies do not necessarily produce workable or useful information.

Even Bourne and Newberger (1979), who appear to have chosen the role of devil's advocate, failed to dissuade this writer from accepting these early findings as valid. While they, too, bemoan the scarcity of scientific investigation and caution against relying too heavily on the conclusions drawn from contaminated studies,*

*(This writer defines a contaminated study as a study which appears to deviate markedly from earlier findings. It is no longer contaminated if the results can be duplicated by using a better research design than the original.

they were unable to refute the information presented in this paper to this writer's satisfaction.

Personality of the Abuser

Adults who harm children seem to display consistent behavior patterns and a unique combination of personality characteristics which can exist in combination with, but independent of, other psychological disorders (Steele & Pollack, 1974). Kempe (1976) and Schmitt (1978), in their practices, found the incidence of psychosis or criminality at only 10%. The other 90% may or may not exhibit various signs of psychological disorders.

These psychological disorders, when present, are usually severe enough to require therapy and interfere significantly with the abusers quality of life (Martin & Beezley, 1977; Steele & Pollack, 1974). According to Kauffman (1974) and Steele (1980), child abuse is a reflection of an internal struggle in the parent. From this perspective, the objective of child abuse is to cope with the overwhelming tension in the parent, not to discipline the child in order to teach a principle. They feel that this holds true no matter what triggers the abusive episode.

Data such as these suggest that the abusers have a maladaptive pattern of caretaker-child interaction which operates independently of any other psychological state, regardless of whether their level of functioning can be classified as normal or abnormal. The particular constellation of emotional states and adaptive patterns common to abusers is hypothesized to have its beginnings in the earliest months of life.

Personality variables which consistently appear in abusive/neglectful people are depressive trends (Fontana, 1964), anti-social behavior, feelings of worthlessness, suspicion, distrust and feeling victimized (Steel & Pollack, 1974). It is common for abusers to report problems coping with their own mothers and to be sensitive to rejection in any form. Low self esteem, loose collections of unintegrated disparate concepts of self and high vulnerability to criticism are all common (Steele & Pollack, 1974). Fontana (1964) also found rigidity, compulsiveness, and a lack of warmth toward the mistreated child to be prevalent.

Davoren (1974) found abusers relied on the defense mechanisms of flight or submission. Even those who asked for help kept distant from it. On a simplistic level, Fontana (1964) believed the greatest single cause for abusive behavior was emotional immaturity. Of course, the causes are much more complex and involve not only personality characteristics but also physical and cognitive capacities, life experiences, situational factors such as the family makeup and living conditions, the social and economic environment and lastly, the abusers attitudes and values toward children and family.

It appears to this writer that child abuse is not unlike a puzzle in which all factors, to a varying degree, become crucial to the whole. Remove a few factors or change them and the puzzle falls apart--there is no abuse or neglect. Put them all together and, abuse/neglect will happen. This is why, while numerous attempts have been made to clarify and classify the personality variables common to abusive/neglectful parents into a classification system,

no agreement has yet been reached. Milowe, for example, (in Ebeling & Hill, 1975) describes four distinct clusters: (a) hostility and aggressiveness due to internal conflicts present at all times; (b) lack of warmth, reasonableness and pliability in thinking and beliefs in combination with rigidity and compulsiveness; (c) strong feeling of passivity and dependence; and (d) the presence of the father at home while the mother worked to support the family. Morris, on the other hand, (in Ebeling & Hill, 1975) describes another four: (a) distress and guilt about the parent-child relationship and treatment; (b) undercontrolled, impulse-ridden parent who blames child for the troubled relationship; (c) overcontrolled parent who feels the relationship is "correct;" and (d) a parent who is responding to inner stimuli and events rather than to the child. Galdstone (1965) expanded his list to seven: (a) use of projection as a defense against intrapsychic stress; (b) tendency to translate affect states into physical activity without benefit of conscious thought; (c) intolerable self-hatred which is taken out on the child; (d) correspondence by sex, age, or family position of the child to events in the parent's lives which caused self-hatred; (e) lack of available alternative methods of handling conflict; (f) compliance with the act by the marriage partner, and (g) absence of available authority figures such as grandparents or religious leaders.

These examples illustrate the problem of formulating workable typologies. While general agreement exists on the personality variables present, no one can agree on the kind of exact combination or combinations which will produce a personality prone to abuse or

neglect.

A person's life experiences, especially those involving parent-child interaction can be expected to have an effect on their own parenting ability. To an overwhelming point, the data suggest that these perpetrators are recreating how they were raised and/or to have experienced a disfunction in the mother-infant bonding process. It is not unusual for an abuser to report a history of being abused as a child.

Their upbringing is perhaps best described by Steele and Pollack (1974): "they have experienced a sense of intensive, pervasive continuous demand from their parents in the form of expectations of good, submissive behavior, prompt obedience, never making mistakes, and sympathetic approval and help for parental action." (p. 95). These adults, when looking back on their childhood, felt that parental demands were excessive in degree and prematurity and were accompanied by a sense of constant criticism. In other words, not only were they unable to understand what was expected of them as children or how to accomplish it, but also that their attempts to please were viewed as "erroneous, inadequate, inept, and ineffectual." (p. 96). This, in turn, led to feelings of being unloved and to an unshakable feeling that their own needs were wrong or unimportant. In time, they came to believe their parent's view of them was justified.

Evidence suggests that this "lack of mothering" which Steele (1974) defines as "the ability to give tender loving care, to be both aware and considerate of the needs and desires of the infant, to

respond to those needs in a constructive, appropriate manner, and to be concerned for the immediate well being and subsequent development of the child," (p. 102) is passed from one generation to the next. And these children, as they grow up to become parents, expect and demand too much from their offspring (Davoren, 1974).

— A list of the situational factors which affect child abuse and neglect reads no differently than a list for non abusers. What differs is how the abusing family copes with the everyday stresses and crises of living.— According to the 1978 Annual Review, mitigating situational factors include: marital status (single, divorce, death), and quality (communication, dependency needs); number, age and spacing of children; family interaction; presence/absence of significant others; and degree of social isolation. Living conditions include: the kind of food, clothing and shelter; health care; geographic location; and availability of transportation. Economic status includes: employment, income level and job satisfaction. Of these, low income, social isolation, and marital discord appear to be the most important variables. The research designs used to reach these conclusions were primarily retrospective and prospective case reports and studies, record reviews, interviews and questionnaires. There were some, but not enough, use of comparison or control groups.

The social isolation factor seems to be a continuation of the lack of confidence and trust engendered in early childhood by the abuser's parents. Transference of this attitude toward society makes it impossible for them to express their real needs and desires

to others (Fontana, 1962). Without someone to turn to for information or help, even the most well adjusted parents can be threatened by the day to day demands and pressures of child rearing. Steele and Pollack (1974) found that abusers, when married, had a relatively stable union. The critical moderating variable appeared to be lack of real love or a happy, cooperative relationship between the spouses. The data reviewed leave the impression that abusers have stable relationships out of a dependency need rather than a genuine commitment to each other. Being frustrated in their desire for love and approval, they turn to their children for their unmet needs.

According to Davoren (1974), who worked with Steele and Pollack on their 5½ year longitudinal, uncontrolled study of 60 families, characteristics of these marriages include: total dependence on each other coupled with an inability to really trust or rely on their spouse; poor communications of feelings and an avoidance of open hostility and disagreement on child rearing practices. She also found that any kind of disinterest or criticism of one spouse by the other was viewed as rejection which sparked fears of abandonment. It is not unusual for these people to be jealous of attention paid to their partner by others, including their own children. They are so insecure in their unions that they feel constantly threatened by other people in their lives.

Gil (1970), in his National Study, as described in Chapter 1, found unemployment, unwanted pregnancy and marital and family conflicts to be the "social causes" of the psychological stresses which lead to abuse/neglect. Gelles (1973) hypothesizes that the

children are a specific source of stress and trouble. In other words, they act as a scapegoat for parental fears and frustration. This has important ramifications on the role of the child in the abuse and the child chosen for abuse/neglect. Martin and Beezley (1977) found the home environment to be unstable as evidenced by many family moves, unemployment, poor household management skills, and divorce or parental separation. Justice and Justice (1976), as an outgrowth of their work with abused families, support the above findings.

Personal attitudes, expectations and values can be expected to affect how a person will relate to children and family and how they will act towards them in time of stress. It is in this area that the abusers/neglectors appear to be the most deviant from the norm. Davoren (1974) found the following attitudes to be characteristic of abusers: (a) not being capable of seeing the infant or child as an immature human being lacking the capacity for adult perceptions and behavior patterns; (b) expecting the child, from birth, to provide a climate of warmth, acceptance, and love for the parents; (c) a complete lack of sensitivity to the child and disregard of the child's needs; (d) expectations of instant obedience and (e) the belief that the abuse was justified in order to teach good behavior and manners.

The data suggest that abusive/neglectful parents misperceive their children in many distorted/unrealistic ways. In general, they expect the child to provide them with emotional support when they are upset and they base developmental task performance on their

unrealistic desire for the child to succeed rather than on the child's ability or readiness to accomplish the task. Performance demand from abusers is usually excessive, premature, and beyond the ability of the infant or child to understand. No matter how old the child, six months or six years, an abusive parent deals with him as if he is older than his chronological age.

This attitude is defined by Morris and Gould (1963) as role reversal-"a reversal of the dependency role, in which parents turn to their infants and small children for nurturing and protection." (p. 31). It involves two basic elements: a high expectation and demand by the parent for the infant's performance and a corresponding parental disregard of the infant's or child's own needs, limited abilities and helplessness.

Evidence suggests that it is in these attitudes and values that the abuser differs markedly from non abuser. Abusers, when compared to non abusers, implement acceptable ideas and standards of child rearing with exaggerated intensity at an inappropriately early age (Steele & Pollack, 1974). They also feel, as opposed to non abusers, that children who do not satisfy their needs as parents or who ask that the child's needs be considered, deserve to be punished (Kempe & Helfer, 1972).

Neglectful and abusing parents seem to be alike in that they need and demand a great deal from their children and experience distress when they get an inadequate response. The differentiation appears to be that neglecting parents respond to their disappointment by giving up and abandoning their efforts to mechanically care

for the child whereas the abuser moves in to punish for perceived failure or to make the child "shape up" (Steele & Pollack, 1974). The data imply that an abusive parent very seldom starts out to severely injure or kill their child. Somewhere during the punishment episode they lose control of themselves and are unable to stop the beating. These parents do love their children as much as their limited capabilities will allow. What they appear to lack is the ability to delay need gratification or to sacrifice their needs for their children's needs. It is when their needs are in conflict with the child's needs that abuse or neglect is most likely to happen.

In summary, the potential for abuse or neglect is determined by the proper combination of personality variables, situational factors, and attitudes and values. Child abusers have a heightened sensitivity and vulnerability to criticism in combination with low self-esteem and self-worth. They recreate how they were raised. Unable to discharge a lifelong rage and anger toward their parents for their unmet needs as a child, they turn to their own-children with these expectations. Then their children, unable to satisfy them, become scapegoats or objects of assault.

The situational variables most often connected with abuse/neglect are a high degree of social isolation; marriages based on immature dependency needs rather than love, mutual trust and cooperation; and low income.

Abused and neglected children are misperceived by their parents both cognitively and developmentally. Neglectful parents turn away or give up on the child while abusive parents attack to

"make them better."

Personality of the Child

Of course, child abuse or neglect cannot exist unless a child is present. Yet, no one can agree as to what kind of child is necessary. The abused or neglected child can be perceived as different, may fail to respond in the expected manner, or he may really be different (retarded, hyperactive, birth defect) (Oliver & Buchanan, 1978). Kempe and Helfer (1972) have concluded that if only one parent is predisposed to abuse then these characteristics will result in a specific child being beaten. If both parents are predisposed, all the children may be beaten. Some battering occurs only when specific developmental stages in the child trigger specific conflicts in the parents. Others occur because the parent punishes the child for attributes which they dislike in themselves or because the child's sex, age or family position correspond to events in the parent's life that they did not like.

The 1977 National Analysis (1979) was inconclusive as to the relationship of special characteristics to abuse. Yet Lynch and Roberts (1977) in a control group study of 50 children found the abused child is often the product of an abnormal pregnancy or an abnormal labor or delivery.

Martin and Beezley (1979) were some of the first researchers to investigate the personality of the abused child and the role that child played in the dynamics of abuse. Their studies, while landmark studies, also suffer from lack of true scientific investigative methods. There were no control groups. They reached their

conclusions by assessing the neurological/intellectual functions of abused/neglected children as compared to previously established norms within the general population and by using both observation and assessment procedures to measure change which could be attributed to the post-abusive environment. They found that the abused or neglected children they observed lived in an unstable, punitive household; that the children expressed a feeling of impermanence in their living situation as evidence by home changes, divorce or separation and that parental emotional distancing was reflected in verbal or non verbal rejection or hostility and/or excessive physical punishment.

In addition, Steele and Pollack (1974) concluded that: (a) since the child's personality is affected and shaped by the total environment in which he lives, the broader picture is in the long run more significant to the child's development than the abusive episode; (b) there is no one classical or typical personality profile for abused children, only certain traits; (c) a major mechanism of survival for an endangered child is modification of his behavior according to the surroundings which results in a chameleon adaptation to various people and settings; (d) the abusive environment does impact and influence the developing child's personality; (e) any particular trait can be seen as a symptom, a distortion, a problem, or an adaptation of the child to his environment.

It will become apparent, quickly, that this section will not be as long nor as detailed as the preceding one on the adults.

This may seem incongruous to the reader, since the child is the one to suffer the consequences of the abuse/neglect. But, in the early investigative stages into the nature of child abuse/neglect, it was found that the children had to be ignored so that the parents could be helped. (Steele & Pollack, 1974; Kempe & Helfer, 1976; Fontana, 1975). In other words, "fussing over the child" was interpreted as criticism by the parents which, in turn, further alienated them from those who could help. These investigators found, through experience, that only by focusing attention on the abuser could the children be rescued. Consequently, early research was in the area of adult epidemiology with little emphasis on the children. It is only recently that more of the research focus has been on the children.

Galdstone (1971) hypothesized that physical abuse creates a predisposition to developing violent behavior as a character trait. Studies of juvenile delinquency (Madden & Lion, 1976; Gil, 1970; Gelles, 1973) and felons (Bach-y-Rita & Veno, 1974) support this notion; i.e., a greater number of adolescent and adult criminals have a history of child abuse than would be expected by the laws of probability.

Abused/neglected children suffer physically, intellectually, cognitively and/or psychologically. A follow-up study by Elmer (1967) found that only 4% of the children involved in the study had escaped some type of defect; 25% had injuries severe enough to require institutionalization or had died. Her original study was designed to determine the condition of children who had once been admitted to the hospital with either suspected or confirmed abuse.

In cases where abuse/neglect started within the first year of life, significant delays in motor, social, cognitive and speech development were noted (Kempe & Kempe, 1978). As a result of observing abused and normal children, Helfer & Kempe (1976), concluded that abused infants less than six months old exhibit the beginnings of motor, speech and social development delays; six to twelve month olds lack separation or stranger anxiety;* and one to two and a half year olds can have speech delays and retarded social development. Again by using observation techniques, experience and follow up studies, they found by pre school age ($1\frac{1}{2}$ - $4\frac{1}{2}$), neurological symptoms had appeared. Behaviorally, the children they studied were anxious, fearful and expected to be punished. Reassurance could not change their attitude. They lacked an ability to play and were unable to express feelings or to talk about their families.

Martin (1972), by utilizing a developmental evaluation consisting of anthropometric measures such as head size, and chest circumference, neurological exams, developmental testing and clinical judgement based on examiner's observation, plus nurses' reports and history, studied 42 children over a five-year period. He concluded that many abused pre-school children suffered some type of permanent brain damage severe enough to require special schooling. Speech and language development were either at a minimal level or grossly impaired. In addition, he found that many of the children were well

*(The average six to twelve month old will cry when left by their mother and/or cry when approached by a stranger. Abused children may not exhibit these behaviors).

below their respective ages in height and weight.

Oliver and Buchanan (1978) suggest that violence should be recognized as a legitimate and major cause of impaired intelligence. The forms of violence they listed include direct blows, shaking or suffocation, malnutrition and emotional trauma severe enough to inhibit intellectual development.

Children who were either abused or raised in a punitive atmosphere have an impaired ability for enjoyment; display deviant behaviors such as enuresis or sleep disturbances which are indicative of psychic disturbance; and have poor peer relationship, low self-esteem and a poor sense of self. Other inappropriate behaviors and/or a condition known as frozen watchfulness (silent; gaze fixated without smiling; sit, stand or lie without moving) (Martin & Beezley, 1977).

Kempe and Kempe (1978) basing their hypothesis on the children they have observed and treated suggest that these symptomatic behaviors of the abused/neglected child appear to be a way of coping with expectations that are not those faced by most children, but are specifically those of the parents: that the parent's needs must always come first, total submission to the parent's wishes, and compliance and acceptance of whatever happens. They also found these children to have pentup feelings of resentment and fury, difficulty in recognizing and verbalizing their own feelings, difficulty in trusting adults or other children, difficulty in maintaining relationships by being either indiscriminately or superficially friendly, and lack of object constancy.

Not all abused children are compliant and anxious to please. One fourth of the children encountered by the Kempe's were negative, aggressive or hyperactive. Their experiences imply that this was due more to disorganizing anxiety than to neurological impairment.

Once a child reaches school age, different behaviors may emerge. Not only do they enter the school situation at a social and emotional disadvantage, but they have a tendency to become disorganized by the anxiety they feel in this new situation. This causes them to resort to inappropriate coping styles such as giving up, refusing to do the work, and procrastination. They perform poorly in reading and writing tasks (Kempe & Kempe, 1978). Thus, they operate at a double disadvantage, lower scholastic skills further crippled by disabling anxiety.

As they become older and more aware of the pathological behavior of their parents, abused children cover up by fabricating reasons for their injuries. Since they do not see changes as possible, they fear breakup of the family if the abuse becomes known. By then, not only have they become brainwashed into accepting parental punishment as valid and right, but they have also incorporated these attitudes into their own consciences and value systems (Helfer & Kempe, 1978). This conclusion is based both on case history and psychological assessment of abusers who were abused as children themselves and of the older abused child. Willingness to be abused appears to be a function of the length of time abuse has occurred and the intergenerational, repetitive aspect of abuse.

While much is still not known about the effects of child abuse/neglect on the children, the data available suggest the following conclusions.

1. While physical assault or neglect are traumas, the atmosphere in which the child lives, i.e., rejection, misperception and expectations, is even more important. An abusive or punitive environment can and will effect the developing child's personality.

2. Just as there is no classic or typical personality profile for abusers, none exists for abused children at the present time.

3. A major mechanism of survival for abused/neglected children is the ability to modify behavior according to their surroundings. This can cause extreme fluctuations in behavior from one situation to the next. This, in turn, compounds the problem of identifying the characteristic behavior of these children.

4. The development of abused/neglected children appears to be more a function of the nature of the family they live with after the abuse rather than before the abuse. This conclusion carries with it the implication that these children have a chance of evolving into mentally healthy adults who can function within the limits of their inherited capabilities provided they can be either extricated from their environment or have the environment (i.g., family) change in order to give them the nurturance they so desperately need.

The Family Bonding Process

As defined and understood by this writer, bonding is the gradual, reciprocal process of uniting a mother-father-child into a family unit. Although the process can begin before and during

pregnancy, it does not fully unfold until after birth. It is the infant who acts as the catalyst. For instance, bonding is what enables adoptive parents to love a child as much as natural parents. Data are still inconclusive as to what causes this, whether it is chemical, psychological or a combination of factors. But there is general agreement that without bonding, the parents will not be sufficiently involved with the child to meet its incessant demands for tender loving care (Gray, Cutler, Dean & Kempe, 1976; Lynch, 1975; Martin, 1977).

It is the opinion of this writer that there is no such thing as an instinct to mother. People, men as well as women, learn to care for and love their children by interacting with them. If something interferes with the process, then they are unable to form the affectional bonds necessary for the growth and maturation of children. For example, Lynch and Roberts (1977), in a study previously discussed, found abusive mothers, when compared to a control group of non abusers to spend significantly less time with their infants during the crucial neo-natal period, or to have had sicker infants, or to have infants who required hospitalization during the first six months of life. These mothers also had illnesses which required separation from their infants during the first year. They concluded that the reason these women abused their children was due to improper bonding or maternal attachment.

It seems that it is the attributes of the child in conjunction with parental needs and expectations that determines the extent of bonding (Gray, Culter, Dean & Kempe, 1976). The parent's ages,

culture, education, affect (sad, happy, bland), the significance (degree of emphasis) of their feelings about the child and their child-rearing ideas must be considered while evaluating the bonding process. It is the family's degree of emphasis on the presence or absence of a factor that determines its importance in that familial hierarchy. It should be noted that it is not the presence of one or two signs that signals a predisposition to abuse, but the combination of a variety of signs appearing throughout the entire pre and post natal period.

Attitudes which could indicate the presence of a bonding dysfunction include: (Gray, et al., 1976)

1. Parental attitudes

- (a) Denial of the inevitability of the birth and/or feeble or no attempts at preparation for the infant.
- (b) Presence of extremes of behavior such as unusual passivity or aggressiveness.
- (c) Overconcern with the unborn baby's sex and how rigid the expectations.
- (d) The presence of a disinclination to look towards friends, spouse, mother for help; not asking questions during the pregnancy.
- (e) Depression over the pregnancy; fear about the birth process.
- (f) Lack of communication with or involvement of the father.

2. After and during delivery

- (a) Lack of interest in the baby, ambivalence, passive reaction, openly hostile remarks.
- (b) Keeping the focus of attention on herself.
- (c) Unwillingness or refusal to hold the baby.

- (d) Hostility directed at the father, who put her "through this."
- (e) Inappropriate verbalizations or hostile glances directed at the baby, i.e., "He looks so much like his father that I feel sick. He looks like an ape."
- (f) Disparaging remarks about the baby's sex or physical characteristics.
- (g) Disappointment over sex or other physical characteristics of the child.

3. Post-partum

- (a) Continued dissatisfaction with the baby's sex.
- (b) Perception of the child as too demanding or as deliberately interfering with the parent's life.
- (c) Perceives feeding and diapering as messy and repulsive (good indicator of neglect).
- (d) Refusal to pick a name or to use the name selected.
- (e) Describes feelings of helplessness or wanting to cry themselves when the child cries.
- (f) Perceives child's crying as deliberate and on purpose; inability to quiet a fussy baby.
- (g) Lack of an effort to establish and maintain eye contact with the baby; unwillingness to talk to or fondle the baby.
- (h) Unwillingness to dress/undress, hold, comfort or play with the baby.
- (i) Jealousy of the baby by the father.

These attitudes should be evaluated in conjunction with positive factors which operate as mediating variables. They include:

1. Seeing the baby as a separate individual and finding things they like in the baby.
2. Baby is healthy and not too disruptive.

3. Either parent can rescue the child or relieve each other in a crisis.
4. A stable, happy marriage with good communication skills.
5. Presence of a good friend or relative to turn to for help.
6. Presence of coping abilities-i.e., the ability to understand and plan for adjustments in life style due to baby.
7. Mother has at least normal intelligence and good health.
8. Parents had good role models when growing up.
9. Birth control planned; baby planned or wanted.
10. Father has a stable job; stable living conditions.
11. Father supportive of mother and involved in baby care.

Point of information: an unwanted pregnancy does not always mean an unwanted child; a wanted pregnancy does not always mean a wanted child.

The above information was culled from the work of Grey, Culter, Dean and Kempe (1976). Their research suggests that potential child abusers display attitudes and behaviors which can help identify them before there is a child at risk. They based their hypothesis on both observation and interviews with pregnant women in a prenatal clinic setting. Then they conducted a control group study in which 100 women, (using the original observation-interviews technique) were selected as "high-risk." They, in turn were equally and randomly divided into 2 groups (intervene and non intervene) and a randomly selected control group (N=50) of women assessed as "low risk" was added. They concluded that: (a) a high risk group, as judged by significant parenting practices (attitudes toward

discipline, parental expectations), can be successfully identified; (b) children at risk can be saved from serious injury through early intervention (5 of the children in the high risk non intervene group required hospitalization for suspicious injury; none in the intervention or control group did); and (c) labor, delivery and nursery observations provide the most accurate predictive information.

While it is important to be aware that these conclusions have been based on a very small samples, other researchers (Lynch, 1975; Lynch & Roberts, 1977; Smith, Hansen & Novel, 1973; and Smith, 1978) reached similar conclusions. An interesting side light to Smith's work (1978) is that he found the observations of the nursing staff during labor and delivery to have better predictive reliability than devices such as questionnaires.

3 THE ETIOLOGY OF CHILD ABUSE

Different theories have evolved as to the reasons why child abuse and neglect exists. In this writer's opinion, what is striking about them is not their differences, but their similarities. While each theory attacks the problem from a different point of view, they all seem to agree that before abuse and neglect can happen three "ingredients" must be present: (a) an adult with a predisposition towards abuse; (b) a child; and (c) stress, either chronic or acute. And each seems to accept the implication that abuse and neglect is an intergenerational phenomenon that operates in a cyclical fashion.

The earliest theories focused on the psychodynamic and behavioral characteristics of abusive adults.

The Mental Illness Model is the oldest and least valid of the psychological theories. Until the work of Kempe (1962) proved otherwise, child abusers were assumed to be deviants, psychotic or aggressive psychopaths. Society seemed unwilling to admit that "normal" people had, within them, the capacity to harm their children. Kempe, basing his findings on case histories of clients he encountered in his early work, estimated that only 5%-10% of the people involved in child abuse and neglect could be legitimately classified as mentally ill, as dictacted by the guidelines set forth in the DSM-II. To date no one has disproved his findings.

Although they do not state how they establish their estimates, Schmitt (1978) and Fontana (1964) also claim that less than 10% of child abusers are psychotic or criminal. The 1977 National Analysis (1979) found 15% of the families with substantiated cases of child abuse/neglect to report some type of mental health problem. Since the type of problems included in this category were not listed, it is impossible to make a judgment as to the seriousness of the conditions.

Based on the research investigated, the conclusion was reached that while some child abusers are criminal and/or seriously disturbed, most are not. In addition, no evidence was found to refute the opinion of those cited that it is these 5%-15% who appear incapable of changing enough to insure the safety and well being of their children.

The Personality or Character Trait Models have attempted to classify, label or cluster abusers either by their behavior or by personality variables (Gil, 1970; Milowe, Kaufman & Galdstone, in Ebling & Hill, 1975). These are purely descriptive methods which do not attempt to explain the reasons for abuse. As such they remain one-dimensional theories of limited usefulness. Yet, typologies can be invaluable as research tools. They can form the foundation for work in the area of prediction and prevention by helping identify the high risk factors which predispose toward abuse.

An exception to the above can be found on the typology created by Walters (1975). His work differs from others in that it

is based on the belief that child abuse is a learned behavior. He also is much more precise and definite in his treatment and prognosis. This makes his typology a more useful tool. While other experts in typology may disagree with the categories he has chosen, at least he has tried to pick out distinguishing characteristics which are then coordinated with treatment programs. The major drawback to this typology are the lack of empirical data upon which he based his paradigm. He relied on his own clinical work, observations and case histories to reach the above conclusion. An outline of his typology can be found in Appendix A.

Advocates of the Psychodynamic Model (Kempe & Helfer, 1972; Steele & Pollack, 1974; Schmitt, 1978; Fontana, 1964; and Martin, 1976) take the position that child abuse is a result of parental pathology and that crisis is the precipitator, but not the cause, of the abuse. They arrived at this opinion by noting a commonality among the personality characteristics of abusers, through evaluating the historical events which might be related to abusive behavior and by collecting intrapsychic data from abusive parents.

The reader is probably getting tired of reading that this information has not been empirically determined but is based on clinical case histories, anecdotal information, clinical intuition and clinical expertise. But, again, that is how this model developed and the reader is correct in assuming that none of the information in this section has an empirical base.

Three precepts appear to be central to this theory: (a) history of physical or emotional abuse as a child; (b) concept of role

reversal and lack of motherliness; and (c) the conviction that no matter how much environmental stress is encountered, abuse will not occur unless the psychological potential is present.

While the historical, psychological and role reversal components have been discussed in the preceding pages, the concept of motherliness needs clarification. It should be noted that this term, while carrying the connotation of femaleness, is used to denote a way of interacting and caring for children. As such, its' occurrence in men is not precluded. Mothering involves meeting the child's needs, providing relief from discomfort and encouraging responsiveness (Roberts, 1975). Steele and Pollack (1974) have chosen to arbitrarily divide the mothering function into a practical and mechanical aspect (feeding, holding, clothing, cleaning, and protecting from harm) and the ability to be tender, and to be aware and considerate of the needs and desires of the infant or child, and to maintain appropriate emotional interaction. Lack of motherliness affects the responses of the child which, in turn, challenges the child's immediate well being and subsequent development. They theorize that neglect is a function of the breakdown in the mechanical aspect; abuse in the motherliness and that inadequate mothering is more damaging before age 3 than afterwards.

A child born to an adult who already has a sense of diminished motherliness will probably have to cope with a parent who has incorporated into their personality a marked imbalance between the empathic, pleasure giving (ego ideal) and the frustrating, pain producing (super ego) facets of parenthood. This over-identification

with a punitive super ego on the parent's part leads to a "parent-against-child" type of aggression in which the parent views the child as an extension of themselves. The data suggest that it is this inability to separate from the child combined with unresolved ambivalences and anger toward their own parents plus the tendency to judge their children in absolute terms of good or bad that establishes the intrapsychic potential for abuse. When the child is perceived as good, the parent is good; when the child is perceived as bad, they judge themselves as being bad. In other words, they are attacking or neglecting themselves, not another person.

If child abusers are "bad" parents, then what are the characteristics of "good" parents? According to Kempe and Kempe (1978) they are:

1. The ability to recognize the needs of a child for: (a) physical care and protection, (b) nurturance, (c) love and the opportunity to relate to others, (d) bodily growth and the exercise of physical and mental function, and (e) help in relating to the environment by way of organizing and mastering experience.

2. The ability to either meet the child's needs or to facilitate those needs being met.

3. To be rewarded and satisfied by the knowledge that the child's needs are being met.

4. To be able to meet their own needs without interfering with the child's needs. A negative example is when a parent pushes a child into an activity (sports, dance, music) which the parent wishes they had done, but in which the child has no interest.

Other elements of psychopathology which can contribute to the potential for abuse include unresolved sibling rivalry, an obsessive-compulsive character structure, or unresolved Oedipal conflict accompanied by excessive guilt (Steele & Pollack, 1976). The last is especially relevant to the role the non-abusing parent plays in the scenario of abuse/neglect because it can cause the non-abusing partner, as well as the abusing spouse, to misperceive the child as a rival for the affection and love of the other.

While only one parent may initiate the actual mistreatment, the other, either through conscious or unconscious motivation, accepts the action as right and proper. This is because abusers have a tendency to pick partners who have had similar life experiences as themselves. Consequently, they have developed like sets of attitudes and values (Steele & Pollack, 1976). Thus, the non-abusing partner plays a significant role in the dynamics of abuse and neglect. If a person with a weak potential for abuse, as determined by the psychological variables already discussed, marries a normally reared person, abuse rarely occurs. If both spouses are predisposed to abuse, or if a person who has a high potential for abuse marries a passive person, then abuse will most likely occur (Kempe & Helfer, 1972; Steele & Pollack, 1976). In any of the above named circumstances, the non-abusing partner should be held accountable for the incidents.

Critics such as Grodner (1977) point to the presence of sampling bias, lack of control groups, low agreement on personality traits, and too many anecdotal or post-facto designs as indicative

of lowered reliability and validity. These criticisms do not differ appreciably from any other derogatory comments directed toward the subjective (i.e., not behavioral) theories of personality development. However, this does not stop mental health practitioners from utilizing them as a basis for their own personal philosophies and intervention techniques. It is the bias and opinion of this writer that the psychological paradigms, while not necessarily provable in an objective fashion, are, none-the-less, viable theories which deserve consideration as probable hypotheses.

Other schools of thought emphasize the role of social stress as the crucial etiological factor. It is theorized that child abuse/neglect is a result of multiple socio-economic, cultural and environmental factors which prevent abusers from acquiring the skills to function adequately at home and in society. These theories suggest that unless poverty, poor education, inadequate housing, etc., are wiped out, it is futile to try to prevent or reduce the incidence of abuse. The sociological paradigms also accent the role of violence at home and in society as a key to perpetuating abuse. Steele (in Helfer & Kempe, 1976) singles out violence as the "most common element in the lives of violent or abusive adults." (p. 117). He theorized that the experience of being neglected or abused (no matter what the degree) by caretakers during their own childhood has caused a predisposition to use aggression as a means of problem solving an inability to empathize with others, lowered the ability to cope with stress and created a vulnerability to examples of aggression and violence presented by the society in which they live.

Gil's (1970) Environmental Stress Model argues that it is the presence of sociological stress in combination with cultural mores which do not prohibit the use of force that creates the "cycle of violence" which helps perpetuate the individual acts of violence towards children. According to his theory, the necessary and sufficient conditions for child abuse are: (a) culturally determined permissive attitude toward physical force accompanied by no clear cut legal prohibitions and sanctions; (b) environmental chance factors; (c) environmental stress factors; (d) deviance or pathology in the physical, social, intellectual or emotional functioning of the caretaker and/or in the abused child; (e) disturbed intrafamily relations involving conflict between spouses and/or rejection of an individual child; or (f) any combination of the above.

He attempted to empirically prove this theory by conducting a nationwide study on the epidemiology of child abuse/neglect. While he did show that environment and stress does play a part in abuse, he was unable to explain why some parents, given the same stress factors, do not abuse or why abuse does not occur more often than it does in the lower socio-economics groups or why it occurs at all in middle and upper income families.

As an interesting sidelight, Gil postulates that the reason so much of a furor is being raised over child abuse today is because abusers have become scapegoats for "society's collective guilt and the individual guilt experienced by parents as a result of aggressive impulses and fantasies towards their children." (p. 54). This writer

believes that the comment is valid. Anger, resentment and frustration are feelings that can be associated with child raising as easily, but not as commonly acknowledged, as joy, love and warmth. Our society tends to glamorize the parent/child relationship. Consequently, parents can experience great shock and guilt when they first realize that they can hate as well as love their children. Not knowing what to do about these negative feelings, they attempt to deny them. Punishing others for doing what they fear they are capable of, can act as a catharsis for their own feelings not unlike the intrapsychic stress reduction that an abuser feels after an attack.

Gelles' (1973) Social-Psychological Model blames intrafamily stresses, in combination with outside influences such as social class, for creating the disordered state which leads to an act of abuse or neglect. He chooses frustration and stress to be the most important variables. The presence of marital problems, the number of children, unemployment, social isolation or the presence of a problem child, are examples of the kinds of factors which he feels contribute to intrafamily stress. This writer has concluded that his theory is not unlike what happens if anger is unable to be directed toward its source. For example, the boss criticizes the employee, the employee yells at his wife, the wife fusses at the kid, and the kid kicks the dog! Frustrated because they are unable to discharge their anger, parents with the potential to abuse turn to the nearest, least threatening object at hand, their children.

Critics of Gil and Gelles (Grodner, 1977; Justice & Justice, 1976) point to the fact that child abuse is manifested across all socio-economic stratas and cultural groups. In addition, because they consider the curing of the world's ills to be of primary importance, their theories have limited adaptability to constructing predictable prevention and intervention techniques.

Steele and Pollack (1974) argue that while social and economic difficulties and disasters put added stress on lives, they only act as incidental enhancers of behavior which may be dormant and should not be considered as the necessary and sufficient causes.

Other sociological theories include the Social Learning Model which, more or less, has evolved on its own (Justice & Justice, 1976; Garbarino, 1977). Briefly, the Social Learning Model is a behaviorally oriented theory which accents the failure of abusive persons to acquire the skills necessary to adequately function at home and in society. Since it does not attempt to explain why they have not acquired these skills, it can be considered a one-sided theory.

However, it is an excellent theory to use for the formulation of intervention and treatment strategies because it emphasizes the identification and modification of specific adult and child behaviors which end in abuse, and encourages both the teaching of parental skills and the modification of parental expectations.

Garbarino (1977) claims that due to changing patterns of family structure, economics and social conditions, approximately 25% of American families are in danger of becoming abuse prone.

He selects social isolation, i.e., keeping oneself separate from others or being alone, as the key factor in child abuse, and implies that the necessary conditions include both the cultural justification for the use of force against children, and isolation from potential support systems which in turn causes stress to become unmanageable. He defines this unmanageability as the product of a mismatch between the level of stress and the availability and potency of support systems due to the failure of the person to use them.

While other data suggest the importance of social isolation as a mediating variable (Steele & Pollack, 1974; Lynch & Roberts, 1977; Kempe & Kempe, 1976; Kempe & Helfer, 1972) this writer interprets it as a symptom of underlying psychological deficiencies which predispose abuse/neglect. Child abusers, due to their faulty upbringing, are deficient in what is known as Erickson's "Basic Trust," i.e., the belief that the world is good. This lack of trust manifests itself, when they become adults, in the inability to form lasting relationships, the inability to ask for or accept help from others, and not only to be suspicious of authority figures but to actively avoid them.

Anecdotally, abusers have been found to change homes frequently, to live without telephones or accessible transportation, to not know or be known by their neighbors, to report having few or no friends, to not going out either singly or as couples or, to belong to any fraternal organizations. Very often they have poor relationships with parents and other family members. In other words, they

can be classified as "loners."

Justice and Justice (1976) and Grodner (1977) view child abuse as a symptom of a family in crisis. Their theories attempt to integrate the psychological and sociological paradigms into a single, workable philosophy. The child is considered to be an integral part of the abuse and is given equal billing along with the parents.

The Family Systems Model (Justice & Justice, 1976) is described in terms of a psycho-social system and shifting symbiosis. This symbiosis is defined in terms of the attachment that one individual establishes with another in an effort to be taken care of. The concepts involved in this position include the following:

1. The entire family and the environment all play a part in abuse.
2. The interlocking symbiosis between spouses and between spouses and child cannot be understood unless viewed as a psycho-social system.
3. The family system operates within the larger environment-cultural system. Because there is continuing interaction and feedback between the family system and the culture system and within the individual systems, many subsystems exist. Changes in any one system will affect the others. (This is their plausible explanation for why no one has been able to pinpoint THE cause for child abuse).
4. Since no family exists in a vacuum, environmental stresses as well as community support networks must be considered.
5. Prevention and alleviation of child abuse will fail unless it is recognized that family, environment and society are all part

of an interdependent system.

6. Societal violence and, specifically, the issue of spanking and discipline are inextricably involved in the problem of abuse. (A fine line exists between physical discipline and abuse. At what point does a spanking become a beating? According to Kempe (1972) it is when the child is left with bruises).

7. The reason that a seemingly minor problem may assume major significance in the eyes of potential abusers is that they have become exhausted by a series of stressful changes more related to intrapersonal problems and losses rather than economic conditions. In other words, they are experiencing a life crisis - a series of situational events that are compressed together and sometimes accompanied by maturational crisis. This exhaustion creates a decreased ability to adjust and an increased risk of losing control. Therefore, the Justices' imply that it is the presence or absence of a life crisis that is the determining factor of why, given the same set of environmental factors, that some abuse and some do not. The everyday situational disturbances are merely appendix' to the life crisis. They are the proverbial "straw that breaks the camel's back." An interesting hypothesis which bears further research is to investigate the possibility that child abuse is as much of a substitute for other outcomes of life crisis as are illness, accident or injury.

Justice and Justice (1976) further hypothesize that, in abusing families, there is constant competition over who will be the caretaker. The "winner" gets to be nurtured and the "loser" turns to the

child for the care he requires. Examples of how the abuser/parent feels he is the loser include: perceiving the child to be closer to the other parent; complaints about their mate's refusal to discipline the child; and, of greater significance, reporting extreme difficulty in getting their spouse to make decisions or accept responsibility in many aspects of their lives.

In this model, both parents are considered to be host (or owners) of the problems of child abuse and neglect, and the child and the stressful conditions or behaviors he embodies, to be the catalyst. Justice and Justice (1976) also speculate that the child is the most common immediate source of external stress because they have either responded to the parent's need by crying, have made unusually great demands, or represent an exceptional stress (i.e., reminding them of a hateful time in their own lives).

They also present an interesting theory on the inter-generational aspect of child abuse and neglect, and a case for why child abuse exists in one parent families. They view this feature as the failure to pass from one generation to the next both the ability to individuate and the ability to overcome the need to fuse with others. Family living involves a balancing act between becoming one's own person and the need to belong. According to Justice and Justice (1976), child abusers have fused with their families of origin to such a degree that belongingness has become stuck-togetherness and individuation is obliterated. This is why child abuse can occur in a one parent nuclear family. Thus, in many cases, that parent has found a relative in the family of origin with which they can

continue to have the dysfunctional symbiotic relationship. When thwarted, they again turn to the child.

Undifferentiation, since it is an unnatural state, creates tension and latent anger. The tension results from the struggle to merge with another, to lose identification; the anger from suppressing the opposing drive to be a separate person. Because the separation process is painful, undifferentiated people continue with their efforts to merge with others. But like everyone, they still want to be apart, and the more they merge themselves (or are merged) into an undifferentiated mass representing the family, the more their latent anger mounts. It is this tension and anger which the abuser seeks to dissipate with an attack.

In conclusion, then, this model is based on the premise that (a) both spouses are basically alike; (b) the child as well as the spouses, the sibling, the environment and the culture play integral roles in the family system; and (c) the causes of abuse are multi-determined, requiring an evaluation of social, cultural and psychological forces. They arrived at these conclusions through clinical work and empirically based studies.

According to the Justices' (1976), this theory evolved over many years of doing group work with abusive parents and as an outgrowth of earlier work in violent behavior. Not only did they base their opinions on their own experiences, but they attempted to prove them where possible, in empirically based studies. For instance, one study (N=35) using a control group which was similar in age, education and income to a group of abusing parents was rated on the

Social Readjustment Rating Scale. They found change, not environmental or economic stress, to be the distinguishing factor (Justice & Ducan, in Justice & Justice, 1976). The results of another study (N-20, 1976) on the epidemiology of their clients compared favorably with studies such as the one by Gil (1970). The relevancy of their work is primarily hampered by the small sample sizes and lack of random selection. Nevertheless, their theories shed new and interesting light on the reasons for abuse.

Grodner's Family Approach (1977) is similar to the Justices'. He feels that the abuse is a part of a pattern of related and reciprocal transactions between parent, child and/or other family members in which all parties play a part. As such he uses transactional terms such as alliances against child/parent, coalitions, enmeshment, scapegoating and the disengagement of the spouse or other family members to describe the family interactions. He feels that it is the interplay of the child's temperament and characteristics, the quality of parental functioning, and the environment that creates a predisposition towards abuse.

These family system approaches seem to be logical, well thought out and easily defended. Not only do they offer an explanation for the abuse but they also facilitate the construction of behaviorally or humanistically oriented intervention techniques.

As mentioned earlier, all the theories cited acknowledge the role of stress or crisis in child abuse, generally, and in the dynamics of the attack, specifically. As Blumberg states (1977), "child abuse is a symptom of a family in crisis." (p. 207). Cooper

(in Smith, 1978) lists three different kinds of stresses: (a) internal stress due to emotional deprivation as a child; (b) stress from immediate family problems such as divorce or separation, too many children, crowded living conditions, a handicapped or retarded child, and (c) stress due to social problems such as poverty or unemployment. Kempe and Kempe (1978), based on their clinical experience and observation, state that abuse almost always happens at the point of a crisis, which in many cases, can be as trivial as a spilled glass of water.

The implication is, then, that crisis is the precipitating factor in child abuse. Why? According to Pollack and Steele (1972), two elements exist in the crisis situation: What is happening to the child in the present, and the past events which have caused a need for reassurance and nurturance from the environment. The parent approaches the child with three incongruous attitudes: a healthy desire to do something good, a deep yearning for the child to demonstrate love and acceptance, and a demand for the correct response, supported by a sense of parental rightness. If the child reacts with persistent crying, if they misread the parent's needs or become stubborn and noncompliant, then the parent, feeling frustrated, loses control of his hostile impulses, and attacks. Above all, persistent crying is perceived by abusers as an accusation of not being a good parent and as rejection by the child. It therefore rouses intolerable anxiety which will cease only when the crying stops (Kempe & Kempe, 1978; Paulson, Savino, Chalett, Sanders, Frish & Dunn, 1974). Afterwards, abusers usually react in one of

two ways: either they maintain a strict, self-righteous attitude with no sense of guilt, insist they have done nothing wrong and resent any help or they are filled with remorse and guilt, seek medical help, if needed, and passively accept help (Steele & Pollack, 1974; Fontana, 1973).

This author feels that there is no one cause for child abuse, and it is futile to continue to look for one. According to the people involved, each factor and variant takes on greater or lesser importance. In one case it might be life crisis (Justice & Justice, 1976), in another it could be environmental stresses (Gil, 1970), and in a third crippling emotional dysfunction (Kempe & Helfer, 1972, 1980). Each case must be decided on its own merit and not according to some artificial formula. Lastly, each variable, in and of itself, it is not sufficient enough to cause neglect or abuse. Thus, it is suggested by this writer that:

1. Abusers lack internal restrictions which prevent them from attacking or neglecting a child (Steele & Pollack, 1974). Why they lack these restrictions depends on the personal orientation of the therapist, i.e., psychodynamic, humanistic or behavioral, etc.

2. Children play an active role in the abuse process (Martin, 1972). They are not merely pawns to be acted upon. The older they are, the more accountable they should be for their actions.

3. The non-abusing parent or significant other is as much at fault as the abuser (Justice & Justice, 1976).

4. Crisis, either real or imagined, should be recognized as the most common precipitating factor in abuse/neglect.

5. People can and should be taught how to parent and what to expect from their children at the different growth and development stages (Martin, 1976; Beezley, 1978).

6. To refuse to deal with child abuse merely because "it can't be cured unless society first improves," is stupid. That attitude is a defeatist and pessimistic attitude. Change should come from within by breaking the intergenerational cycle of abuse.

7. Child abuse is a symptom of a dysfunctioning family (Grodner, 1977; Justice & Justice, 1976). The family as a whole and all the members, individually, are in need of help.

It should be noted that these "conclusions," are, in fact, speculation based neither on experience nor empirical data. While each component appears to have a sound foundation, the combination has not been tested. Therefore, it cannot be scientifically defended. Hopefully, in the future, through experience and actual research, these ideas will develop into a viable paradigm.

4 SEXUAL ABUSE (INCEST)

This section will be handled a little differently from the others. No paper on child abuse would be complete without the inclusion of some type of discussion about sexual abuse. Due to the length of this paper and time limitation, only two main sources were used to collect data on sexual abuse, Walters, The Physical & Sexual Abuse of Children (1975) and Lauer, Lourie, Salus and Broadhurst, The Role of the Mental Health Professional in the Prevention & Treatment of Child Abuse & Neglect (1979). Both of these base their information on clinical experience. As Kempe (in Kempe & Helfer, 1974) states, "Scientific studies. . . are even more rare in the field of sex abuse than . . . physical abuse. Data collection has been impaired by what has been referred to as a family affair." (p. 63).

Walters arrived at his findings after working with or being a consultant on more than 2,000 sexual abuse cases. The other, working under the auspices of the National Center on Child Abuse and Neglect, have produced a comprehensive, easy to use manual. Although she did not choose to include the sources, much of the information in the booklet was also found, by this author, to be documented in the research work read during the data collection for this specialty paper.

Very little literature exists on the sexual abuse of children (Walters, 1975; Lauer, et.al., 1979; Schecter & Roberge, 1976). As

a subject surrounded by taboos, misinformation and ignorance are rife. Commonly held myths include such tidbits as the abuser is a stranger to the child (he is most often a relative); it only happens among the poor (unsubstantiated); multiple sex abuse is rare (sexually abusive fathers can be involved with all the daughters); daughters bring on the abuse by themselves (the cause rests in the adult male-female relationship); sexual abuse is unlawful (it may be religiously prohibited, but very few laws cover sexual abuse; those that do are, for the most part, vague and unenforceable); sexual abusers are mentally ill and sexual abuse is easy to treat (they are not ill; it can be one of the most difficult types of abuse to treat) (Walters, 1975).

Most sexual abuse referrals involve minor girls in an incestuous relationship. Other less common types include molestation, rape and deviant acts. The most frequently reported abusers are natural fathers, stepfathers or mother's boyfriends. It is extremely rare for the abuser to be prosecuted. If the abuse is reported, the girl very often is put into the position of proving she is telling the truth.

It is suggested that incest frequently involves a mother-father-daughter triad. Often the husband/father is portrayed as a tyrant in order for the mother and child to avoid responsibility. He is usually a rigid disciplinarian, needs to be in control of the family and is passive outside the home. He does not usually have a police record or engage in deviant behavior. He has few friends. He is jealous and protective of the child, and may "reward" her with

special attention which can cause sibling jealousy. He is not "over sexed," has had limited sexual experience and has no taste for sexual "perversions." (Lauer, et.al., 1979).

The implication is that the mother/wife portrays herself as the "innocent victim" and whenever possible projects all the blame on the daughter. It is hypothesized that she is often overtly or covertly aware of the abuse and may be tacitly assisting the father due to her own passive, immature dependency needs. She chooses the sexual activity as being preferable to extra marital affairs, as a compensation for her own promiscuity or may be relieved that she no longer has to fulfill her "wifely duties." Even if she does not condone the behavior, she may not report it for fear of destroying her marriage. She often feels a mixture of guilt and jealousy toward her daughter (Walters, 1975; Lauer, 1979).

Their marriages are usually unhappy, full of unexpressed hostility and lack of communication. Many times the abuse becomes the justification for separation or divorce. The wife may have assumed a passive, dependent role based on somatic illnesses, may become very unattractive as a woman, or may have become, in every respect, the husband's mother. The father then becomes, dynamically, an adolescent who perceives the daughter as a sister or girlfriend. More often than not, the couple has not had sexual relationships for at least a year. (Walters, 1975)

According to Walters (1975) it is not unusual for the abuse to evolve slowly over a period of years. The daughter usually knows the behavior is "wrong" due to admonishments not "to tell," but is

either powerless or unwilling to stop. Older daughters may continue the relationship to protect younger sisters. If the girl becomes their father's lover, Walter's (1975) found the relationship to become very resistant to change.

If the abuse remains undiscovered, it is not unusual for the involved daughter to develop resentment towards and early separation from her parents. She may develop character logical defenses against all sexual feelings, or she may become promiscuous. Any guilt feelings seem to be an outgrowth of societal reactions rather than from the incestuous relationship itself. Incest that stops before the child reaches adolescence seems to be less damaging to the psyche or to later sexual identification than incest that starts or continues into adolescence (Walters, 1975; Lauer, et.al., 1979).

Behavioral indicators of sexual abuse include poor peer relationships, unwillingness to participate in physical activities, engaging in fantasy or infantile behavior, withdrawal, becoming delinquent, running away from home, or displaying bizarre, sophisticated or unusual sexual knowledge. She may actually state that the abuse has occurred (Walters, 1975; Lauer, et.al., 1979).

Walters(1975) recommends that treatment of sexual abuse should first focus on the cessation of further sexual involvement and then change familial relationships so that sex is no longer used as a controlling mechanism in parent/child interaction. All family members should be considered equally responsible and participate in therapy. The complaint itself, along with sexual attitudes and behavior, need to be discussed. Change in one family member will

not, by osmosis, change the others in the triad. He has found in his experience that the prognosis is poor if the primary motivation for therapy is avoidance of the legal consequences. He also believes that flexible therapy is essential for successful intervention.

5 DIAGNOSIS AND ASSESSMENT

Indicators of Child Abuse and Neglect

Over 50% of maltreated children are estimated to have serious developmental, psychological and medical problems (Martin, 1979). Historically, confirmation of a diagnosis of child abuse or neglect is primarily a medical task. Even when the initial report is from outside the medical community, (i.e., neighbors, police, family,) the first step in the assessment process should be a physical. In the case of suspected emotional abuse without concurrent physical abuse, the doctor of choice should be a psychiatrist.

According to Helfer and Kempe (1972) and Fontana (1974), the diagnosis of abuse or neglect can be considered when at least three of the following psycho-social factors are present:

When the parent:

1. Shows evidence of loss of control, or fear of losing control.
2. Presents a contradictory history.
3. Projects the cause of the injury onto a sibling or third party.
4. Has delayed unduly in bringing the child in for care.
5. Shows detachment.
6. Reveals inappropriate awareness of seriousness of the situation (either overreaction or underreaction).

7. Continues to complain about irrelevant problems unrelated to the injury.
 8. Personally is misusing drugs or alcohol.
 9. Is disliked, for unknown reasons, by the physician.
 10. Presents a history that cannot or does not explain the injury.
 11. Gives specific "eye witness" history of abuse.
 12. Gives a history of repeated injury.
 13. Has no one to "bail" her(him) out when "up tight" with the child.
 14. Is reluctant to give information.
 15. Refuses consent for further diagnostic studies.
 16. Hospital "shops."
 17. Cannot be located.
 18. Is psychotic or psychopathic.
 19. Has been reared in a "motherless" atmosphere.
 20. Has unrealistic expectations of the child.
- When a child:
1. Has an unexplained injury.
 2. Shows evidence of dehydration and/or malnutrition without obvious cause.
 3. Has been given inappropriate food, drink and/or drugs.
 4. Shows evidence of overall poor care.
 5. Is unusually fearful.
 6. Shows evidence of repeated injury.
 7. "Takes over" and begins to care for parents' needs.

8. Is seen as "different" or "bad" by the parent.
9. Is indeed different in physical or emotional makeup.
10. Is dressed inappropriately for degree or type of injury.
11. Shows evidence of sexual abuse.
12. Shows evidence of repeated skin injuries.
13. Shows evidence of repeated fractures.
14. Shows evidence of "characteristic" x-ray changes to long bones.
15. Has injuries that are not mentioned in history.

When a physician has reasonable cause, as defined by a suspicious psycho-social history (as outlined above), in combination with physical evidence, such as:

1. Signs of general neglect, failure to thrive, poor skin hygiene, malnutrition, withdrawal, irritability, repressed personality.
2. Bruises, abrasions, burns, soft tissue swellings, bites, hematomas, ocular damage, old healed lesions.
3. Evidence of dislocation and/or fractures of the extremities.
4. Unexplained symptoms of an acute abdomen-ruptured viscera.
5. Neurologic findings associated with brain damage.
6. Coma, convulsions, death.
7. Symptoms of drug withdrawal or drug intoxication.

(Fontana & Besharov, 1977)

To suspect a case of abuse and neglect, the first responsibility is to protect the child from further harm; and then to attempt to obtain help for the parents (Helfter, 1977; Fontana & Besharov, 1977; Smith, 1978). The immediate injury to be attended to and the long term handicapping sequelae and medical problems, (e.g., anemia, immunizations, malnutrition) which relate to inadequate parenting must be identified and treated (Beezley, Martin, & Alexander, 1976).

After the preliminary diagnosis of child abuse and neglect, Fontana and Besharov (1977) suggest the following steps:

1. Immediate intervention and/or admission of the child to the hospital.
2. Complete assessment, including medical history, physical and neurological examination, skeletal survey, and colored shots of injuries.
3. Report of the case to the proper Department of Social Security or Child Protection Unit.
4. Investigation and report of the family, if it has not already been done, by the case worker during the period of hospitalization, if possible.
5. Staffing to discuss the findings.
6. In substantiated cases or in cases where abuse/neglect is suspected but still not provable, referral of both abuser and child to an intervention and/or care program.

Adult Assessment

A complete psycho-social assessment of the suspected abuser should include both a psychiatric diagnosis and an evaluation of the

current life situation, the potential for abuse, the capacity to be a parent and lastly the motivation for treatment and change (Kempe & Kempe, 1976). All the nuclear family members, others significant to the family and caretakers (if different from the above) should be interviewed separately and together. Kempe and Kempe (1976) suggest that the following areas be explored: (a) story of incident and preceding crisis; (b) parents' view of the current situation; (c) absence or presence of friends; (d) degree of social isolation; (e) marital history and relationship, (especially why they married); (f) early memories and own history as a child; (g) job history (stable vs. unstable); (h) how parent sees his/her self, the child and the parental role; and (i) how they feel about the other children in the family. According to Schneider's experience (1972), factors which determine which baby in the family will be abused include: (a) the stability of family at that time of birth; (b) the presence/absence of crisis, and (c) any potential misperception of the child. If the baby is born during a relatively stable time, doesn't cry much, sleeps and eats well, doesn't get sick, has no birth defects and doesn't remind either of the parents of someone they do not like, the chances of abuse are small. Reverse the situation and a child at-risk exists. Even if the child starts off "lucky," crisis or a change in parental expectations can cause him to become at-risk. (Please note that this information is opinion based on clinical experience and is not empirically determined).

Schneider, Pollack and Helfer (1972) structure their clinical interviews according to the potential for abuse, the child and the

crisis. They caution against trying to find out who actually hurt the child, as they have found that line of questioning to be too threatening and unproductive. In order to develop rapport they suggest: (a) keeping the interview parent-centered; (b) seeing the parents in a relaxed setting; (c) avoiding prolonged interviews; (d) being honest at all times; and (e) seeing the parents separately and then together. They also recommend that the clinician be available to see them at once when they arrive, and to go out of his way to keep them informed about everything that is going on. The interviews should be structured in such a way that at least one person who talks with them gathers data in each of the three major areas, i.e., The Potential to Abuse, The Child, and The Crisis (es).

The parental interviews should collect information about how the parents were raised, the pattern of isolation, the interrelationship between parents, and how the parents see the child. Appendix B includes a list of sample questions that could be asked to elicit the required information. Things to look for include:

1. A feeling that the abuser's parents did not consider them worthwhile people and they concur with that judgment.
2. An overidealized conception of their parents by refusing to acknowledge any failures or deficiencies.
3. History of seeking to meet their parent's needs by volunteering accounts of how they pleased them as children, coupled with a glossing over of their failures to please.
4. No realistic way of handling the usual problems of child rearing, such as the eating behavior, crying and accidents of young

children or the defiance and disobedience of older children.

5. Lack of both the understanding of the necessity of getting help when "up-tight" and the capacity of acting to get help.*

6. Feelings of anxiety, anger or despair in dealing with problems.

7. Lack of communication between spouses.

8. Any marital dysfunction.

9. Poor problem solving techniques.

10. Presence of unrealistic expectations about marriage and children.

11. Unhappiness that their children are not "good" enough or that they can be better than they are.

12. Rigid, righteous attitudes toward punishment and discipline.

13. Apathy toward child's needs and injuries or being overly distrustful or fearful.

14. Denial or forgetfulness about the abusive situation(s).

15. Presence or absence of guilt over incidents.

16. A seemingly insignificant crisis that precipitated the attack or a buildup of stress that might precipitate one.

17. The permanent loss or temporary absence of someone who the abuser perceives as able to rescue them when the child care

*(A past history "of coping successfully" with the problems inherent to child rearing was found by Schneider, [in Pollack and Helfer, 1972] in their clinical practice to be indicative of a low probability of child abuse).

becomes difficult.

Part of the adult assessment procedure should be a determination of the motivation for change. The child abuser may be faced with increasing their self-concept, resolving various intrapsychic problems, developing stress reduction skills, changing a dysfunctional marital situation, improving job and home management skills, and, above all, learning how to be a good parent. In Martin's opinion (1979), none of the rest matters unless they can change their harmful parenting pattern. In other words, while the potential for abuse may be reduced by eliminating stress and improving self-esteem, unless the parent can learn how to be a good parent, they will be unable to give their children the nurturance and guidance they need. If the ultimate goal is to break the inter-generational cycle of abuse and reduce violence in the home, it is not enough to just stop the physical abuse/neglect without improving the quality of emotional care these children receive.

Positive indicators for therapy motivation include (Carrol, in Schmitt, 1978): (a) the presence, in the abuser's past, of a person with a warm affect in terms of a parenting role; (b) some kind of a good work history, since this requires something both in terms of reality testing and of conceptualizing one's needs and the ability to act upon those needs; and (c) the ability to have used help in the past.

Stern (1978) suggests that a past history of receiving and utilizing help and the ability to control impulses are good indices for the ability to "use" therapy. She implies that successful

therapy is doubtful if the parent is generally impulsive and has a history of acting out, if he does not have the capacity for insight, or if he is unable to learn to trust the therapist.

The presence of psycho-social data is supportive of the medical diagnosis but not considered diagnostic in itself. The medical confirmation of abuse/neglect in the absence of psycho-social data usually indicates that the injury was more likely inflicted by a third party such as a babysitter, sibling or consort (Schmitt, 1978).

Child Assessment

Schneider, Pollack and Helfer (1972) have found, through clinical experience, that it is important to observe parent-child interaction to see how the child deals with periods of parental stress, to see which child(ren) has started to take care of parental needs, and to note the roles all children take in the family. Kempe and Kempe (1976) recommend that intellectual functions be tested and school records be reviewed to get an idea about school adjustment and level of performance as it relates to intelligence.

Kempe and Kempe (1976) also suggest, in addition to the physical and neurological assessments which are needed to ascertain the actual degree and type of injury, that the psycho-social assessment of the child should include a developmental assessment or psychological testing. They also recommend observation of parent-child interaction and, if older than 2, a speech evaluation. They observed developmental delays indicative of abuse/neglect in children as young as 3 or 4 months and speculate that speech delays are indicative of long term abuse.

It is important to evaluate all the children in the family, as the evidence suggests that the psychologically deprived atmosphere that is common in abusive/neglectful homes may be more damaging to personality development than the acts of abuse themselves (Martin & Beezley, 1977). Therefore all of the children in the home must be considered potential victims of an abusive environment.

Martin (1972, 1974, 1976) has corroborated these findings through follow-up studies of abused children encountered in his work in Denver, Colorado. When comparing studies concerning the sequale of abuse, it is important to make sure that the criteria for inclusion (i.e., definition) and study populations are similar, otherwise the conclusions may be invalid. Another problem with these studies is the drop out rate. For example, Elmer (1967) could not locate 33% of the children involved in her study 5 years after the original hospitalization. Therefore, it cannot be assumed that the characteristics of the children who were found are similar to the ones who weren't. Intuitively, this author feels that the ones who do drop out probably experience greater deprivation than the children and families who cooperate in these studies.

Emotional abuse can be defined (Schmitt, 1978) as the continual scapegoating and rejection of a specific child by his caretakers. Severe verbal abuse and berating is always a part of the picture. Psychological terrorism, such as locking a child in a dark cellar or threats of mutilation, may be present. Guidelines for diagnosis include: (a) severe psychopathology and disturbed behavior in the child which has been documented by a psychiatrist; (b) treatment

offered to the family and refused by the parents at least twice; and (c) situations where the only parent is overtly psychotic, and hence, inadequate to care for the children; or severely depressed and a danger to the children, should also be considered as emotional abuse.

The child's temperament and age, the psychological functioning of the parents, parental behavior and feelings toward the child, the amount of time the child has endured the abuse/neglect, and what happens after the diagnosis will all effect the psychological adaptation that the child will have to make (Martin, 1979). A determination will have to be made if the child is psychologically normal (i.e., functioning within the age-appropriate psychological milestones and developmental stages), somewhat trouble or seriously maladjusted. To do this, it is necessary to be acquainted with the psychological and social milestones and to be able to recognize unusual behavior such as aggression, hyperactivity, destructiveness, excessive shyness, fearfulness, inhibition and fear of failure, and unusual affect such as sadness, adult-like seriousness, fear, anxiety, anger, apathy or depression. See Appendix C for examples of appropriate questions to ask. Once these questions are answered, a determination can be made as to the proper intervention techniques needed for the child.

According to Beezley, Martin and Alexander (1978) the child's psycho-social and neurological assessment should determine: (a) the developmental status of the child; (b) the personality of the child; and (c) the effect on the child of the various treatment

plans being made. It can be seen that the child's assessment is a complex procedure that requires input from experts in the areas of child development, child psychiatry or psychology and/or speech and language pathologists. The ironic part is that not nearly as much is known about the effect of child abuse and neglect on children as is known about the abusers.

A definite need exists for more research into the effects on children and appropriate assessment procedures. Those that have been done are poor. For example, Elmer's (1967, 1979) longitudinal study on the effects of abuse on children revealed, surprisingly, that the effect of lower class membership on child development may be a more potent variable than abuse on the subsequent development of the child. The anticipated results, that traumatized children would fall below non-abused in health, history and development, intellectual functioning, language and self-concept, and higher in impulsivity did not happen. The final report also showed that there had been errors, such as ignoring the role of neglect, made in the initial classification.

Indices for Formal Assessment

To summarize, it has been concluded that diagnosis and assessment appear to be a three-phase procedure consisting of medical diagnosis and assessment, psychological and developmental screening, and psychiatric consultation. Once the medical component is confirmed, then the parents and child should be screened for unusual psychopathology. The following guidelines can be used to determine if a formal psychiatric/psychological consultation is required (Schmitt,

1978):

1. Severe abuse, especially if premeditated or sadistic.
2. Reabuse after initial report and intervention.
3. Parent(s) suspected of being dangerous, i.e., (a) psychotic, (b) suicidal, (c) homicidal, (d) sociopathic, (e) drug addiction/severe alcoholism, (f) past psychiatric hospitalization, (g) past intensive psychotherapy without significant improvement, and (h) past suicide attempt.
4. Parent suspected of having intellectual limitations.
5. Perpetrator uncertain (evaluate both parents).
6. Child: (a) appears severely emotionally disturbed, (b) recipient of longstanding, profound abuse/neglect regardless of symptoms, (c) claims sexual abuse or other severe abuse/neglect without any evidence, (d) parent claims child is severely disturbed without any evidence, and (e) psychometrics when intellectual/developmental limitations are suspected.
7. Recommendations include criminal investigation.
8. Recommendations include permanent severance of parental rights.
9. Parents demonstrate ongoing resistance to intervention and treatment.

Stern (1978) endorses a psychiatric referral when a second opinion is needed to assess the degree of risk of child abuse or it is suspected that the case will go to court; to diagnosis psychopathology other than the risk of child abuse; to assess motivation for change and to recommend treatment priorities; and to assess the

parents' ability to use existing resources in order to predict the likelihood of success and to identify possible problems.

Kempe and Kempe (1976) feel that a complete psychiatric assessment is necessary only when:

1. The family dynamics do not fit or match any of the standard case histories found in the majority of abuse/neglect cases.
2. Premeditated abuse or torture have occurred.
3. One part of the body is constantly picked on.
4. There is distortion of reality or bizzare ideas that seem to make little or no sense.
5. Inappropriate responses which indicate a loss of affect or the presence of severe depression.
6. Religious or culturally based fanaticism.
7. Ongoing drug/alcohol addiction.

These lists are so broad that the only people who do not seem to be included are the first time offenders who have mildly injured or neglected their child(ren). It seems unreasonable not to do a complete workup in these people before starting an intervention program. If something were not wrong, they would not have abused/neglected their children at all. It seems inappropriate not to determine the reason for the abuse, e.g., psychological, sociological, lack of knowledge, before intervention is started. How else is the counselor or therapist supposed to choose the right course of treatment? This does not mean that all abusers need or will benefit from psycho-therapy. All it may mean is that they need a class in parenting or stress management. How can this be determined without a

psycho-social assessment conducted by a qualified diagnostician?

Perhaps if all abusers/neglectors had a full assessment there would be less recidivism. This is an interesting hypothesis to investigate the effect of a full psychological assessment vs. a screening procedure on therapy outcome or recidivism rates.

Role of the Clinician and Social Worker in Diagnosis and Assessment

Specific skills that psychiatrists and clinical psychologists can bring to the assessment procedure include an evaluation of the quality of parenting, and the ability to determine the presence or absence of psychiatric illness. Bond (1978) also includes, as justification for the use of clinicians, the psychologists skills in differential diagnosis and modification of behavioral patterns, and the psychiatrists' ability to deal with psychosomatic or psychopharmacological problems. The immediate safety of the home, the treatability of the parents and the most appropriate type of treatment can also be evaluated. Ten to fifteen percent of the perpetrators will have a psychiatric problem severe enough to interfere with a positive prognosis (Kempe, 1972; Steele & Pollack, 1974). The presence of a psychosis such as paranoid schizophrenia or a delusional system that involves the child or a severe depression are usually indicative of poor prognosis (Kempe, 1972, clinical experience). It is the opinion of Kempe and Kempe (1976) that in those cases, termination of parental right should be considered.

This writer agrees with Kempe and Kempe (1976) when they suggest that a competent psychiatrist or clinical psychologist should be involved in the assessment of every case of abuse or neglect.

The realities at hand (i.e., too many cases, not enough professionals, funding problems), seem to limit the psychiatrist/psychologists to the roles of differential diagnosticians, supervisors, court experts, and treatment consultants (Stern, 1978; Schmitt, 1978).

Carroll (1978) states that the social worker is obliged to mobilize the untapped abilities of the parent, to enlist the support of the extended family, and to utilize community resources in order to meet the family needs. She visualizes the social worker as a role model for the parents, a teacher of new ways of relating, and a friend. Schmitt (1978) divides the social worker's role into a consultant who is responsible for evaluating the safety of the home and recommending treatment strategies and an involved worker who works closely with the family in the same capacity as outlined by Carroll.

Fontana (1964) assigns the following responsibilities to the social worker: (a) to integrate the medical, legal and social aspects of maltreatment; (b) to present the social and medical findings at court, if necessary; (c) to cooperate with medical personnel and assist in the identification of any existing destructive drives within the family unit; (d) to protect the child from further trauma; (e) to help parents accept and receive the help necessary to strengthen family understanding; and (f) to protect the parent and the child from further consequences of this behavior.

Martin (1979) defines the social worker's role in terms of being an advocate for the child; to raise questions about the child's

developmental, psychiatric and medical status, to note maladaptive behaviors and to clarify the exact nature of concern. In other words, as part of this obligation they should be cognizant of the child's developmental status, psychological state and both emergency and non-emergency medical needs so that treatment can be arranged. Lastly, they must be prepared to act as a psychotherapeutic agent for the child by providing a healthy adult model. Kempe and Kempe (1976) cautioned that lack of training or too high a case load may interfere with proper involvement. They suggest the utilization of non professionals to provide the nurturance needed by both parents and child.

Case management and advocacy can be as simple as just being accessible to the parents and child or as difficult as petitioning the court for termination of parental rights. As such, it should be considered a full time, responsible job. It seems to this writer that, except for the medical or neurological exams, social workers do indepth assessments, select a course of intervention and treatment, and take major responsibility for counseling and therapy without the benefit of input from other mental health practitioners (Schmitt, 1978; Carroll, 1978; Kempe & Kempe, 1976; Fontana, 1974). If case management is a full time job, then social workers certainly do not have the time, and do not need the additional stress (Bandoli, 1977) of therapy. If practical considerations must limit the use of high level clinical practitioners in direct therapy, it is essential to provide extensive training for social workers or use Master's level clinical psychologists. In either case, a clinical psychologist/

psychiatrist should be available to discuss the ongoing therapy, any problems as they arise, and to provide support and guidance.

The complexities of child abuse and neglect necessitate a complex case management. With so many different agencies involved and so many "hands in the pot" it is easy to avoid responsibility and to let children "fall through the cracks." The Team Management concept (Helfer, 1976; Schmitt, 1978) appears to be a viable solution. Instead of many different agencies avoiding responsibility or fighting over who is in charge, they all operate under the auspices of a central agency known as the Child Protection Team. The team coordinator is the case manager in charge of communication with all the agencies and professionals involved in a case.

While the make-up of the team can differ from one place to the other, a team should ideally include, in addition to the coordinator; a psychiatric social worker for evaluation and screening purposes, a physician for medical diagnosis; a psychologist or psychiatrist for adult assessment; a developmental specialist such as a child psychologist for child assessment; an attorney to answer legal questions; a law enforcement representative; a public health nurse; the child protective services intake worker and whoever else has been directly involved with the case. Examples of those directly involved include the doctor who may have been called, the parent's lawyer (especially if abuse is severe or if termination of rights may be advised), nursing staff who have cared for the child in the hospital, school officials if the child is school age, and any other agency which has been previously involved with the family. The

object, of course, is to amass as much information as possible about the family in question. Notice that what is missing from this extensive list is a person such as a mental health clinic representative who is designated to handle the treatment aspects.

As good as the team concept seems to be (it is so new that no research was found as to its effectiveness as a case management technique), even it neglects to designate a mental health clinician as the professional of choice for therapy and counseling.

6 THE QUESTION OF FOSTER CARE

One of the most important and possibly the hardest decisions that has to be made during the assessment process is whether to permit the child to stay at home, to be remanded into temporary or permanent foster home care or to be released for adoption. Not only must a decision be made during the initial assessment, but that decision must be continually reevaluated during the intervention process. Change in parental attitudes or position could necessitate changes in home placement. The only time that the decision appears to be irrevocable is when the child has been adopted.

The first question that needs to be answered is if it is safe for the child to remain at home with his parents. A checklist prepared by Kempe and Kempe (1976) from their work with abusive parents is very similar to questions that must be answered during the diagnostic process. Positive replies would indicate that, for the moment, the child should not be returned to the home.

1. Was the parent repeatedly beaten or deprived as a child?
2. Does the parent have a record of mental illness or criminal activity?
3. Is the parent suspected of previous physical abuse?
4. Is the parent suffering loss of self-esteem, social isolation, or depression?
5. Has the parent experienced multiple stresses within the last year (i.e., debt, frequent moves, marital problems)?

6. Does the parent have violent temper outbursts?

7. Does the parent have rigid, unrealistic expectations of the child's behavior?

8. Does the parent use harsh punishment?

9. Is the child perceived as difficult and provocative (whether or not he really is)?

10. Does the parent reject the child or have difficulty forming a bond?

Schmitt's guidelines (1978), which are a result of his work with abuse and an outgrowth of the Team Management Concept, for permitting a child to stay at home are more objective and precise than Kempe's.

1. Perpetrator removed, lives elsewhere, or has definitely left town.

2. A combination of all of the following: (a) minor injury, (b) injury inflicted in the name of discipline for a specific misbehavior, (c) abuse happened only once or twice, (d) child is older than two, (e) child is not unduly provocative or obnoxious, (f) parent is not a dangerous person by initial evaluation, (g) no major home crisis, according to initial evaluation, (h) the parent admits to problems and is willing to accept counseling and close supervision, and (i) the nonperpetrator parent is protective of the child and will not leave them alone with the abuser.

3. Factors increasing the Safety of the Home: (a) child over five, (b) parents feel child has many loveable qualities, (c) the perpetrator is openly remorseful, (d) both parents have good health

and normal intelligence, (e) the father has a stable job, (f) a stable marriage, (g) lifelines (firends, neighbors) are available, and (h) other professionals, agencies or relatives provide collateral confirmation that the home is safe.

(These factors are also indicative of motivation for treatment and indicators of good prognosis).

If these conditions are not met, temporary foster care placement should be considered. Schmitt's (1978) guidelines are again a compilation of his clinical experience.

1. Severe physical or sexual abuse.
 - A. Physical abuse resulting in hospitalization, death (then other sibling's need to be removed), life-threatening abuse, multiple fractures, deliberate assault, or aggravated assault (using a weapon).
 - B. Failure to thrive to a severely malnourished level.
 - C. Premeditated murder (such as poisoning with intent to kill).
 - D. Incest or any type of sexual abuse using force.
2. Evidence of repeated and frequent abuse even though not previously reported.
3. Reabuse after intital report and intervention.
4. Severe emotional abuse (severe disturbance or total rejection by parents).
5. Child less than one year old with physical abuse.
6. Child has behaviors which are unduly upsetting to the parents.

7. Child is afraid to return home or, if an adolescent, refuses to return home or is beyond the parent's control.

8. Parent is dangerous, i.e., overtly psychotic, addicted to drugs.

9. Nonperpetrator parent is not protective.

10. Parent requests that child be placed elsewhere.

11. Parents persistently refuse intervention and treatment services from onset.

A. Persistently deny diagnosis.

B. Persistently state that physical abuse is necessary and justified to correct misbehavior.

C. Consistently refuse treatment services with open hostility, passive-aggressiveness, or total indifference.

12. Multiple, ongoing crises.

(Analysis of cases handled by the Child Protection Team showed that 10-20% of the children required temporary home care. Termination of parental rights was required in 1-2% of the cases).

Sometimes, even when parents agree to voluntary foster care, it is necessary to make the children wards of the court. This should be done when there is severe physical or sexual abuse; when there is reabuse; when there is severe emotional abuse; when a parent is dangerous; when parents deny the diagnosis persistently, refuse to stop punishing, or refuse treatment services; or when voluntary efforts have been nonproductive for more than three months (Schmitt, 1978).

Other times that decisions about foster homes vs natural home care have to be made is during intervention and at the time of treatment is terminated. Davoren (1974) hypothesizes that children in foster care should be returned to the home as soon as they are out of danger of severe beating, with an accompanying reduction of physical punishment and emotional abuse. Her criteria include: (a) an improvement in economic stability; (b) engagement in more useful, less frustrating behavior; (c) development of a capacity for fun; (d) the ability to establish a more meaningful relationship with own mother; (e) showing an ability to make friends; and (f) not being threatened by, but enjoying the relationship between therapist and child.

Schmitt's guidelines (1978) for return to the home include:

1. Parents are utilizing therapy.
2. Child management has improved.
 - A. The parents have learned alternate ways to deal with anger.
 - B. The parents have demonstrated impulse control.
 - C. Parents can tolerate the child's expression of some negative feeling toward them.
 - D. Parents use discipline techniques that are fair, nonpunitive and consistent.
 - E. Parents have asked for and implemented advise regarding child rearing.
 - F. Parents have demonstrated the ability to recognize and solve specific child rearing problems.

- G. Parents are beginning to recognize the child as an individual; expectations are realistic.
 - H. Parents speak about the child in positive terms.
 - I. Parents keep all scheduled visits with the child, and interact positively.
 - J. Child is no longer fearful of parents.
 - K. Perpetrator has shown more improvement than the non-perpetrator.
 - L. Perpetrator can recognize potentially dangerous situations and knows how to remove himself from the child.
 - M. Nonperpetrator is able to intervene on the child's behalf.
3. Crisis management had improved.
- A. Parents no longer live chaotic lives.
 - B. Marriage is stable.
 - C. Parents have learned to communicate, especially about different ways to deal with crisis.
 - D. Parents have solved crisis.
 - E. Parents have asked for and utilized help during crisis.
 - F. Parents have avoided crisis by recognizing and solving specific stresses.
 - G. Interpersonal relationships have increased; isolation has decreased.

(It should be noted that, in this writer's estimation, these are also excellent guidelines and objective for planning and evaluat-

ing therapy sessions).

He deems the following prerequisites to be necessary before the child should go home.

1. The severely disturbed person is permanently out of the home or is no longer dangerous.

2. The child's behavior has improved.

3. Follow-up services will continue for at least one year and preferably until school age.

4. Telephone lifelines with several resources will remain available and the parents have a phone.

Unfortunately, 20-25% of all abused children will be unable to return to their homes (Kempe & Helfer, case studies, 1972). They include those children who have been abandoned for over two years; those who have been in voluntary placement for over two years without being visited by their parents; those who have both parents either in mental institutions or jail for more than one year; and those whose parents are so dysfunctional that they continue to abuse, have a dangerous psychiatric diagnosis and/or have not had any significant improvement after one year of therapy or have resisted receiving therapy for over six months (Schmitt, 1978). In these cases, an effort needs to be made to terminate parental rights so that the children have a chance for a permanent, stable home environment.

It might appear then, that the decisions and guidelines governing home vs foster care vs permanent placement are fairly clear. However, it is not. While the child may be safe from further

physical injury, the psychological damage and (even the battering) can continue (Martin, an opinion, 1977).

Davoren (1974), has also found, through experience, that foster care can be used as a motivational tool to get parents into therapy (can't get child back unless they go) and as a distancing method by which both parent and child can come to terms with their feelings toward each other. She also found that some parents are relieved because they cannot injure their child any longer. On the negative side, foster home placement can be disruptive of the lives of both parent and child, and create additional emotional damage. A possible buildup of hostility in the parents can create therapy problems.

There appears to be a tendency, since the child is safe, to keep him in foster home placement far too long (Kempe & Kempe, 1976). They postulate the following reasons: It is easier to keep the child in a foster home than to work with the parents; unconscious wishes to punish the parent may interfere with willingness to recommend return; or, as happens, the child becomes lost in the system.

Martin (1979) postulates that the child, since he loves his parents, can see this separation as a true loss. Feeling additional rejection or punishment, his self-image of unworthiness is further reinforced. In order to avoid this happening, he suggests that the parents be able to see the child regularly. Unfortunately, this is not very realistic in many cases. Factors such as transportation or distance can interfere. And it must be accepted that parents may not want to see the child. If this happens, the child, at an

appropriate time, should be made to understand that the cause of a problem is in the parent, not in themselves.

Parental visits may be discouraged by the foster parents since they can interfere with the foster care relationship. Tension between the foster and natural parents can interfere with the child's adjustment. In addition, the current foster care system just does not allow foster parents to become real psychological parents to the child (Martin, 1979).

Another problem in foster care is that foster parents do not have the training to cope with the abused/neglected child's emotional needs or developmental handicaps (Beezley, 1976; Elmer, 1979, in already discussed studies). Unable to handle the child, they often request him/her to be transferred. It is not unusual for these children to be moved from one institution to another, not getting the help they need, only having their angry, hostile feelings reinforced.

If the goal of foster care is to provide a stable and continuous parent-child relationship (Wiltse, opinion, 1976), then the implication is that no child should be allowed to drift along in an out-of-home placement. An effort should be made to return the child to his parents as quickly, but safely, as possible. If that is not feasible, the child should be freed for adoption or, as a last resort, placed in permanent care. This writer feels that these children, as do all children, need the security of knowing where they are going to live and have a right to expect the parenting necessary for proper growth and development. It is better for them

to adjust to the fact that they will never return home than to live with the hope (or fear) that Mommy and Daddy will come "tomorrow."

How then, can good or adequate parenting be evaluated or judged? According to Beezley, Martin and Alexander (1976) this is provided when:

1. Parents can find joy and mutual sexual satisfaction with each other.

2. The parents are able to see the child as an individual.

3. The parents can enjoy the child.

4. The expectations of the child are age-appropriate.

5. The parents have the ability to tolerate the child's negative behavior.

6. The parents can allow the child to receive emotional rewards outside the family.

7. The parents are comfortable about expressing positive affects to the child.

They base these guidelines on their therapeutic work with abusive parents.

The New York State Youth Commission focusing on the obligations of parents to their children, constructed a children's Bill of Rights (in Fontana, 1964).

For each child, regardless of race, color, or creed:

1. The right to the affection and intelligent guidance of understanding parents.

2. The right to be raised in a decent home in which he or she is adequately fed, clothed and sheltered.

3. The right to the benefits of religious guidance and training.

4. The right to a school program which, in addition to sound academic training, offers maximum opportunity for individual development and preparation for living.

5. The right to receive constructive discipline for the proper development of good character, conduct and habits.

6. The right to be secure in his or her community against all influence detrimental to proper and wholesome development.

7. The right to individual selection of free and wholesome recreation.

8. The right to live in a community in which adults practice the belief that the welfare of their children is of primary importance.

9. The right to receive good adult example.

10. The right to a job commensurate with his or her ability, training and experience and protection against physical or moral employment hazards which adversely affect wholesome development.

11. The right to early diagnosis and treatment of physical handicap and mental and social maladjustments at public expense whenever necessary.

This bill of rights not only enumerates the rights of children, but also the obligations and the responsibilities of parents and society. Abused and neglected children have as much of, even more of, a right to good parenting in the foster home situation as they do from their natural parents. If it takes two years of good teach-

ing to void the effect of bad teaching, how many years does it take to void the effects of bad parenting?

The remainder of this section will present this writer's opinion and conclusions. The case for the use of foster care, as it stands today, is poor, the implication being that more emotional damage is done in the foster home situation than by any beating the child may suffer at the hands of his parent (Martin, 1979; Helfer & Kempe, 1976; DeCourcy & DeCourcy, 1973). Children who have to go to foster care seem to be in a no win situation: physical abuse vs continued emotional abuse.

Ideally, in those cases where rehabilitation is not possible, the child should be removed from parental control in order to be adopted. If unadoptable, they should be placed in a home or institution where the parental figures have received adequate training in the art of parenting and in working with child abuse/neglect.

Temporary foster homes should be just that, a place where a child can stay overnight or a few weeks, so that the crisis can be resolved or until the case can be evaluated and intervention started. Better licensing and control of foster homes are needed and, for those homes licensed to care for abused/neglected children, training programs should be mandatory.

Foster parents should take part in both the case management and intervention procedures. They can provide valuable input as to the progress and needs of the child. They should be utilized as lay personnel who can give the child the love and attention they need while serving as a liason between natural parent and child. A good

foster home atmosphere in conjunction with effective therapy or counseling is the ideal framework for reversing the effects of child abuse and neglect.

7 INTERVENTION AND TREATMENT

This chapter on the common adult and child treatment modalities is, basically, a limited discussion. The reader should assume that the information presented is based upon hypothesis, speculation, opinion, clinical experience and clinical intuition rather than hard empirical data. Intervention and treatment is, in this writer's estimation, an area greatly in need of hard empirical data to support the methods being used.

The National Center on Child Abuse and Neglect publishes a manual containing abstracts of ongoing projects and published work. The March, 1978 issue lists 700 entries for published work and 159 ongoing projects covering the years 1965-1977. Each entry is cross referenced 3 to 8 times.

Analysis of the subject index of the published work yielded 116 (or approximately 15% of the 700) entries which were under some kind of therapy or intervention heading. Twenty-six, or 23% of the 116, were rejected as not having to do with intervention as defined by the treatment modalities that will be discussed in this chapter. For example, CD-01371 (p. 99) deals with the attitudes of Pueblo County residents regarding the reporting of abuse/neglect cases, and CD-01383 (p. 101) presents techniques for police to use when handling family conflicts.

Of the remaining 90 entries, 55 or 47% of the 116 were classified as discussions and/or descriptions, 6 were program evaluations

(of which 3 were evaluating the same program), 12 were case history presentations, and 6 did not seem to fit any of the above. Only 11 could be classified as studies or research designs. Of these, only 3 or .025% of the 116, had to do with the efficacy of therapeutic techniques. The rest dealt with topics such as the characteristics of abused children in psycho-therapy (CD-01395), the efficacy of training programs for call line volunteers (CD-01756) or the effects of medication on abusing parents (CD-01919).

This analysis underscores the need for more research on treatment efficacy and outcome and explains the lack of empirical data in this chapter. As part of the abstract for CD-01491 (p. 129) states, "with regard to child abuse and neglect, research should be aimed at (1) identification and description of exemplary treatment and prevention approaches, '''. "

While those in mental health think of intervention or treatment in terms of therapy, child abuse workers think in terms of doing whatever is necessary to keep the child from harm. Treatment for the perpetrator includes those services given in an effort to ameliorate the causes of the behavior and to prevent its recurrence. Treatment for the victims include those services which protect the child from further harm and which seek to undo or lessen the damage.

The Kempes' (1976) optimistically predict that 80% - 90% of child abusers can be helped and that 75% of the children should be able to live safely in their home within one year. In their experience, the other 10% - 20% includes those who have: (a) psychosis involving the child or are aggressive psychopaths, exhibit extreme

cruelty or are "fanatics;" i.e., whipping as a way to exorcise sins from the child; (b) have deeply entrenched alcohol or drug problems; (c) are very young (under fifteen) or have limited intelligence (less than 60 IQ) which should interfere with their ability to learn and change behavior; and (d) have caused serious reabuse, which has resulted in hospitalization or death. Also contraindicated for therapy and included in this estimate are families who, after being in therapy 6-9 months, show little or no improvement; parents who are unable to utilize or accept help; or those who have abandoned (made no effort to contact child for at least 2 years) the child(ren). In those instances, they suggest that the child be permanently removed from the home. This opinion and estimate is supported by others such as Steele (1970) and Schmitt (1978). No information, speculative or factual, was found to refute the estimate.

Historically, interventions were first used to punish the abuser/neglector. This method yielded to a combination of traditional psychotherapy and social work practices in which the child was considered a victim requiring protection and medical care. Only the abuser was given psycho-therapy. High recidivism rates strongly suggested that this approach did not work (1978 Annual Review). Modern strategies focus on the familial and crisis nature of child abuse. Today, it seems to be generally accepted that effective programs must involve a variety of treatment methods and services which serve to relieve the immediate crisis and provide long range help to both victim and abuser(s).

① Treatment is, for the most part, a three phase operation (Helfer & Schmidt, clinical experience, 1976). During the acute phase, lasting 1-4 weeks, diagnostic assessment and crisis resolution take place and long term plans are formulated by the case worker or, if available, the child protection team. ② The next step, the transition phase, involves the implementation of the selected programs. It is not uncommon for families at this time to show enough significant improvement that no further planning is required (Helfer & Schmidt, 1976). If not, the third phase—long term treatment, is entered. It is considered long term because the timeframe is anywhere from 1 - 3 years with an additional probationary period after treatment terminates. Because of the length of time involved, it is crucial that one person accept the responsibility of coordination and program assessment.

Helfer and Schmidt (1976) and Newberger (1975) also address the issue of designating an agency or person to be in charge of long term treatment. In their opinion, child welfare departments, both philosophically and legislatively, are accustomed to handling only short term (1 - 3 months) crisis situations and, for the most part, are not equipped to handle long range treatment. Mental health agencies are not equipped to handle the social work aspect. They recommend the establishment of a new bureaucratic agency which would function both as an interagency and interdisciplinary manager supervising all three phases of treatment, and as an evaluator of the intervention.

This author feels that the creation of such an agency does not appear feasible at the present time, nor is it necessarily warranted. Even though it appears that such coordination is needed, it seems more logical and less complicated to create such a position within the framework of the social work system, under the aegis of child protective services, or by expanding the function of the child protective teams to include the necessary long term management.

Fontana and Beshorov (1977) suggest, through clinical experience, that the overall objectives of child abuse prevention and treatment programs should be:

1. To prevent separation of parents and child whenever possible.
2. To prevent the placement of children in institutions.
3. To encourage the attainment of self-care status on the part of parents.
4. To stimulate the attainment of self-sufficiency for the family unit.
5. To prevent further abuse or neglect by removing children from families who show an unwillingness or inability to profit from the treatment program.

This appears to be best accomplished by utilizing a variety of treatment modalities. Fontana and Beshorov (1977) base their selection of intervention procedures upon: (a) the factors responsible for the parent's dysfunction, (b) the severity of the parent's psychopathology, (c) the overall prognosis for achieving adequate mothering, (d) time estimated to achieve meaningful

change in the mother's ability to mother, (e) whether the parent's dysfunction is confined to this child or involves all of the children, (f) the extent to which the mother's malfunctioning extends to her other roles, such as wife, homemaker, and housekeeper, (g) the extent to which the parent's overall malfunctioning, if this is the case, is acute or chronic, (h) the extent to which the mother's malfunctioning is confined to infants as opposed to older children, (i) the parent's willingness to participate in the intervention plan, (j) the availability of personnel and physical resources to implement the various intervention strategies, and (k) the risk of the child's sustaining physical abuse by remaining in the home.

Rosenfeld and Newberger (1979), emphasizing a need for standards which would guide the choice of intervention, suggest the following considerations be evaluated.

1. Acute vs chronic injury - is this an isolated incident due to situational stress or severe reinjury?

2. The abusive incident acceptable or unacceptable - does the perpetrator manifest guilt over the incident?

3. Social vs dissocial - is the pattern of behavior in tune with cultural or subcultural norms or is it greatly deviant (isolation, drug or alcohol abuse, criminality)?

4. Love vs hate of child - is the child seen as good or intrinsically bad?

5. The child as separate from vs fused to the parent - is the parent able to conceive of the child having its own needs?

6. Integrated vs disintegrated parental ego - does the parent have sufficient ego control to inhibit destructive impulses?

They caution that care should be taken when utilizing these parameters and stress the importance of sound clinical judgement when designing intervention programs.

Parental functioning can be considered improved if:

1. The social or environmental stresses are eliminated or diminished.

2. The adverse psychological impact of the social factors on the parent are lessened.

3. The demands on the mother are reduced to a level which is within her capacity.

4. Emotional support, encouragement, sympathy, stimulation, instruction in maternal care, and aid in learning to plan for, assess, and meet the needs of the infant, are provided.

5. The inner psychic conflict is resolved or diminished.

(Fontana & Beshorov, 1977).

Adult Treatment

Adult treatment modalities include traditional therapies such as individual psychotherapy, marital counseling, crisis intervention, or group therapy. Supplemental interventions can be provided by paraprofessionals and crisis hot lines.

Individual psychotherapy (Beezley, 1978; Kempe & Kempe, 1978*) can

*(The references that will be found in the beginning of each subsection relate to all the information found in that section unless otherwise specified).

be provided by a wide range of mental health specialists. The type of therapy offered will depend on the client, the therapists' experience and style, and the treatment techniques chosen.

The advantage to individual therapy is that it not only focuses on here and now reality problems but also on intellectual and emotional insight through exploration of behaviors and feelings. Its limitations include lack of focus on parent-child interaction and too slow a rate of behavior change to protect the child. The mistrust and erratic behavior of abusers may interfere with keeping regular office appointments. If the abuser comes to therapy motivated by a desire to have their child returned rather than a wish to make personal changes, this kind of therapy may not be effective. Specific, limited goals are necessary. The clients' life situation, their ability to express feelings, their capacity for change, and to use support plus the length of time the therapist is available, all need to be considered when deciding on individual therapy.

The more contemporary therapies such as transactional analysis, behavior modification, reality training, and Gestalt therapy have been largely untried as treatments. Justice and Justice (1976) report success, (as measured by no further abuse by 8 out of 10 couples in a parent abuse group), utilizing behavior modification and transactional analysis in the group setting. Denicola (1978) experienced limited success, (reduction of aversive behaviors) when training in coping skills was combined with parent education and training methods. A high dropout rate interfered with the ability to generalize his findings. More investigation is needed as to the

applicability of these methods. The data implies that individual therapy is not, by itself, sufficient to stop or reduce abuse/neglect. Perhaps the utilization of these other methods will increase therapy efficacy and reduce recidivism.

Because these therapies do not traditionally provide the support and nurturance needed by abusers, it is important to use parprofessionals such as lay parent aides or homemakers services as adjuncts to treatment.

Parent Aides (Beezley, 1978; Kempe & Kempe, 1978; Martin, 1979) can be used to provide long term nurturance to the abusive parent by visiting in the homes at least once a week. They can also provide transportation, as needed, and social experiences. Many times they give the isolated parent their first opportunity to make a friend. While parent aides cannot be responsible for the child's safety, their presence can afford an opportunity for a child to return to the home instead of being put into foster care. Parent aides should plan on being intensely involved with the family for as long as two years, and slightly involved for as long as the family remains in the area.

Parent aides, since they do not have the authority to remove the child, are much less threatening to these families than traditional mental health or social workers. Consequently they are often used in times of crisis to support the parent before the child is reinjured. In addition, aides can also save valuable social work and psychiatric time by defusing problem situations before professional intervention is required. Disadvantages include difficulty in

recognizing problems, overidentification with either one of the parents or with the parent against the therapists, or keeping the parents too dependent. These limitations can be solved if supportive services and good training programs are provided.

The major considerations for the choice of parent aids, should be the quality of their early parenting experiences, the ability to feel empty towards abusers, the ability to cope with problems successfully and the presence of support systems in their own life. They should be matched with families according to age, children, income level, cultural and racial background whenever possible. These suggestions have been based on experiences using parental aides.

Homemaker Services (Martin, 1979; Kempe & Helfer, 1972), can be utilized to reduce stress by moving in with the family on a temporary basis. This enables the child to be kept at home and affords the parents the opportunity to be freed from home management and child care. This type of service can be especially useful in neglect cases or when a mother cannot cope with the home or children.

Marital Therapy (Beezley, 1976, 1978; Kempe & Helfer, 1972), is preferably provided by cotherapists who see the husband and wife together in an office setting. The focus is on solving marital problems and improving communication. It is especially useful in cases where parents are displacing anger about their marriage onto the child. Marital therapy is contraindicated if there is an overriding need for a one-to-one therapeutic relationship or if one of the parents is mentally ill. In those cases it is important to initiate individual counseling before trying marriage counseling.

Group Therapy (Beezley, 1976, 1978; Paulson, 1974; Justice & Justice, 1976) should be provided by male-female cotherapists whenever possible. This allows for the group to attack one therapist while the other is available for support, and solves the problems of group continuance during illness or vacation. The group purpose will depend on the types of people involved and the issue focus. Examples of issue focus include: individual problems, marital problems and child management.

Advantages include reaching more people with fewer staff, reducing parental isolation and facilitating mutual support systems. Increased confrontation of denial and problems usually takes place earlier than in individual therapy. Accurate child rearing and child development information can be provided and the parents can have their first experience with socialization and being helpful to others. Group therapy is contraindicated in severe crisis situations or when extreme psychopathology is present.

The group business issues of time, place, transportation, babysitting, size and pregroup preparation are very important. A safe, anonymous meeting place and consistent day and time are crucial. The group should remain open ended, if possible, with a range of 5-10 members, 7 being the ideal. Individual pregroup sessions should be utilized to build therapist rapport, lessen fears and misconceptions and explain how group therapy works. Lastly, clinicians may be required to do outreach during difficult times. It is also suggested that groups are most beneficial when the parents are also in some kind of individual therapy. These recommendations have been

been grounded in clinical experience.

Parents Anonymous (Beezley, 1976, 1978; Kempe & Kempe, 1976; Starkweather & Turner, in Ebeling & Hill, 1975; Collins, 1978) is a self help group for parents which provides anonymity, emergency lifelines and support to other members and nonjudgemental, unconditional mutual acceptance. Members feel free to come to grips with their feelings about their children and their lives. Since they all share the same problems, there is less reluctance to admit to feelings or to comfort one another. There is also sharing of information on child rearing and practical, pre-tested solutions to problems. Many groups have a sponsor, usually someone with clinical experience, who is used as a resource in case a member is in need of individual counseling.

Crisis Hotlines (Beezley, 1978; Kempe & Kempe, 1976) which provide supportive crisis counseling as well as referral services can become lifelines to abusive and neglectful parents under stress. The more lifelines or numbers available, the more likely it is that they will be able to get help before they become overwhelmed. Besides providing emergency crisis treatment, hotlines can help parents cope with their problems and provide reassurance that they will get help before they lose control. They also facilitate asking for help before a crisis is blown out of proportion.

To be effective, hotlines should operate 24 hours a day, 365 days a year, and be under the supervision of someone skilled in crisis intervention. The worker should have extensive training in dealing with distraught people and exact knowledge of facilities and

available resources.

Treatment Options for Children

Children may require treatment for medical problems, developmental problems and/or psychological problems. Medical intervention needs to be handled by appropriate medical personnel. The treatment modalities for developmental delays (Beezley, 1976; Martin, 1979) will depend on the child's problems and community resources.

No matter which modality is selected, it is crucially important to help the parents deal with the child's developmental or personality changes. Otherwise, they may, in an effort to regain control, sabotage treatment or resort to reabuse (Martin, clinical experience, 1979). This writer speculates that as the child becomes more psychologically, developmentally and behaviorally normal, as measured by an increased ability to value and assert their own needs and wants, the parents feel threatened in two ways. They fear the loss of nurturance that has been provided by the child and they equate this increased assertiveness with a diminishment of their role as an effective and adequate parent. Just as the abuser needs to learn to accept the polarities of "good and bad" that exist in themselves and in their parents, they need to learn to accept them in their children.

Possible ways to forestall this problem could be by forewarning the parent as to the possible ramifications of therapy, by educating as to what can be expected during the developmental stages, and by initiating or keeping communication open with the child's therapist, the parent's therapist and other parents. In addition, the involved

therapists should keep each other informed as to changes which might affect their respective clients. Lastly, in those instances where the child is handicapped or has suffered irreparable damage such as mental retardation, the parent should also be helped to accept the child's limitations and to deal with any accompanying guilt.

Developmental

In Martin's (1979) experience, generalized developmental delays in children between birth - 3 years can be treated at home by stimulation programs, in therapeutic day care centers or by placement in a part time or full time foster home for a diagnostic trial period. A diagnostic trial period is when a child is placed in an "improved" environment to see whether the child's development will accelerate. If that does not happen within 3 - 6 months, more formal strategies such as treatment by a developmental specialist should be instituted.

He also has experienced success when children between 3 - 6 years are placed in special or therapeutic preschools or in a diagnostic trial situation. The preschool has several advantages. It can function as a respite for parents and child without interrupting their relationship, provide general developmental stimulation act as a vehicle for remediation of specific developmental delays, give the children an opportunity to learn healthier socialization patterns and help with personality traits.

In his opinion, children older than 6 can benefit from the specialized services provided by public schools. They include learning disability classes; reading, speech and hearing clinics; classes for mentally retarded children and after school day care

programs.

Specific or intensive therapies provided by a trained specialist may be required if the developmental problem is limited to a particular area such as motor skills or perception or when the deficit is so debilitating or complex that a parent or day care worker is unable to supply the necessary stimulation or training.

Psychological Treatment Modalities

Treatment modalities for psychological problems include playschools, play therapy and group therapy.

Therapeutic Playschools (Beezley, 1978; Miranda in Martin, 1979; Bean & Gardiner in Ebeling & Hill, 1975) staffed by early childhood educators and aides can provide intensive, therapeutic experiences and planned stimulation. Developmental and emotional growth is emphasized through positive interaction among peers, other children and adults.

Children between 2 - 5 who have not had other types of preschool experience and are isolated from others in their homes seem to benefit the most, providing the parents are able to tolerate daily separation and are willing to participate in parent groups and conferences (Beezley, 1978). Other therapeutic choices can be regular day care centers, preschools, Head Start or day camps. It seems to be a consensus of opinion that children who are so emotionally disturbed or retarded that they will not be able to keep up with the group should be placed in specialized settings.

Individual Play Therapy uses play materials, a safe setting, and an understanding therapist to teach the abused child to express

conflict and fears. Beezley (1976, 1978) has used this therapy with children as young as 3 - 4. In her opinion, this modality should be reserved for those children whose conflicts cannot be resolved through a group experience alone. She reports treating children with extremely low self-esteem, depression, extreme aggressiveness or severe behavioral management problems by this method with good results, as judged by positive behavioral changes. She found the parents of such children to be ambivalent about the treatment or openly resistant. If a child is fairly healthy but the parent sees him as "sick," he should not be seen individually as this would only reinforce the parent's distorted image.

Group Therapy for children is a relatively new application of an accepted adult modality. It is appropriate for latency age children, and their siblings, who have interactional problems with their peers (Beezley, 1978). The same advantages of adult group therapy apply.

It has been noted throughout this paper that more information is known about the offenders than their victims. In this writer's opinion, the data investigated suggest that there has not been sufficient experience with the various treatment modalities for children to pass judgement on their efficacy. The therapeutic needs of abused children need to be more fully identified, and the efficacy of these programs need further evaluation.

Family Treatment

The focus of Family Treatment is to improve both parent-child interaction and family interaction. Crisis nurseries, family

therapy, family residential treatment, parent-child visits, home visits, and parent education and modeling behavior can be used to reach that goal.

Crisis Nurseries (Beezley, 1976, 1978; Kempe & Helfer, 1972) can be located in foster homes, hospitals, preschools or day care centers. In order to be readily available in times of crisis, it is suggested that they be open 24 hours a day, 7 days a week. Their primary purpose is to provide an outlet for parents during crisis situations in order to prevent injuries to children. They can serve many other useful purposes. Parents can be helped to feel comfortable about getting away from their children, they can be a stepping stone to voluntary foster placement or act as a holding facility between hospitalization and foster placement. Short term care (72 hours or less) and child care during therapy appointments can be supplied. Most of the nurseries give space priority to newborns and children under 5, since these children are in the greatest danger of abuse (Schmitt, 1976). Children with severe emotional and medical problems are contraindicated, because these centers usually do not have staff capable of handling these problems.

Family Therapy (Beezley, 1978; Martin, 1979) has not been used very much, yet, to treat abuse, so little empirical evidence exists. As understood by this writer, the premise of family therapy: that the family, not the individual, is the client, makes it possible to change the deviant patterns of interaction without having to focus on the abusive or neglectful behavior. This kind of therapy is most beneficial if the children can express their feelings. It can be used

diagnostically as an observation technique if the children are young. Intense anger or competition among family members for therapist attention or nurturance are contraindicators. In those cases, individual and or marital therapy would be appropriate before family therapy is initiated.

Family Residential Treatment (Beezley, 1978; Lynch & Ohmstead, 1975; Fontana & Besharov, 1977) is another concept in child abuse treatment. In this approach, the whole family moves into a treatment facility as an alternative to foster care. This type of treatment can provide intensive therapeutic work, prevent the weakening of parent-child bonds and correct parental distortions about the children. Residential treatment allows the opportunity for around-the-clock observation in order to diagnose the severity of the problem, facilitates realistic treatment planning, and enables the parents to establish meaningful relationships with staff. This modality is so new that there is very little written data available.

Additional Modalities These methods are educationally and behaviorally oriented in that they are aimed at teaching new methods of parent-child behavior (Beezley, 1978; Martin, 1979). Martin (1979) recommends using parent-child visits (when the child is separated from the parent) to help the parent understand the child's behavior and to learn better child rearing methods. He also suggests that home visits by workers can afford an opportunity to model appropriate interpersonal and parental behaviors.

Parent education classes, as used by Beezley (1978), can provide basic information in a non-critical atmosphere. Video-taping

of parent-therapist and parent-child interactions and role playing, followed by discussions, may be of value in changing parent/child interactions. Alexander, McQuiston & Rodeheffer (1976) reported success, (behavioral change), when this method was used as part of a therapy program in a residential center.

This writer feels that these methods should not be used as a primary means of changing behavior, but should be considered as adjuncts to the more intensive interventions.

Treatment Goals, Guidelines and Techniques

Beezley (1978) and Jeffery, (1976), in their treatment of abusive parents, plan first and foremost, for the relinquishing of the abusive/neglectful pattern of child rearing and then for the establishment of a more rewarding method of caring. It appears to be their concerns of opinion among the author's researched for this paper. That this is best accomplished by focusing on the parents, rather than the child or the abusive situation (Kempe & Helfer, clinical experience, 1972; Steele & Pollack 1976; Schmitt, 1978; Lauer, et al, 1979). The following treatment goals which they use should give the reader some idea of the amount of change expected of abusers and explains, to some extent the reasons for recidivism and dropouts from therapy programs. Abusers need to build self-esteem, develop better trust and confidence, learn how to make contact with others, establish responsive liveliness and to learn how to enjoy life and have rewarding, pleasurable experiences with others. In addition they must learn (or relearn) how to communicate with their children, how to play, how to give and get positive attention, how

to make the house adapt to the people in it (taking breakables away if the children are fiddlers, not having a white livingroom rug), how to discipline without punishing and how to be assertive.

This writer has concluded that the treatment needs of abusive parents differ from other psychiatric clients. Beezley, Martin and Miranda (in Kempe & Kempe, 1976) based on their clinical experiences, suggest the following differences: (Items in parenthesis are this writer's personal comments).

1. More than one person must be involved in the treatment process. This facilitates decision making, the fusion of the good and bad polarities in the abuser, and the nurturance demands (in addition it helps protect against therapist burn-out).

2. Requires much more outreach and availability of services (due to the crisis aspect and nurturance demands, and need for specialty services such as aides, hot lines, etc.).

3. Contact must go on for a longer period of time. Minimum length of therapy is 1 year; average length of time 18 - 24 months. Child abusers may reduce their frequency of appointments, but are never really terminated.

4. In order to enhance self-esteem, experience pleasure and improve basic child care, the parents must role play and practice.

5. Therapy is a 2-part process: first involving restitution - a nurturing or reparenting and then conflict resolution.

The Kempe's (1976) found, in their practices, that the outcome of the therapy depended on the intensity and the longevity of the family dysfunction, the age of the child(ren), how long the abuse/

neglect has been on and the effect on the child. Jeffery (1976) found, through clinical experience, that abuse was not likely to occur again, if, at the end of treatment the parents' image has improved enough to have at least one friend with whom to share joys and concerns, if both parents are able to find something attractive in the child as demonstrated by the ability to be overtly affectionate, and if they have learned to use liveliness during crisis.

Positive signs of improvement in children (Lauer, et. al., 1979, and Martin, clinical experience, 1979; Martin & Beezley, behavioral observations, 1977) include the ability to respond to and actively seek praise, to abide by controls and limits, to be able to initiate and maintain appropriate peer relationships, to communicate feelings and needs in a verbal and confident manner, and to enjoy being a child.

It is this writer's conclusion that abusive or neglectful people are not easy to "love," to have empathy for, or to work with. Their needs are so great and complex that therapists should not work with them unless they are able to listen to the expertise of other disciplines without feeling threatened, are able to acknowledge weakness and ask for consultation, and are able to tolerate a lot of dependency. The ability to be nonjudgemental, to move slowly in therapy, and to be cautious and low keyed with expectations and goals is essential (Beezley, 1978; Martin, 1979; Davoren, 1974, clinical experiences). They also found it helpful if therapists were willing "to put themselves out without being a martyr," and had a general satisfaction with life. A strong working knowledge

of child behavior was found to be also useful in helping the therapist sort out parental distortions and misperceptions about their children.

To facilitate working with abusers, Davoren (1974) and Steele and Pollack (1974) make the following suggestions to the counselor:

1. Find something to like about the abusers.
2. Reduce therapist expectations of parental performance without reducing the abusers already low self-esteem.
3. Avoid setting limits and being tricked into dominating.
4. Be willing to share one-self with parents.
5. Give your complete attention to parents to reinforce the feeling that they are important.
6. Investigate the total person - not just the abuse, which should be viewed as a symptom of a deeper conflict.
7. Be prepared to be rebuffed and/or for belligerence, aggression or docile submission (which is a subterfuge for passive-aggressive behavior). Avoid interpreting these behaviors as personal rejections.
8. Avoid questions that carry a sense of accusation; avoid direct interest in the child.
9. Help establish a support system and social contacts for the abuser.
10. Avoid giving advice, even if asked for. Give them "permission" to make their own decisions, instead.
11. In order for abusers to gain confidence and self-respect, involve them in the decision making process.

12. Prepare them for changes in therapy, such as vacations, rescheduling of appointments, therapist illness and termination.
13. Leave the door open for return at termination of treatment.
14. Provide a mother substitute to supply additional nurturance and good role modeling.
15. Last but not least, the therapist must come to terms with their own feelings about a person who has hurt a child.

It is this writer's opinion that, during any course of treatment, therapists have to deal with their clients' blocks. Most of these situations are common to therapy and will not be elaborated upon. According to Pollack and Steele (1974), Kempe and Kempe (1976), Walters (1975), and Justice and Justice, (1976), problems which they have encountered in their treatment of abuse and neglect include a general reluctance to talk with authority figures who are perceived as critical parents; transference of this feeling to helpers; increased loss of self-esteem and depression due to misconceptions about therapy; and fear that frankness about feelings, the past, or the abuse, will lead to arrest or prosecution.* Other problems are attempts to control the situation by hostility, if male, or crying, if female; exaggerated concern over "who reported me;" use of verbal seduction as a way to establish a relationship, to avoid discussing the abuse, or as a way of "handling" the counselor; and verbal attacks. Discounting, a thought process by which someone devalues the existence of a problem, its significance, its

(*Confidentiality is a particularly crucial issue when dealing with abusers).

solvability, and the person's ability to cope with it is a favorite method of abusers to avoid responsibility and remain dependent.

Walters (1975) also found that people sometimes interfere with therapy. The appearance of an attorney, news media, the police, or investigators from other agencies, have caused his clients undue anxiety and can threaten therapist-client rapport and trust. He deals with these others honestly and firmly, but without breaking confidence. He also found that children, especially if they have been sexually abused, are vulnerable to unwanted invention from a variety of sources such as schools, shelter personnel, relatives, and ministers. He recommends that they be counseled to refuse to talk about the incident, and/or to refer questions to their case worker or therapist.

8 EARLY IDENTIFICATION AND PREVENTION OF CHILD ABUSE AND NEGLECT

Where a physically and psychologically unhealthy family milieu exists, the combined resources of skilled professionals and a responsible community can contribute to the rehabilitation of abusive parents, and the continued protection of their children. Researchers, individually as well as collectively, must work toward the goals of providing an educational and therapeutic environment in which the abusive parents may eventually assume a more useful and responsible parenting role in our society. In addition, and of equal importance, is the need to establish prevention programs in centers of family life, so that "parents at risk" can be identified and helped, prior to the identification of "a child at risk."

(Paulson, Savino, Chaleff, Sanders, Frisch and Dunn, 1974, p. 31)

Child abuse and neglect cannot be eradicated unless parents-at-risk are recognized and treated before there is a child-at-risk. This sounds simpler than it is. Whereas much is known about the dynamics of abuse and the effects of abuse and neglect, this knowledge has yet to be successfully applied to the prediction and prevention of child abuse and neglect.

Research in the area of prediction (Helfer, 1976; Schneider, 1976; Kempe & Kempe, 1976; Justice & Justice, 1976) has suggested

that what is needed is some kind of early warning system to identify those people who may be predisposed toward abuse/neglect. Then supportive intervention techniques could be initiated to change personal dynamics, attitudes and values, and parent-child interactions.

The implication, as deduced by this author, is that the most logical way to do this identification is by screening procedures such as questionnaires, or by direct observation of parental-child interaction. Helfer (1976) suggests that the best time to dispense mass screening procedures would be at the junior and senior high schools (to the next generation of parents), to women during prenatal care or after delivery while they are still in the hospital, or when the child first enters the public school system. A good time to observe parent-child interactions is after delivery, during the post-partum period, and at pediatrician's offices and well-baby clinics. It is his theory that the above mentioned times and situations would enable at least 95% of the population to be identified according to the potential for abuse, and that it allows for a continual reevaluation (like having to get your driver's license renewed).

As great as this plan may sound, there are problems. First, no one has yet to construct a screening procedure that is accurate. Schneider, Hoffmeister and Helfer (1972, 1976) have been involved in the construction of a predictive screening questionnaire for a number of years. While the face validity has continued to be substantiated, reliability remains too low for it to be considered

a viable clinical tool. Beswick (1977), Lynch (1977) and Bourne and Newberger (1979) all point to the problem of false positives and false negatives in screening tools. Possible reasons for this include incorrect diagnosis at the beginning of the experiment, social bias and, a problem which has already been presented, the lack of commonly agreed upon typologies as personality clusters upon which to base a screening procedure.

This author argues that even if questionnaires were both valid and reliable, many ethical, practical and legal questions are raised. Who would be responsible for grading or evaluating them? How much training would be required? Would medical personnel or educators be willing to be involved? Should the government require the tests the way marriage licenses are required? Must a future parent pass before she/he is allowed to have children? When would a questionnaire be considered prying or helpful? How much interference could be construed as "Big Brother is watching"? What about the issue of confidentiality? Do high risk parents have the right to be protected from stigma which may become attached if this should become known (blood type: O; child abuse factor: high). What about parents who may be identified as high risk or, even more importantly, as low risk, when they are not?

The implication of the above questions is that predictive tests should be administered only in those instances where the information can be thoroughly evaluated and carefully used. They should not become the "do it yourself quiz of the month," but should remain, at all times, a guide for prevention and identification.

Labeling should be avoided and test results should not be interpreted as the definitive and ultimate diagnosis. Care must be taken that high risk abusers do not become stigmatized, nor low risk abusers subjected to a host of interventions that are not needed. To avoid these problems, screening devices should be used in combination with such assessment tools as interviews and observations. In this way, this author speculates that there would be less of a chance that they would be misused.

While the major thrust of treatment is the prevention of reabuse or continued neglect, primary and secondary prevention is aimed at stopping them from happening at all. This author has concluded that unless the community, both public and professional, is willing to provide programs and create an effective service delivery system for them, this goal will not be reached.

Education almost immediately comes to the front when prevention is discussed (Helfer, 1976; Lauer, et.al., 1979; Justice & Justice, 1976; Cooper, in Smith, 1978; Gil, 1970; Bourne, 1979).* Family and parent training programs in public schools and parent education programs aimed at the general parent population could include such topics as proper parenting and home management skills; child management and development knowledge; and disseminate information on family planning, proper discipline methods, and communication skills.

*(The area of prediction and prevention is in its infancy, therefore, most of the recommendations included in this section are speculative or in the developmental stages, rather than existing programs which have proved their worth).

Education in coping skills can teach ways to deal effectively with stress, how to find help or support in crisis situations and how to recognize the signs of stress. Learning to recognize anger, frustration and fear, and express them constructively should be part of stress reduction programs.

Outreach efforts by visiting health nurses and mental health workers, by establishing rapport, could encourage participation in available programs. Media coverage can be utilized to make the community aware of both the problems of child abuse and neglect and the availability of services. It is hypothesized that the correct useage of the media will not only furnish information but also change public opinion.

Family Life Resource Centers can be developed to provide informal guidance services for all families, not just preabuse ones. This would allow counseling and support to be supplied in a non-threatening atmosphere.

Emotional Bonding Programs are directed at professionals who work with mothers and infants. These programs teach how to encourage the emotional bonding of parents and siblings and how to recognize bonding problems.

Education and outreach should not only be directed at the public. It is also important to provide both in-service and multi-disciplinary training and staff development programs. It should not be automatically assumed that every discipline involved in child abuse is cognizant of the other's roles and limitations. These programs should furnish information on professional roles and responsibili-

ties and case management, provide opportunities for discussion of mutual interests and problems, and distribute information on new research and empirical findings as they become available.

Role of Research

The Child Abuse and Neglect Research: Projects and Publications, published by the U.S. Dept. of Health, Education and Welfare, March 1978 issue, lists 159 ongoing research projects involving at least 200 investigators and 2,058 research publications produced by well over 800 authors. Why, then, is more research necessary? Don't the experts know all there is to know about child abuse? The answer, in this writer's estimation is, quite simply, no.

This author has concluded that some of the research is not valid due to incorrect hypotheses, poor research designs or methods, poor sampling, bias, incorrect statistical analysis, or any of the other myriad factors which act to invalidate research. Much of the information produced by these investigators and authors is based upon anecdotal or case histories, case reviews, observations, or other historical research methods. While recognized as legitimate research techniques, these are the ones most vulnerable to reporter bias. On one hand it is very hard to reproduce and test out hypotheses concerning child abuse and neglect in laboratories; on the other hand, it is morally and legally impossible to do nothing or create control groups which would deliberately put a child at risk in order to evaluate the results. Longitudinal studies in which children or adults are monitored for the before and after effects of abuse and efficacy of treatment are time consuming and costly.

Due to the nature of child abuse and neglect, drop out rates and/or recidivism are high. Either would distort the results.

Research, in and of itself, has its own cause and effect relationship. First, someone must decide there is a problem to be solved which has no answers. Then the search begins, and this search reveals further questions for which there are no answers. In the beginning, most abuse research was directed toward finding out why children were abused. As this base of information grew, researchers turned their energies toward the investigation of appropriate treatment methods and the effect on the child. The lesser known and more uncommon sequelae became easier to identify. For example, research interest has gotten around to investigating the parameters of sexual abuse and judging the effectiveness of primary prevention methods.

Areas in which further research are indicated include both the identification of the consequences of growing up in abusive/neglectful homes and the modification of them. Better indices for measuring the incidence of abuse and neglect are needed. Parent-child interactional dynamics and the role of the child as a scapegoat or catalyst, need additional investigation. The establishment of an instrument similar to the MMPI to identify potential abusers and evaluate the risk factor would be helpful. More information is needed on the effect of abuse/neglect on siblings. This list is not, by any means, complete. Other suggestions have been included in discussions throughout this paper. No matter how much is already known, there is more to be learned. This will make better intervention possible. Hopefully the incidence of child abuse and neglect

will decrease, and ultimately, the intergenerational chain will be broken.

9 LEGAL CONSIDERATIONS

A discussion of child abuse and neglect would not be complete without inclusion of the legal ramifications of child abuse and how they effect treatment. Due to the length of this paper, this will be a very limited discussion. There are two types of laws dealing with child abuse and neglect, criminal and civil (Lauer, et.al, 1979; Delaney, 1976; Walters, 1978; Beezley, 1972). Criminal courts are authorized to determine the guilt or innocence of the accused and to pass sentence where needed. They have no authority over the victim. The juvenile or family court focuses on the child's need for protection and on providing help and services to the parents and child. They are also responsible for terminating parental rights if it is established that the parents are unable to care for the child. Involvement with the court may occur at any time during the assessment and intervention process.

Society's reaction to child abuse and neglect, especially severe abuse or death, is similar to the reaction to any crime-- apprehension, punishment, incarceration, a demand for rehabilitation, and lack of interest in the victim. This does nothing to resolve either the abuser's or victim's problems; it may even exacerbate them.

If the abuser is acquitted, he feels vindicated, that his conduct is justified. He interprets the acquittal as an acceptance of his "corrective" parental measures. This reinforces his tendencies

while, at the same time, he becomes more cunning and subtle (so as to avoid detection) (Delaney, jurisprudence experience, 1972).

Conviction will ultimately lead to parole. Probation surveillance is usually punitive and repressive. Very seldom is therapy or counseling provided to decrease the hostility or rage level or to increase the ability to cope with the child or with stress. The perpetrator will return to the same situation that caused the abuse in the first place. (Walter's opinion, 1978). It appears to this writer that court intervention can cause as many problems as the original family dysfunction that the system set out to alleviate. The chief value of the criminal process, as it stands today, is to satisfy the conscience of the community that the wrong done to a child has been avenged.

Child abuse, as far as this writer is concerned, needs to be viewed as a psycho-social problem of family dysfunction. As such, the police/court system should not be involved except in emergencies or when parents are resistant to intervention. Early police involvement can jeopardize therapy (Walter's opinion, 1978).

Adequate treatment of child abuse and neglect requires a close working relationship between the law and the social sciences. The legal protection of the child should be foremost, but not to the exclusion of help for the abuser or the family.

Delaney (1976) feels that the court should also have the responsibility of helping to define the community needs as well as to mandate laws to fill them. It should act as a buffer between the individual and the state and must protect the parent's rights as well

as the childrens'. Cooperation and understanding between the two systems, legal and psycho-social, will result in the best of both, family rehabilitation and child protection without sacrificing human rights and dignity.

10 SUMMARY AND CONCLUSIONS

Child Abuse and Neglect, the conscious or unconscious disregard for the physical and emotional well-being and rights of a child, has been around for a long time. Unless society's attitudes towards children and violence change, it will continue to be a problem for many more years to come.

There is no "typical" child abuser and there is no "typical" child who is abused. Abuse is a symptom of a family dysfunction which has been handed down from one generation to the next. The perpetrator in the majority of abuse/neglect cases is either the natural father or mother. Child abuse/neglect transcends cultural, economic and international lines. It is not known if the preponderance of abuse/neglect in the lower socio-economic group is due to a true incidence or due to sampling and reporting bias.

The reasons for abuse/neglect are many and complex. The three most important variables seem to be the potential for abuse, the presence of a child, and some type of precipitating factor, or crisis.

The potential for abuse is determined by a person's psychosocial history. This history differs from a non abusers. Only a small minority of child abusers/neglectors have an accompanying psychological disorder such as schizophrenia or depression. The most common factors appear to be social isolation, low self-esteem and a history of being abused as a child. Neglectful parents seem to suffer from a breakdown in the ability to mechanically care for the

child; abusers loose control during a punishment episode motivated by a desire to "teach a lesson" or to make the child behave.

Abused/neglected children can be different (e.g., mental retardation, hyperactivity, birth defects) or they can be perceived as different by their parents. Not enough is known about their role (active vs passive) in the dynamics of abuse nor about the short or long term effects of abuse/neglect on them. Some children continue to be abused when placed in foster homes. This has led researchers to question the role of the child in the dynamics of abuse/neglect. In almost all cases of abuse/neglect, the parent's are profoundly disappointed that the child is either not meeting the parental expectation of good behavior or the parental need for nurturance. The disturbed parent-child relationship is commonly referred to as a role reversal in which the child is expected to care for and nurture the adult.

Another school of thought theorized that it is a defect in the mother-child bonding process at birth that predisposes the potential for abuse/neglect. Unable to properly relate to the child, the mother cannot or will not care for the child. While lack of bonding does play an important part in abuse/neglect (especially neglect) it does not appear to be sufficient, by itself, to account for all instances of abuse/neglect.

Sexual abuse occurs primarily as incest. As such, it is also a symptom of a dysfunctional family. Just as physical abuse/neglect requires the implicit or explicit knowledge or consent of the non-abuser, incest usually involves a mother-father-daughter triad. The

abuse usually evolves over a period of time, with the father becoming more demanding as the relationship progresses. The daughter either feels powerless to stop or enjoys the relationship. The mother may prefer the incestuous activity over the threat of an extramarital affair, may be relieved that she no longer has to perform her "wifely duties" or may condone the acts due to guilt about her own promiscuous behavior. The father usually has low self-esteem in combination with a need to control the family. Dynamically, he very often perceives his daughter as a sister or girlfriend and himself as an adolescent.

The true incidence of incest is hampered by taboo's, social injunctions and mores, and a general reluctance to talk about the family involvement. These factors also hamper treatment. Many times the mother, when presented with unrefutable evidence, will continue to deny the incidents. Adverse psychological effects on the daughter seem to be more of a function of how the abuse is handled after the fact, than of the abuse itself. Incest occurring in pre-adolescent girls seems to be less damaging than incest which starts or continues into adolescence.

Once a medical examination substantiates the presence of abuse/neglect, both the alleged perpetrator and child must have either a psycho-social screening or complete assessment. This assessment should consist of a psychiatric diagnosis and an evaluation of the current life situation, potential for abuse, capacity to be a parent, and the motivation for treatment and change. Children, in addition to the psycho-social assessment, should have a developmental screening

or a complete assessment to ascertain the presence/absence of developmental delays, learning disabilities and other manifestations of the mistreatment.

The current practice of not requiring a formal assessment by a clinical psychologist or psychiatrist unless psychopathology, low intelligence or severe abuse is suspected, is questionable. Maybe, if all abusers were given formal assessments there would be less recidivism and treatment efficacy would improve.

The best way to handle the complexities of child abuse and neglect case management appears to be through a team management approach. All the agencies and involved personnel work together in a coordinated effort. This enables better, more efficient servicing of cases, provides support and help for the caseworkers, and hopefully avoids the problems of a child "falling through cracks" in the system. While the team approach works well for emergency care and short term case management and treatment, a need exists for some agency to be responsible for long term management and follow-up.

Foster care is a "necessary evil" in those cases where it is unwise to return the child to the natural home. To be effective in counteracting the affect of abuse/neglect, foster parents should be permitted to become the child's psychological parents. This does not happen in most of the cases. Foster parents need training and support in order to cope with the nurturance needs and behavioral problems of abused/neglected children. Ideally, temporary foster care should be for no longer than one year. In reality, these children are kept in the foster care system for much longer. Many

continue to suffer emotionally. In some instances, poorly run foster home systems create more psychological damage than the original abuse or neglect.

The overall objective of child abuse/neglect intervention and treatment is to "cure" a family dysfunction. A common operational goal is to have at least 75 - 80% of the children living safely with their natural parents within one year from the reported abuse. This is best accomplished by utilizing a number of treatment modalities.

Adult modalities include individual therapy, marital counseling, self-help groups, crisis intervention, group therapy, parent aides, and hot lines. Individual psychotherapy appears to be the least effective in changing poor parenting practices. Parent aides and hot lines should be used as adjuncts to more formal procedures.

Children can be treated for developmental delays and various psychological problems through the use of playschools, play therapy, or group therapy. Crisis nurseries, family therapy and family residential treatment are ways used to treat the entire family. These therapies can be supplemented by methods to teach good parenting and child development and through appropriate role modeling.

Treatment is contraindicated in only 10 - 20% of child abuse/neglect cases. Parents who are unwilling or unable to care for their children or to change bad parenting habits should have their parental rights terminated. It is in the best interests of these children to be permanently removed from their homes and, hopefully, adopted.

Working with abusers/neglectors requires special therapists skills. Of greatest importance, the therapist must be able to empathize with people who hurt small children, to be nonjudgemental, and to have either worked through or at least be aware of feelings of anger or resentment towards the perpetrators. When dealing with married couples, it is as important to treat the non perpetrator as it is the perpetrator.

In order for child abuse and neglect to be eradicated, an effort must be made to establish methods of identifying parents-at-risk before there is a child-at-risk. To date, no valid or reliable screening devices have been developed. Even if such tools existed, a great many ethical questions such as a parent's right to privacy vs a child's right to be protected, would have to be resolved.

Education appears to be a partial solution to the prevention problem. It might be possible to forestall the misperceptions and unrealistic expectations that abusive/neglectful parents have of their children if teenagers, new parents and parents-to-be could be taught child development and proper parenting methods. Coping skills education might help reduce the tension associated with a crisis before it reaches the "blow up" level.

Outreach programs could be designed to spot dysfunctional parent-child relationship problems before they get out of hand. None of these programs have been used enough or tested enough to comment on their efficacy in preventing abuse/neglect.

Child abuse and neglect research is complicated by the need to use the more biased kinds of research methods such as case history

reviews and observations. More research is needed, (to name of few) in the areas of prediction and prevention, parent-child interaction, effects of abuse/neglect on the child, and the role of the child in the dynamics of abuse/neglect.

Legally, child abuse/neglect is a criminal offense punishable by incarceration. While this may satisfy societies' collective conscience that a wrong has been righted, it does nothing to solve the original problem of a dysfunctional family system. Once the perpetrator serves the sentence, they usually return to the same conditions that caused the problem.

The majority of child abuse and neglect incidents can and should be treated without police/court involvement. The court system should be utilized in only those cases where an adult is deemed untreatable. In those instances, it may be necessary to remove the perpetrator from society either by incarceration or by placement in a mental institution, whichever is more appropriate. It is the responsibility of the juvenile or family court system to protect the child and whenever necessary, to petition for termination of parental rights.

Child abuse and neglect is a formidable problem - it is difficult to handle, emotionally; it is difficult to treat; and it is difficult to eradicate. It maims and kills thousands of children a year; thousands more are subjected to crippling emotional abuse that distorts their personality, their ability to function normally, and their chance to lead a satisfying life. It is a shameful waste of human potential. Unless society joins forces to change the

dysfunctional psycho-social family system that causes abuse and neglect, children will continue to suffer for years to come.

Epilogue

...
 I've heard there are children who NEVER are bad!
 Who never act sullen or snippy or sad;
 Who always say "Thank you." and sit up real straight,
 And never are lazy and never are late;
 Who never would dream to be sassy or bold,
 And go to bed early, and do as they're told;
 Who won't touch a thing if they're told "Don't you touch!"
 Do I like that kind of children?

Not much!

For it isn't normal to always be good-
 I don't think you'd want to, and don't think you SHOULD;
 Just as food tastes better with a shake of salt,
 A small bit of mischief is hardly a fault.
 And life would be boring, and life would be grim,
 If children were all goody-goody and prim,
 For children will tickle, and poke, and wiggle,
 And just when they're not supposed to, they'll giggle;
 And they are inclined to make too much noise
 (This is true of the girls--but, goodness! The boys!)*

*Taken from: Preface to Beastly Boys and Ghastly Girls,
 William Cole, Philomel Books: New York, (1964).

APPENDIX A

Outline of Walter's Typology

<u>Type of Abuse</u>	<u>Causes</u>	<u>Therapy</u>	<u>Therapy Goals and/or Problems</u>	<u>Prognosis</u>
I. Socially, Parently Incompetent	Learned, due to own faulty up bringing.	Group	Deal with feelings that changing behavior is a rejection of their own parents. Minimize family and neighborhood pressures which perpetuate harsh punitive treatment.	Excellent
II. Frustrated, Displaced Abuser	Projection of feelings onto children as a defense mechanism.	Group	Develop other ways of coping with feelings; Identify and recognize the sequence of behaviors which lead to the abuse. Tendency to view others as "objects" rather than human beings; Increased use of denial as a defense mechanism or the appearance of inversion (turning within or withdrawal).	Good
III. Situational Abuse	Overwhelmed by, and see no immediate or long term relief for problems.	Individual	Identify factors which cause pressure in order to reduce them, set up system of priorities.	Excellent

IV. Neglectful Abuser	Passive aggressive behavior.	No specific types recommended due to personality characteristics.	Develop a network of support to protect children; when all else fails, placement.	Poor
V.a. Accidental Abuse	Discipline which is carried "too far"	No specific recommendations.	Assist abuser to living with consequences of the behavior.	Excellent
b. Unknown Abuser	Poor parental judgement.	No specific recommendations.	Protect child.	Guarded to Poor
VI. Victim Precipitated Abuse	Child learned to precipitate violence.	Group therapy; behavior modification.	Lack of generalization of knowledge.	Good to Fair
VII. Subcultural Abuse	A. Belief that violence is a good, desirable trait	Explore the high value usually placed on children in these cultures.	Parents reward desirable behavior/ignore behaviors which induce violence.	Poor
			Problem of "mixed" verbal and nonverbal signals by parents which confuse child.	
			Get parents to exempt the child from the violence.	
			Values and life style are reinforced by culture in which they live.	

VIII. Mentally ill Abusers	B. Religious	Inlist aid of minister, if possible.	"Going against God" if change treatment of children.	Poor to None
	Symptom of Mental illness.	Treatment by a qualified mental health practitioner.	Improve mental stability in order to protect child.	Very poor to very good depending on length of illness and individual diagnosis.
IX. Institutionally Prescribed Abuse	Approved of and established policies for abuse, i.e., corporal punishment in schools, jails, mental institution.	None	Expose practice; change rules; better licensing protection and supervision.	Fair to Excellent
X. Self Identified Abuser	Recognize their own problems and are disturbed by own or child's behavior.	Group or Individual	Improve parenting skills.	Excellent
			Not enough professional help available. Stigma associated with abuse prevents parents coming forward.	

APPENDIX B

Sample questions used to assess the potential for abuse (Schneider, Pollack & Helfer, 1972, pp. 58-59):

I. How the parents themselves were reared:

1. How did your parents punish you when you misbehaved or displeased them as a child?
2. Do you feel the way your parents punished you is the best way to get children to behave?
3. Did you feel your parents were pleased with you?
4. Do you feel you've let your parents down?
5. What kind of things did you try to do to please your parents?
6. What kind of relationship did you have with your mother when you were younger?
7. How would you describe your relationship with your mother now?

II. The Pattern of Isolation:

1. What kind of things make you feel really nervous and upset?
2. Are you having any problems with your child's behavior? (If yes, what kind of things have you tried to solve these problems? How have these worked?)
3. How do you feel inside when the baby cries?
4. Does it make you feel like crying yourself?
5. How do you handle the problem of a baby messing when he eats?
6. What is a good method of toilet training a child?
7. How do you handle accidents when they happen to your child?
8. Do you ever feel "at the end of your rope" or helpless

to deal with problems like crying, disobedience or misbehavior?

9. Whom do you have to turn to at such times?
10. How do you reach this person(s) at 10 P.M. on Saturday night?
11. Who has been helpful?
12. Do you use a babysitter? How often? Who?
13. What do you do when you have concerns about your children?

III. The Interrelationship between the parents:

1. Can you rely on your spouse?
2. What happens when you and your husband (wife) disagree on how to handle the children?
3. Does your husband (wife) recognize when you are "up tight"?
4. Is he (she) helpful at these times?
5. To whom do you turn in times like this?
6. Is your spouse helpful with the children?
7. What is there about your marriage that could be better?

IV. How the parents see the child:

1. When should parents start toilet training a child?
At what age should the child be fully trained?
2. How well do your children understand your feelings?
3. How have your children been of help to you?
4. Can they tell you're upset and do they help you then?
5. Do any of your children seem to have problems being warm and loving enough?
6. Do all your children live up to your expectations?
7. When you're upset do you expect your children to comfort you?

APPENDIX C

Psychological assessment of the child (Martin, 1979, pp. 47-48):

1. How does this child's behavior fit the normal milestones of psycho-social development?
2. How far away does the child seem from the normal sequence of such behaviors?
3. How does the child fit into a conceptual framework of psychological development?
 - a. Is the adolescent dealing appropriately with his/her development of identity and autonomy?
 - b. Is the latency aged child coping with academics and peer relations?
 - c. Is the preschooler capable of autonomy and initiative?
4. What are the prominent or significant affects of the child?
 - a. Under what conditions is the child sad, happy, frustrated, afraid, and how does the child deal with those feelings?
 - b. How does his/her affective state interfere with learning, socialization, and maturation?
5. Does the child have unusual symptoms or behaviors?
6. What is the nature of the child's interactions with others, especially with peers?
7. What is the play of the child like, and is it what would be expected at his/her chronological or developmental age?
8. How does the child respond to stress? (Underreaction is as significant as overreaction to stress).

APPENDIX D

PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT*

<u>Type of CA/N</u>	<u>Physical Indicators</u>	<u>Behavioral Indicators</u>
Physical Abuse	<p>Unexplained bruises and welts:</p> <ul style="list-style-type: none"> -on face, lips, mouth -on torso, back, buttocks, thighs -in various stages of healing -clustered, forming regular patterns -reflecting shape of article used -on several different surface areas -regularly appearing after absence, week-end or vacation <p>Unexplained burns:</p> <ul style="list-style-type: none"> -cigar, cigarette burns, especially on soles, palms, back or buttocks -immersion burns -patterned like electric burner, iron, etc. -rope burns on arms, legs neck or torso <p>Unexplained lacerations or abrasions:</p> <ul style="list-style-type: none"> -to mouth, lips, gums, eyes -to external genitalia <p>Unexplained fractures:</p> <ul style="list-style-type: none"> -to skull, nose, facial structure -in various stages of healing -multiple or spiral fractures 	<p>Wary of adult contacts</p> <p>Apprehensive when other children cry</p> <p>Behavioral extremes:</p> <ul style="list-style-type: none"> -aggressiveness -withdrawal <p>Frightened of parents</p> <p>Afraid to go home</p> <p>Reports injury by parents</p>

Physical Neglect	Consistent hunger, poor hygiene, inappropriate dress	Begging, Stealing food Extended stays at school
	Constant lack of supervision, especially in dangerous activities or long periods	Constant fatigue, listlessness or falling asleep in class
	Unattended physical problems or medical needs	Alcohol or drug abuse Delinquency
	Abandonment	States there is no caretaker
Sexual Abuse	Difficulty in walking or sitting	Unwilling to change for gym or participate in physical education class
	Torn, stained or bloody underclothing	Withdrawal, fantasy or infantile behavior
	Pain or itching in genital area	Bizzare, sophisticated, or unusual sexual behavior or knowledge
	Bruises or bleeding in external genitalia, vaginal or anal areas	Poor peer relationships
	Venereal disease, especially in pre-teens	Delinquency or running away from home
	Pregnancy	Reports sexual assault by caretaker
Emotional Maltreatment	Speech Disorders	Habit disorders
	Lags in physical development	Conduct disorders
	Failure to thrive	Neurotic traits
		Psychoneurotic reactions
		Behavior extremes, suicide
		Overly adaptive behavior
		Developmental lags

*Adapted from: Lauer, Lourie, Salus and Broadhurst (1979).

APPENDIX E
INDICATORS OF EMOTIONAL ABUSE*

<u>Parent Behavior</u>	<u>Child Behavior</u>	
Failure to provide:	Too little may result in:	Too much may result in:
Love	Psycho-social dwarfism, poor self esteem, self-destructive behavior, apathy, depression, withdrawal	Passive sheltered, naive, "over self-esteem"
Stimulation	Academic failure, pseudomental retardation, developmental delays, withdrawal	Hyperactivity
Individuation	Symbiotic, stranger and separation anxiety	Pseudo-maturity
Stability/permanence/continuity of care	Lack of integrative ability, disorganization, lack of trust	Rigid-compulsive
Opportunities and rewards for learning and mastering	Feelings of inadequacy, passive-dependent, poor self-esteem	Pseudo-maturity, role reversal
Adequate standard of reality	Autistic, delusional, excessive fantasy	Lack of fantasy, play
Limits, guidance, consequences for behavior	Tantrums, impulsivity, testing behavior defiance, antisocial behavior, conduct disorders	Fearful, hyperalert, passive, lack of creativity and exploration
Control for/of aggression	Impulsivity, inappropriate aggressive behavior, defiance, sado-masochistic behavior	Passive-aggressive, lack of awareness of anger in self/others

Opportunity for extra-familial experience	Interpersonal difficulty, developmental lags, stranger anxiety	Lack of familial attachment, excessive peer dependence
Appropriate behavior model	Poor peer relations, deviant behavior	Stereotyping, rigidity, lack of creativity
Sexual identity model	Gender confusion, poor peer relations, poor self-esteem	Rigid, Stereotyping
Sense of provision of security/safety	Night terrors, anxiety, excessive fears	Oblivious to hazards and risks, naive

*Adapted from Lauer, Lourie, Salus and Broadhurst (1979).

APPENDIX F

Some Child Abuse and Neglect Organizations

National Center on Child Abuse and Neglect
Children's Bureau
Office of Child Development
Office of Human Development
Department of Health, Education and Welfare
P.O. Box 1182
Washington, D.C. 20013

(Focal point for the development of plans, policies and programs related to child abuse/neglect.)

American Humane Association
Children's Division
P.O. Box 1266
Denver, Colorado 80210

(An information service center for child welfare organizations.)

Child Welfare League of America
67 Irving Place
New York, New York 10003

(A national voluntary organization devoted to improving services for children and their families.)

National Alliance for the Prevention and Treatment of Child Abuse
and Maltreatment
41-17 169th Street
Flushing, New York 11258

(An organization of leading professionals in the field of child abuse and neglect in the United States.)

National Committee for the Prevention of Child Abuse and Neglect
111 East Wacker Drive
Suite 510
Chicago, Illinois 60601

(A private nonprofit organization dedicated to stimulating citizens interest and involvement in prevention programs.)

National Center for the Prevention and Treatment of
Child Abuse
University of Colorado Medical Center
1001 Jasmine Street
Denver, Colorado 80220

(A treatment, research and training center.)

Parents Anonymous
2810 Artesia Boulevard
Redondo Beach, California 90278

(A national self-help group for abusive/neglectful
parents.)

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