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The Abused Child: Problems and Proposals

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Comment

The Abused Child: Problems and Proposals

Introduction

In 1962 a team of physicians led by Dr. C. Henry Kempe identified a problem they called "the battered child syndrome." The Kempe study defined the problem as a clinical condition in young children who have received serious physical abuse from a parent or foster parent.[1] Graham Parker, a student of the syndrome, defined the battered child as "one who has suffered serious physical injury in circumstances which indicate it was caused wilfully rather than by accident."[2] Later students have distinguished the battered or abused child from the neglected child and have begun to inquire into the psychological condition of the abusing adult as well as the psychological impact of abuse on the child.

The abused child syndrome is now seen as the totality of intentional or unintentional physical and mental abuse a child suffers at the hands of a psychologically disturbed parent or guardian.

Scope of the Problem

Nationwide surveys show that an estimated 200,000 to 250,000 children receive treatment for child abuse annually In addition, many cases are not reported because of the lack of a standard definition of child abuse. In some instances a child receives medical attention but the injury is not attributed to an abusing parent. Even where treatment is administered and child abuse is suspected, few reports are made. Finally many cases never receive medical attention.

The Kempe study indicated that among the 71 hospitals replying, 302 cases were reported; 33 of the children died; and 85 suffered permanent brain injury In one-third of the cases, proper medical

1. H. Kempe, *et al.*, *The Battered-Child Syndrome*, 181 J.A.M.A. 17.
2. G. Parker, *The Battered-Child Syndrome*, 5 Medicine, Science and the Law 160.

diagnosis was followed by legal action. Seventy-seven District Attorneys surveyed reported having knowledge of 447 cases in a one year period. Of these children, 45 died and 290 suffered permanent brain damage; court action resulted in 46 per cent of the cases. In Kempe's experience at Children's Hospital in Denver, on a single day in November, 1961, the Pediatric Service was caring for four infants suffering from parent-inflicted child abuse. Two of the four died of central nervous system trauma, one died in an unexplained manner four weeks after discharge from the hospital while under the care of its parents, the fourth was still in good health.[3]

Chesser reports that 7 per cent of all children are abused, neglected, ill-treated or become so maladjusted as to require help from the National Society for Prevention of Cruelty to Children.[4] He indicates that a 1964 California study showed 20,000 children in need of protective services. The American Public Welfare Association reports 100 cases of child abuse monthly in Denver, Colorado.

A 1965-1966 report published in the Journal of the American Dental Association studied 476 cases of child abuse. Twenty-five of the children were dead on arrival and 23 died within 12 days of hospitalization. The majority were under two years of age, and more than half of these were under age one. Beatings, fractures, malnutrition, burns, or combinations of these were involved in 83.8 per cent of the cases. One-fifth of the cases involved families with one child. Forty per cent of the parents admitted violence while 36 per cent denied any involvement in the injury. October and November were peak months, indicating that abuse occurs as holiday periods draw near. There were also indications that abuse occurs on particular days.[5]

Law enforcement agencies investigated cases involving 212 children. Ninety-six investigations led to criminal prosecution. Of these six were dismissed, seven were found guilty and given probationary sentences, 13 were jailed and fined. One hundred and two children were placed in foster homes with voluntary parental consent.

Fontana has stated that if complete statistics were available, the

3. H. Kempe, *supra* note 1, at 17.
4. E. CHESSER, CRUELTY TO CHILDREN (1952).
5. *Legislation and Litigation*, 75 J.A.M.A. 1087.

battered child syndrome could be the most common cause of death in children.[6]

General Characteristics

Although child abuse can occur to children at any age, in most instances the victim is less than three years old. In about half of these cases, the child is under the age of one year. Thus, in a majority of the cases the child is too young to appreciate the seriousness of the physical acts against him and has no way of understanding the psychological problems involved. The child cannot obtain medical or legal help in his own behalf, and in some extreme cases, he is unwilling to incriminate his abuser.

A recent survey conducted at Children's Hospital, Pittsburgh[7] shows a specific correlation between socio-economic variables and incidence of child abuse. The study group was composed of abused children from 20 families living in urban Pittsburgh or small neighboring communities; their economic status was low, their stated religion was Protestant; 13 were Caucasian and seven were Negro. Ten were male and ten were female. All but one were between the ages of three and 39 months. The children were separated into two groups, based on their medical histories.

The first group was composed of 11 children who had been healthy at birth, of normal weight and without a history of serious illness. Only two showed signs of growth failure. The second group consisted of nine children with significant medical histories in early life. Six were chronically underweight. Of these, four were premature infants who had done well, but two had been ill during the neonatal period. The other three in the second group were normal according to birth weight but each had a subsequent history of serious disease. These nine children might have been predisposed to failure to thrive; all showed signs of severe growth failure when hospitalized.

At the time of the study, four of the eleven in the first group scored

6. V. Fontana, D. Donovan, and R. Wong, *The Maltreatment Syndrome in Children*, 269 New England Journal of Medicine 1389.
7. E. Elmer and G. Gregg, *Developmental Characteristics of Abused Children*, 40 Pediatrics 596.

below 80 on intelligence tests and were classified as mentally retarded.[8] Three children were emotionally disturbed; over half had speech problems.

Of the second group, mental retardation characterized six of the nine when the study began. Emotional disturbances and speech problems occurred frequently. Of the six premature births in this group, three were well below normal height and weight while two others were greatly obese. The remaining members of this group were of normal height and weight. Seven of the 20 children studied had serious physical defects which were related to injuries resulting from parental abuse.

The seven Negro children studied showed less growth retardation and emotional disturbance than their Caucasian counterparts. None of the Negro children had physical defects related to trauma. The proportion of speech problems and mental retardation was about the same, regardless of race. This particular study suggests that prolonged neglect more frequently acompanies the abuse of Caucasian children and that Negro children receive better daily care, a conclusion supported by the fact that upon re-evaluation only two children were normal, both Negro.

At the time of this re-evaluation half of the children studied were living in substitute homes or institutions. Those among them who had exhibited growth failure at the time of hospital treatment had fully recovered physically and were within the normal range of intelligence. In contrast, of the ten still living in their original homes, six remained below normal physical growth standards and only three had normal I. Q. scores.

Investigations show that the abused child comes from a troubled home, with chronic problems of unemployment, inferior housing,

8. *Id.* at 596. The distribution of I.Q. scores of the 20 abused children evaluated by the authors was as follows:

I.Q. Range	Number of Children
50-60	2
60-70	2
70-80	6
80-90	3
90-100	5
100-110	2

food, and clothing. Mental and physical ill health often exist in both the parent and the child. There may be a history of marital discord, criminal behavior, or excessive drinking or drug abuse by one or both parents. It is clear that the battering of a child is but one symptom of a more serious problem.

A British study of the battered child syndrome which correlates socio-economic variables with parental involvement notes that, with few exceptions, none of the parents of battered children has been occupied in any work which required mental ability.[9] The majority of the parents involved in this study were of below average intelligence, the mothers being especially low.[10]

Although this British study implies that child abuse is more prevalent in families having low socio-economic backgrounds, an Ameri-

9. J. Cameron, H. Johnson, and F. Camps, *The Battered Child Syndrome*, 6 MEDICINE, SCIENCE AND THE LAW 16. The authors have tabulated the occupations of the parents of the children whom they have studied and find an absence of jobs requiring mental ability to be highly developed.

OCCUPATION OF PARENTS

Group	Male Occupation		No.	Female Occupation		No.
1	Labourer		5	Prostitute		4
2	Lorry-driver		3	Housewife—including occasional prostitution		18
3	Manual—skilled/simi-skilled		7	Manual—skilled/simi-skilled		4
	Plumber	2		Threadworker	1	
	Electrician	2		Dry-cleaning	1	
	Bricklayer	1		Shoe worker	1	
	Motor Mechanic	1		Garage hand	1	
	Tailor	1				
4	Confectioner	1		Waitress	1	
	Barman	1	2	Barmaid	1	2
5	Services		3	S.R.N.		1
6	Student		2	—		—
7	Unemployed		5	—		—
8	Unknown father		2	—		—
	Total		29			29

10. *Id.* at 16. The authors' analysis of the intelligence of parents of battered children reveal a strong tendency toward below normal intelligence.

	Average	Low Average	Low	Very Low	Total
Fathers	8(30%)	8(30%)	6(22%)	5(18%)	27
Mothers	2(7%)	8(30%)	9(31%)	10(34%)	29
Totals	10	16	15	15	56

can study reports a few cases of child abuse among high income families.[11] In the American study 19 abused children had parents or guardians with annual income of over $7000.00 per year, 121 (42.3 per cent) of the families had income ranging from $4-7000.00, and 146 (51.1 per cent) of the families earned less than $4000.00 annually.

Clinical Manifestations

A dead 13 month old child was brought into the emergency room of a hospital by his parents. There was a large bruise on his head and his pupils were fixed. The father said that the child fell off the couch several hours earlier but he had been unable to get transportation to the hospital. The examining physician noticed several bruises of varying sizes and teeth marks on the child's buttocks. The parent denied violence but the doctor had the case investigated. The child had been born four months after his parents' marriage. The father admitted that he beat the child because he cried and that he had thrown the child against the wall.

This case is typical of the child abuse syndrome; physical abuse, however, may take many other forms, such as beatings, burnings, scaldings, biting, and intentional fractures of the fingers or arms. What appears to be an unrelated clinical condition may, following investigation, be determined as a case of child abuse. There are numerous reports of homicide which are attributed to the battered child syndrome.

Frequently the parents cannot satisfactorily explain the child's injuries; such unsatisfactory explanations should alert the physician to the possibility of child abuse. Abusive injuries often include the following: abrasions, contusions, warm or swollen areas, tender or painful extremities, decreased voluntary movement, limping or failure to bear weight. There may also be evidence of trauma: hematuria, shock, vomiting, ataxia, impaired vision, ruptured viscera, subdural hematoma, retinal hemorrhage or detached retina. There may also be evidence of previous trauma: burns, scars, or deformities.

With a clear history of injury, the doctor will immediately attribute

11. *Legislation and Litigation, supra* note 5, at 1087.

the signs of trauma to injury. But these same signs without a history of injury raise the possibility that non-traumatic disease is their cause. Scurvy, syphilis and tuberculosis of the bones, for example, may produce characteristics of child abuse, but generally are accompanied by distinguishing symptoms. As the use of reasonable force in punishing a child may produce unintentional secondary injuries which are serious and sometimes fatal, there is great danger of making an incorrect diagnosis of child abuse. This is especially so as the clinical manifestations of the battered child syndrome may vary from very mild trauma to cases of the most florid evidence of injury to the soft tissues and skeleton.

Psychiatric Manifestations

The Kempe study classifies the psychiatric condition of the child abusor according to the degree of physical harm he inflicts.[12] It is an extreme condition when homicide is committed by a psychotic parent or close relative. The other extreme is the case in which no physical harm occurs, but one parent, usually the mother, comes to the psychiatrist filled with anxiety and guilt related to fantasies of hurting the child. Between these two fall the large number of cases of children suffering from injuries which do not cause death.

The abusor in most cases is of low intelligence; in roughly half of the families investigated premarital conception had occurred.[13] The parents of abused children were often found to be impulsive, immature, self-centered, hypersensitive and quick to react with poorly controlled aggression. The data suggest that child abuse is the product of defects in character structure which allow aggressive impulses to be expressed too freely. Such character defects are frequent among parents who were themselves abused during childhood. This it has been suggested, is due to an identification with the aggressive parent despite strong individual desires to be different. This identification may also explain why patterns of child rearing, both good and bad, are passed from one generation to the next.[14]

Merrill recognized distinct clusters of personality characteristics

12. H. Kempe, *supra* note 1, at 18.
13. J. Cameron, *et al.*, *supra* note 9, at 17.
14. H. Kempe, *supra* note 1, at 18.

among abusing parents in his study.[15] The first group of parents demonstrated hostility and aggressiveness with an appearance of continual anger. A second group of personalities were rigid, compulsive, and lacked warmth. These persons demonstrated marked attitudes of child rejection, evidenced by a primary concern for their own pleasure and inability to feel love and protectiveness toward their children. The third group exhibited strong feelings of passivity and dependency and competed with their children for the love and attention of their spouses.

Merrill also noted a group of abusing fathers who were physically disabled and unable to support their families. In those cases the burden of economic support fell on the mother, while the father stayed at home acting as the mother figure.[16]

Morris and Gould indicate that the abusing parent is involved in role reversal.[17] They noted that to the current parent the child appears as the original parent in all that parent's malign, primitive meaning. From birth, babies were perceived by their parents as having adult powers for deliberately displeasing or judging, and appeared to be as unsatisfying and insatiable to the current parent as their own parents had been. The natural dependency of babies reinforced the projected image of the original parents who demanded, could not satisfy, and did not satisfy, the current parent.

The Morris investigation also revealed marked differences between the attitudes of protective parents and those of parents who abuse their children.[18] Often one parent is the active batterer while the other

15. L. Silver, *Child Abuse Syndrome: A Review*, 96 MEDICAL TIMES 803 at 812.
16. *Id.*
17. *Id.*
18. *Id.* Morris and Gould have contrasted the attitudes of protective parents with those of parents who have abused their children.

REACTIONS AND ATTITUDES OF PROTECTIVE PARENTS COMPARED TO TYPICAL REACTIONS AND ATTITUDES OF NEGLECTING, ABUSIVE PARENTS

Protective	Abusive
1. Voluble, spontaneous reporting of details.	1a. Do not volunteer information. b. Are evasive and contradictory in details. c. Appear irritated at being questioned.
2. Concerned with child's injury.	2. Critical of child; angry with him for being injured.
3. Concerned about treatment.	3. Not concerned.

parent passively accepts the action because the abusing of the child diverts a conflict in which the passive parent does not wish to become involved, or because the parent feels too weak and inadequate to interfere. Parents are found to account for 72 per cent of all child abuse injuries. Three of every four children who die from child abuse are victims of one or both parents.[19] Studies show that fathers injure more boys and mothers injure more girls. Injuries inflicted by the mother are often more serious and involve more fatalities.[20]

In Milowe's words, the parent's childhood loads the gun; present life conflicts cause the parent to raise the gun; and the child's "phase-specific needs" help pull the trigger.[21] The child becomes a symbol to the adult and it is against this symbol that the parent's anger explodes.

Milowe and Lourie feel the child is a precipitating factor, especially when possessing defects which lead to a lack of responsiveness or other

4. Concerned about residual damage.	4. ———
5. Exhibit sense of guilt, even when faultless.	5. No indication of guilt feelings or remorse.
6. Question prognosis of child's condition.	6. No concern.
7. Difficult to detach from child who is admitted.	7. Seldom touch or look at child.
8. Attempt restitution by visits, toys.	8. No visits. Not concerned about care.
9. Inquire about discharge.	9. No concern.
10. Inquire about follow-up treatment.	10. No concern.
11. Identify with child's feelings, physically and emotionally.	11. No response to child, or inappropriate response; no indication of perception of child's feelings—physical or emotional.
12. Positively relate to child.	12. ———
	13. Act as though child's injuries are an assault upon themselves.
	14. Consistently criticize child's actions.

19. *Id.* at 810.
20. J. Cameron, *et al.*, *supra* note 9, at 19.

RELATIONSHIP BETWEEN SEX OF CHILD AND SEX OF ASSAULTING PARENT

Child	Mother	Accused Father	Both	No Action
Male	3	6	2	6
Female	4	3	2	3
Total	7	9	4	9

21. Silver, *supra* note 15, at 809.

irritating reactions, creating frustration in the parents. Moreover, the study goes on to indicate that factors in the child's personality development may lead him to invite others to hurt him, or to hurt himself—"a hurt and be hurt relationship pattern."

Morris found typical forms of behavior of well nurtured children in a hospital differed from forms of behavior in abused children in similar circumstances.[22] The differences offer some support to the theory that the child's development leads him to invite hurt.

Aside from the psychological problems of the parent and child, attitudes typical of physicians hinder efforts to deal with the problem of child abuse. Kempe reveals two typical mistakes made by examining physicians who treat injured children. First, they doubt that a parent could have attacked the child, and second, they fail to properly question the parents on this subject.[23] Kempe noted in his 1966 report that 20 per cent of the physicians surveyed reported that they *rarely* or *never* considered child abuse when examining an injured child, one in six physicians *mistakenly had not* considered child abuse, 50 per cent did not know the procedure to be followed in their own community if child abuse was suspected, one-third did not know what follow up procedures were to be used, and 25 per cent stated that they *would not* report a suspected case of child abuse, even with legal protection. The

22. *Id.* at 813.

Typical Behavior of Well Nurtured Child	Typical Behavior of Abused—Neglected Child
1. Cling to parents.	1. Wary of physical contact with parents or others.
2. Turn to parents for assurance.	2. Do not turn to parents for assurance.
3. Turn to parent for comfort during and after examination.	3. No expectation of being comforted; cry hopelessly during treatment and examination.
4. Demonstrates desire for parents and home.	4. No similar expression or desire.
5. Seek safety and reassured by parent's visit.	5. Do not seek safety from parent but from sizing up situation.
6. ————	6. Cry very little.
7. ————	7. Apprehensive when other children cry; watch them curiously.
8. ————	8. Apprehensive when others approach with crying children.
9. ————	9. Constantly alert for danger.
10. ————	10. Inquisitive about chain of events.

23. H. Kempe, *supra* note 1, at 20 and 21.

latter group was concerned that their evidence would not hold up in court or that reporting a suspected case would have an adverse affect on their practice.

The survey suggested many physicians have difficulty admitting the existence of the child abuse syndrome and hesitate to follow through in cases of suspected child abuse. The lack of cooperation suggests frustration or bad experiences were encountered when the physician did report a suspected case to the proper agency. Thus the "malpractice syndrome" compounds an already complicated problem.

Existing Legislative Solution

Reporting Statutes

The first legislative action taken to remedy the problem of child abuse was in the form of a mandatory Reporting Statute. In 1966, 49 states had enacted such legislation.[24] Following a 1963 recommendation

24.

Battered Child Reporting Laws*

	Date	Mandatory	Permissive	Immunity from Suit	Reports to:	Reports by:	Physician-Patient privilege not a bar to testimony
Alabama	1965	x		x	2, 5	1, 2, 3, 4, 6, 7	x
Alaska	1965		x	x	1, 2	1, 2, 3, 4	x
Arizona	1964	x		x	2, 4	1	x
Arkansas	1965	x		x	2, 4	1, 2, 3, 6	x
California	1963	x			2, 5	1	
Colorado	1963	x		x	2, 4	1	x
Connecticut ...	1965	x		x	1, 2	1	
Delaware	1965	x		x	3, 4	1	x
Florida	1963	x		x	3, 4	1	x
Georgia	1965	x		x	2, 4, 5	1, 2, 3	
Hawaii	Legislation pending.						
Idaho	1965	x		x	1	1	
Illinois	1965	x		x	2, 5	1, 8, 10, 11	x
Indiana	1965	x		x	1, 2, 4	1, 5, 6	x
Iowa	1965	x		x	1, 2, 4	1, 8, 11, 2	x
Kansas	1965	x		x	3, 4	1, 3	x
Kentucky	1965	x		x	1, 2, 4	1, 7	x
Louisiana	1964	x		x	2, 4	1	x
Maine	1965	x		x	1, 2, 4	1	
Maryland	1964	x		x	2	1	
Massachusetts ..	1964	x		x		1	
Michigan	1964	x		x	1, 2, 4	1	x

of the Children's Bureau of the Department of Health, Education and Welfare, all statutes contain five basic features: 1) Reporting by physician or institution of any case in which there is reasonable cause to

BATTERED CHILD REPORTING LAWS*

	Date	Mandatory	Permissive	Immunity from Suit	Reports to:	Reports by:	Physician-Patient privilege not a bar to testimony
Minnesota	1965	x			2	1, 2, 6	
Mississippi	1966			x		1, 2, 8	
Missouri	1965		x	x	2, 4	1	x
Montana	1965	x		x	2, 4	1, 2, 3, 4	x
Nebraska	1965	x		x	2	7	
Nevada	1965	x		x	2, 4	1, 8, 2, 3, 4, 12, 13	x
New Hampshire	1965	x		x	4, 5	1	x
New Jersey	1964	x		x	2, 4	1	
New Mexico ..	1965		x	x	2, 4	1, 2, 3, 4, 13	x
New York	1964	x		x	5	1, 8	
North Carolina.	1965		x	x	1	1, 2, 3, 4	x
North Dakota..	1965	x		x	5	1, 2	x
Ohio	1963	x		x	2, 4	1	x
Oklahoma	1965	x		x	1, 2, 4	1, 8, 2	x
Oregon	1965	x			6	1, 2	
Pennsylvania ..	1963	x		x	2, 3	1	x
Rhode Island...	1964	x		x	1, 4	1	
South Carolina.	1965	x		x	2, 5	1	
South Dakota..	1964	x		x	3, 4	1, 8, 9	x
Tennessee	1965	x		x	5	7	
Texas	1965		x	x	2, 3	1	
Utah	1965	x		x	4	7	x
Vermont	1965	x		x	1, 4	1	
Virginia	1966	x		x	2, 3, 4	1, 2	x
Washington ...	1965		x	x	2, 4	1	x
West Virginia..	1965	x		x	2, 4	1, 2, 3, 4	
Wisconsin	1963-65	x			2	1	x
Wyoming	1963	x		x	1, 4	1, 2, 5, 6, 7	x
Dec. 1966.....	49						

EXPLANATION OF CHART ON BATTERED CHILD REPORTING LAWS

Column headed "Reports by"

1. Healing arts personnel (includes one or all of the following: physicians, surgeons, osteopaths, chiropractors, interns, residents, hospital administrators, clinics).
2. Nurses (registered, practical, public health).
3. Social workers.
4. Teachers, principals, etc.
5. Laboratory technicians.
6. Pharmacists.
7. Any person.
8. Dentists.
9. Law enforcement officers.
10. Christian Science practitioners.
11. Pediatricians.
12. Attorneys.
13. Clergymen.

suspect child abuse, 2) Procedures to be followed in making the report, 3) Immunity from liability of person filing the report, 4) Neither physician-patient privilege, nor husband-wife privilege can be a ground for excluding evidence if a court so chooses, and 5) Anyone not reporting a suspected case of child abuse is guilty of a misdemeanor.

From the outset, medical, legal, and social professions have been concerned with the effectiveness of the reporting statutes.

> Reporting of the abused child is not an end in itself; the ultimate aim is the protection of the child and of the other children in the family and the restoration of family adequacy, if this is possible. The question must be raised whether the law as proposed makes enough headway in these directions.[25]

The most serious drawback of the existing legislation is its concentration on the child seen by the physician and its failure to consider other children in the family.

A second disadvantage of the reporting statute is the increased hazard to the injured child. Parents who are aware of the statute are reluctant to bring in an injured child for treatment. In cases where criminal sanctions may be imposed, the child abusor is more reluctant to seek medical attention for an abused child. This also applies to well meaning parents who have injured a child through inadvertance. In addition, the unwillingness of a parent to seek medical attention compounds the problem of obtaining accurate statistics on the actual number of cases occurring each year.

Miller noted another danger to the abused child created by the passage of reporting legislation. He states:

> No matter how a parent is handled, he is likely to feel accused and affronted by being reported. If he is later exonerated and reunited

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Column headed "Reports to"

1. Department of Health, Social Welfare, Welfare, Health and Welfare, Public Health, etc.
2. Police and law enforcement officers (police, sheriff, states attorney, county attorney, etc.)
3. Family Court, Juvenile Court, County Court, etc.
4. Hospital or institution in which child is located.
5. Child Welfare Agency.
6. Coroner or Medical Examiner.

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25. J. Reinhart and E. Elmer, *The Abused Child*, 188 J.A.M.A. 110.

with the child, his pent up anger felt for the authorities may be released against the child, the person who has been the unwitting means of harassment for the adult.[26]

Premature criminal reporting of the parents may cause an additional hardship on them. In some instances where the injuries can be reasonably explained, the police harassment merely adds to the already burdened parent. Furthermore, an unnecessary encounter with authorities destroys any possibility of rehabilitating adults with potential for more adequate child rearing.

Alternatives to Reporting Statutes

Existing criminal laws may be used to punish those persons who inflict harm on a child. For example, general criminal laws defining murder, manslaughter, aggravated assault and battery and simple battery may be found in the Penal Code of any state. More recently, some states have enacted cruelty to children statutes which prescribe imprisonment or fines for anyone convicted of the misdemeanor. It must be noted, however, these laws recognize the parental privilege to discipline a child and permit the use of reasonable force to this end. The result is an indefinite standard of guilt, a major constitutional shortcoming of such legislation.

Only seven states require reports of child abuse be directed to the Juvenile Court System. For most Juvenile Courts, the power to act in cases of child abuse is limited to the "neglected" child. While this type of program provides relief for the undernourished or poorly cared for child, it provides little or no relief for the child who is intentionally abused, physically or psychologically.

The major problem with any juvenile court system rests on involving the court at the outset. The quality and quantity of evidence are first considered by the juvenile court prosecutor before any action is commenced. If the prosecutor feels the action is without merit, he simply does not prosecute, thus permitting the abusing parent to escape from rehabilitation. On the occasions when the Juvenile Court acts, its shortcomings become clear. The court may fail at the outset to form an adequate plan; for example, it may fail to plan for all the children in

26. *Id.*

the family, dealing only with the child who was reported as being abused. Other courts may attempt to do too much. Recently, in a family with three children, the youngest was retarded and subject to abuse. The court permanently removed all three from the family home without a complete investigation.

Child protection services are available in some instances. At the national level, the United States Children's Bureau has been established as a result of recognition of a duty to promote conditions which are conducive to wholesome development of the family and the child. However, more effective work is being done in communities which have established their own local procedures. One such program involves representatives who go to the family suspected of child abuse in an effort to evaluate the situation. The representative discusses the possibility of family difficulty and offers assistance to help alleviate the problem. This program emphasizes helping the family rather than penalizing the parent. If the child is in danger legal action is made available to remove him from the home. The delay in obtaining legal disposition is the major drawback of the plan as delay presents opportunity for further abuse. Another approach involves an investigation by the police department. While the primary interest is the evaluation of the situation and the protection of the child, the officer's appearance—uniform and badge—tends to make the parent defensive and results in his being less receptive to social service asistance at a later date. A third approach involves a combination of the first two. Representatives from social service and police go into the home together and each evaluates his particular area of concern.

Reporting statutes as well as all other alternatives discussed rely on implementation through the adversary system of justice. This system has done litle more than compound the problems of confusion and lack of direction already plaguing those who work with abused children and their families. An attorney who is representing the parents may ignore the interests of the abused child. The parents' attorney often chooses to overlook all evidence of abuse of the child. While he delays and appeals in his client's interests, the child remains in the hostile environment. The attorney may also be faced with a conflict of interest. If he knows of the child's injury but helps the parents to avoid incrimina-

tion and conviction, he unwittingly helps to perpetuate a situation dangerous to the child; if he reveals his knowledge of the parents' responsibility for the injury, he feels he is breaching his duty to his client.[27]

Another major objection to the adversary system in this setting is the prosecutor's one sided duty to bring to trial the abusing parent without any corresponding sense of obligation to keep the family intact and functioning. The prosecutor's only interest is whether or not the parents "did it on purpose" or whether he has sufficient evidence to "win." Moreover, prosecutors often are attentive only to those cases which cause visible external disfigurement. The decision to prosecute is often influenced by the amount of public attention a case receives. Premature "leaking the story" to the press may force the prosecutor's hand. Prosecution results in delay and wastes considerable time and effort which could have been used to treat the family unit. Prosecution can destroy the will to enter into a program of treatment and rehabilitation if the parent thinks he may end up in jail.

The results of prosecution and punishment without additional rehabilitation and treatment leave much to be desired. Inaction, although it may appear preferable to prosecution in some cases, does nothing to solve the problem in a particular family or in society itself.

Proposed Legislative Solutions

The present system of handling child abuse is completely inadequate and unsuccessful. In the legal field prosecutors appear to be unwilling to enforce the law as it stands, or at best, minimize the child abuse problem. The use of the juvenile court system today is ineffective. In the medical profession some doctors are unwilling even to report suspected child abuse while many psychiatrists refuse to assert the leadership necessary to overcome the problem.

All studies of child abuse lead to the conclusion that legislation is needed; as yet, little has been proposed. The legislative solution must begin with the care of the child. In order to provide an adequate program of medical care, examining physicians must be aware of the

27. This dilemma could be resolved by legislative modification of the attorney-client privilege.

clinical manifestations which characterize this problem. The second step in the program must be the rehabilitation of the injuror. Criminal prosecution is not the solution. All authorities indicate that child abuse is one symptom of a much more serious problem, the psychiatric dilemma of the parent. The model legislation which follows is by no means definitive; it is proposed as a first step toward overcoming the apathetic attitude which prevails among both the medical and legal professions. Discussion with members of the legal and medical communities have pointed to pragmatic difficulties in implementing this program. At the present time, the involuntary commitment procedure of the Pennsylvania Mental Health and Retardation Act of 1966 are under scrutiny as being violative of certain basic civil rights. Some psychiatrists express dissatisfaction with involuntary commitments for fear of personal liability in false imprisonment suits. Other psychiatrists feel that the time required to defend their actions in court outweighs possible benefits derived from forced treatment. In theory, the facilities and staff necessary to implement this program exist within the concept of the community mental health center; in reality, the "one center for every two hundred thousand people" concept has yet to materialize. Finally, the most serious difficulty to be overcome is financing. A program of the magnitude suggested would require millions of dollars. The question becomes whether or not the lives of children are worth the expense.

There have been enough studies—all leading to the same conclusion. But not enough serious thought has been given to the enactment of the necessary legislation. With that in mind, the following draft is submitted:

§ 1. *Title*: This enactment is entitled "The Child Abuse Prevention and Rehabilitation Act of 1969."

§ 2. *Statement of Policy and Purpose:*

This enactment specifically intends to aid medical doctors, psychiatrists, nurses and social workers in the conduct of their professional duties and services rendered to, or in connection with an abused child, as defined in this act. This act does not intend to punish the child

abusor, nor to destroy the family unit, but is enacted to provide for the rehabilitation of the injuror, as well as to provide for the physical and psychological treatment, the care, and the protection of abused children.

§ 3. *Definitions*:

As used in this act, the words and phases enumerated below have the following meaning:

(1) "child" includes all natural born persons under the age of eighteen.
(2) "child abuse" means conduct which includes the totality of intentional and/or unintentional physical and/or mental harm a child may suffer at the hands of a parent, guardian, or any other person responsible for the care or welfare of any child.
(3) "child abusor" is one whose conduct consists of child abuse, as defined herein.
(4) "parent" includes all mothers and fathers, both natural and adoptive, all guardians, or any other person responsible for the care and welfare of any child.
(5) "physician" includes doctors of medicine or osteopathy, psychiatrists, nurses, aides, and social workers.
(6) "hospital" includes any public or private institution or any other facility which provides medical diagnosis, treatment or care.

§ 4. *Scope of the Act*:

This enactment hereby provides for a program of rehabilitation to be administered as follows:

A. *Voluntary Submission*:

1. Any child abuser, as defined herein, who voluntarily submits to the rehabilitation procedures of this act is immune from criminal prosecution, unless it is determined that at the time of the abuse, the abuser acted with specific criminal intent.

2. The abuser is not immune from prosecution if his conduct amounts to any of the following crimes: murder in the first degree, assault with intent to kill, and assault with intent to maim. All other crimes are excluded from prosecution.

Comment.
This enactment intends to treat child abuse not as a crime, but as a psychological disease. However, any conduct which manifests a prima facie case in which a mens rea is found, such as first degree murder, is expressly excluded from the shelter of immunity provided by the act. The spirit of the act requires that those abusers who would be guilty of voluntary manslaughter, for example, would not be held accountable for their crime.

B. *Involuntary Commitment*:

1. Any child abuser, as defined herein, is also subject to the involuntary commitment procedure as provided for in the Pennsylvania Mental Health and Retardation Act of 1966. The child abuser who is involuntarily commited under this section is also granted immunity from criminal prosecution, as provided in § 4 (A).
2. Any person subject to involuntary commitment is hereby guaranteed those due process safeguards enumerated in the Constitutions of the United States and Pennsylvania.

Comment.
It is specifically intended to incorporate by reference the commitment provisions of the Pennsylvania Mental Health and Retardation Act of 1966. If these procedures are eliminated from the Mental Health and Retardation Act of 1966, new procedures for involuntary treatment will have to be established.

§ 5. *General Provisions*:

A. *Medical Care—The Child*:

All physicians and hospitals as defined herein are required to follow the procedure outlined in this act whenever probable

cause indicated by the clinical manifestations point to child abuse as defined in this act.

(1) When the injured child is brought to a physician or hospital, a medical examination is required.

(2) The examining physician may require a psychiatric examination of the injured child.

(3) The injured child may be detained if the circumstances indicate that such action is necessary for the protection of the child.

(4) Each case of child abuse as defined in this act must be reported within twenty-four hours after the mandatory examination to a central coordinating agency as provided herein. (§ 5(c) of this act)

(5) Child abuse, as defined herein, must be reported to the central coordinating agency, whether or not child abuse is suspected or confirmed, in order that this program may reach those cases in which abuse is difficult to recognize, or in which abuse may occur for the first time and a satisfactory explanation is made. These reports must be submitted weekly.

Comments.

1. "Probable cause" as used in § 5 means an apparent state of facts found to exist upon reasonable inquiry which would induce a reasonable, intelligent and prudent man to believe that child abuse has taken place.

2. "Clinical manifestation" as used in § 5(a) are those observations made of a patient by a physician with or without the aid of instruments, apparatus, or chemical examination for the discovery of the existence of child abuse. [These conditions were discussed in detail in the paper which accompanies these proposals.]

B. *Medical Care—the Parent*:

All physicians and hospitals, as defined herein, are required to follow this procedure:

(1) Comply with § 5 A(1-4) regarding care of the child.

(2) A complete physical examination and a psychiatric examination of both parents are required when the injured child is brought to any physician or hospital.

i. If either parent is found to be "psychotic", he or she must be detained following the procedure outlined in the Pennsylvania Mental Health and Retardation Act of 1966.

ii. If either parent is found to be "neurotic", he or she must submit to out-patient psychiatric care in a Community Mental Health Center, or seek, at his or her option, private psychiatric aid under the supervision of the central coordinating agency. The physician-patient privilege cannot be asserted in connection with any examination under this act.

iii. The "conjoin interview" is to be the basic unit for rehabilitation. The parent, children and psychiatrist must work as a unit to analyze the problems involved in the parent-child relationship. [Specific procedures are to be set up under the administration of the central coordinating agency.]

Comments:

1. The psychiatric examination referred to in § 5 B (2) are a series of tests to be established by the administrators of the central coordinating agency.

2. The detention provisions of the Pennsylvania Mental Health and Retardation Act of 1966 are currently being re-examined. If those provisions are ultimately amended, corresponding changes will have to be made in this enactment.

3. Inpatient versus outpatient treatment cannot be determined by definitions such as "psychotic" and "neurotic"; but some guide is necessary to separate those cases which are more severe than others. Conversely, the law requires avoidance of language which is so broad in definition as to be vague and therefore unenforceable.

4. "Psychotic" as used in § 5 B (2) (i) is a psychological disturbance of such magnitude that there is personality disintegration and loss of contact with reality by the person interviewed.

5. "Neurotic" as used in § 5 B (2) (ii) is a minor psychic dis-

order in which a person's conduct is inefficient and inadequate, but not antisocial.

6. Current authorities suggest the use of peer group discussion as the backbone of rehabilitation. While this now appears to be the best method to attain the goals established by this enactment, the legislature does not wish to restrict the program to any one procedure. The administrators of the central coordinating agency, as health professionals, will be better able to establish detailed and efficient procedures for rehabilitation.

C. *The Central Coordinating Agency*:

1. The central coordinating agency is hereby named "The Pennsylvania State Child Abuse Prevention and Rehabilitation Services."

2. This enactment establishes a framework for a state administrative agency. It is specifically intended that the health professionals and experts in psychiatry and social welfare services employed by this state will establish a detailed program within the spirit and policy of this act. The administrative agency is responsible for establishing the following program:

i. A clearing house is to be established to service the reports of child abuse.

ii. A detailed procedure designed to protect abused children from re-abuse must be established and implemented.

iii. All plans must be submitted to the state mental health director for approval.

iv. The agency is hereby granted all power necessary for the fulfillment of the basic policy of this act.

3. This enactment hereby authorizes the juvenile court system to act in conjunction with physicians and hospitals and the "Pennsylvania State Child Abuse and Rehabilitation Services".

i. The court may, at its discretion, temporarily remove any child from the home of a parent who is under rehabilitation.

ii. Where a child, who has been removed, is returned, daily or weekly visits by coordinating agency employees are required to evaluate parental progress in rehabilitation and the mental and physical well-being of the child.

iii. The court may, at its discretion, provide an attorney to represent the interests of the child in any legal proceeding, hearing or similar conference in which any child's welfare is in issue.

Comments:

1. The power given to juvenile court in § 5 C(3)(i) to remove a child temporarily means that a child can be separated from his parents by a writ in the nature of a temporary restraining order, for a period no longer than 90 days, while the parents are being rehabilitated. If, after this period, the court finds that the safety of the child might be endangered if the child were returned to the custody of his parents, it can restrict the parent's access to the child only by a judicial hearing.
2. "Any child" as used in § 5 C(3)(i) of this enactment includes an abused child or any other children in the family unit, who may also be in danger of abuse as a result of the psychological disturbances which affect the parents.

D. *Sanctions*:

1. No person with a prior conviction of a crime related to child abuse has the absolute right to submit to this program. The alleged repeater is presumed ineligible. This presumption is not conclusive and may be rebutted by evidence of a clear and convincing nature, presented to the juvenile court as to the parent's eligibility.
2. Any person who is disqualified from participation in this program is subject to criminal prosecution under the Penal Code of Pennsylvania.

E. *Other Provisions*:

To overcome the problem of child abuse and its consequences, the policy and procedures hereby enacted must be publicized through the state's information media. The non-punitive, rehabilitative and low cost features of these procedures should be emphasized.

Comment:

As most studies of child abuse indicate, there can be no protection

for the children nor rehabilitation of the parents unless and until the abuse is brought to the attention of the proper health professionals. It is therefore important to inform potential and actual child abusers of the appealing procedure of this enactment in order to secure their cooperation.

F. *Financial Obligations, Liabilities and Payments*:

1. The expenses of the psychiatric examination and treatment of the parents are to be met in two ways:

i. If the parent voluntarily submits to the rehabilitative process, costs are to be assumed by the State of Pennsylvania.

ii. Where the parents elect to use private psychiatric counseling under § 5B(2)(i), he or she must bear the individual costs incurred.

Comment:

It is suggested that the financial burden placed upon parents under § 5 F(2)(ii) may be relieved in the future through Federal aid. As a nationwide child abuse and rehabilitation program is established, financing may even encompass some type of Federal Income Tax incentive program for psychiatrists and other professionals who volunteer to provide low cost services to the patients under this program. It is probably more feasible to suggest direct Federal aid for the alleviation of this problem.

G. *Immunity From Liability*:

Any physician, hospital or other person acting pursuant to this statute shall be immune from any liability, civil or criminal.

§ 6. *Specific Repealer.*

This enactment hereby repeals 1939, June 24, P.L. 872, § 330(A), added 1963, Aug. 24, P.L. 1156, § 1 as amended, 1967, Aug. 11, P.L. —, No. 79, § 1 and 1967, Aug. 14, P.L. —, No. 91.

Comment:

1. The penalty of a summary offense for failure of a physician or hospital to report a case of child abuse as found in 1939, June 24, P.L. 872, § 330(B) is expressly retained. This is an effective way

to insure success for a program of care and safety for the abused child and rehabilitation of the parent by coercing, if necessary, the cooperation of the physicians and hospitals.

§ 7. *Effective Date*:

This enactment shall become effective on January 1, 1970.

Postscript

As this legislative proposal was being written, an indictment was returned by the Grand Jury in the third case of child abuse in Pittsburgh, Pennsylvania, within two months. It charged that a nineteen-year-old mother beat her three-year-old infant to death.

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