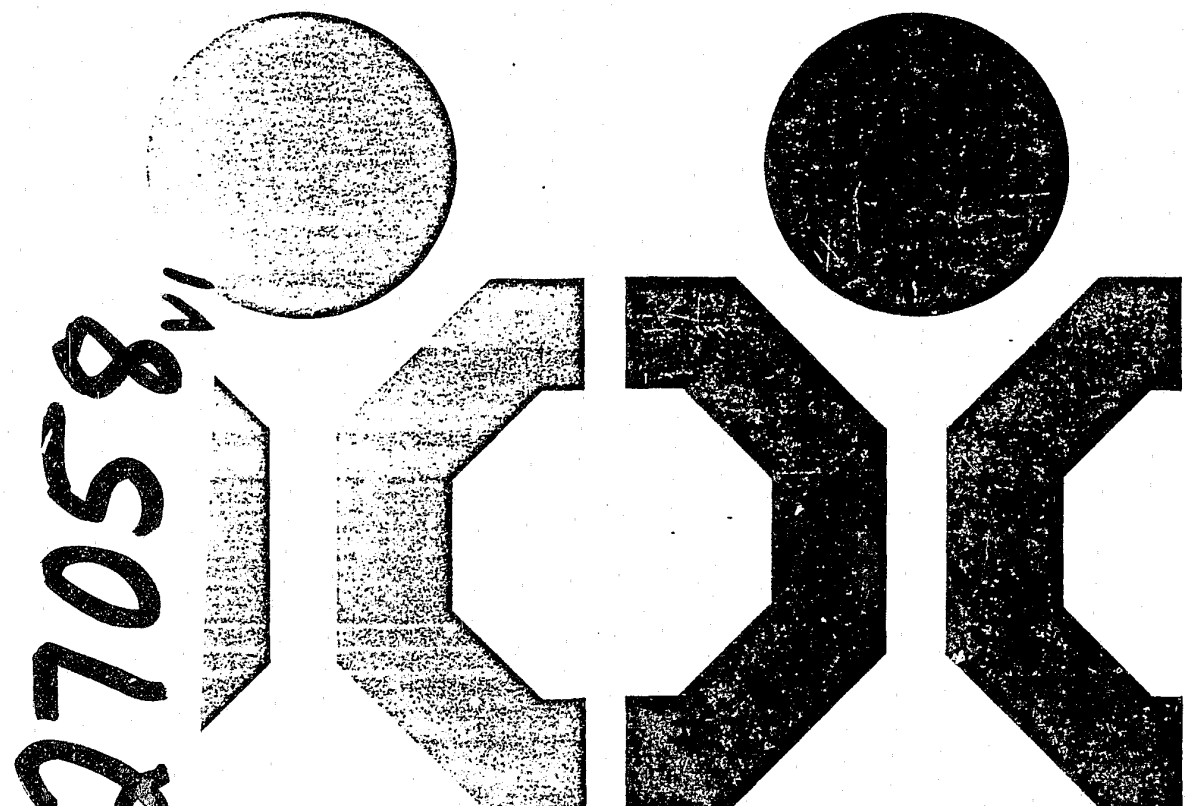
Vol. 1

Child Abuse and Neglect: Issues on Innovation and Implementation

Proceedings of the
Second National Conference on
Child Abuse and Neglect
April 17-20, 1977



Presented by

The Region VI Resource Center on Child Abuse and Neglect

Center for Social Work Research

School of Social Work

The University of Texas at Austin

Austin, Texas

In Cooperation with

The National Center on Child Abuse and Neglect

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CHILD ABUSE AND NEGLECT: ISSUES ON INNOVATION AND IMPLEMENTATION

Proceedings of the Second Annual National Conference on Child Abuse and Neglect April 17–20, 1977

Volume I

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1978

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OVERVIEW

The Second Annual National Conference on Child Abuse and Neglect, sponsored by the Region VI Resource Center on Child Abuse and Neglect in cooperation with the National Center on Child Abuse and Neglect, Children's Bureau, Administration for Children, Youth, and Families, U.S. Department of Health, Education, and Welfare, was held in Houston, Texas, on April 17-20, 1977. During those four days, some 1,100 participants interacted with experts in child abuse and neglect from the fields of social work, psychology, psychiatry, medicine, government, education, and law.

In four major plenary sessions, leaders from the various disciplines discussed the role of the consumer/family, the role of the community, the role of state and federal governments, and the role of the political process in dealing with the problems posed by child maltreatment. In addition, 25 panels and 80 workshops provided detailed information and discussion relating to the many issues of child abuse and neglect and suggested various levels of intervention with children, parents, families, communities, legislatures, and the federal government.

In the year that has passed since the First National Conference, the National Center and local, state and federal governments have supported many research and demonstration projects. The results reported on at this conference showed many approaches that work, and a few that do not. They demonstrated clearly that although we still do not know all the answers, we are improving our abilities to choose the right questions to ask.

If any theme could be said to have run through the whole massive proceeding, it was probably this: that child abuse and neglect is not merely a private affair between caretaker and child, but rather a crisis that affects and is affected by the entire community—and "community" may be defined as broadly as one wishes. Although our efforts for social reforms must not overshadow intervention with individuals, which is still a viable and needed modality, the field has moved past the concept of the "sick parent" to that of the "conflicted society."

One thing an overview needs to recognize is that the Conference was more than the sum of its plenary addresses, panels, and workshops, that speakers and participants interacted in many ways, and that a few words—enthusiastic, thoughtful, discouraged, challenging—spoken between two individuals, perhaps over coffee, perhaps during a reception, may have more immediate relevance than an extensive research study

If the Conference was more than the sum of its meetings, this book is more than a compilation of what was said at those meetings. The goal of the editors was to produce a publication that went beyond reporting to make a statement about the state of the art in child abuse and neglect, and to provide a context for a collection of papers by professionals and lay people vitally concerned with child maltreatment which would form a lasting and useful addition to the literature.

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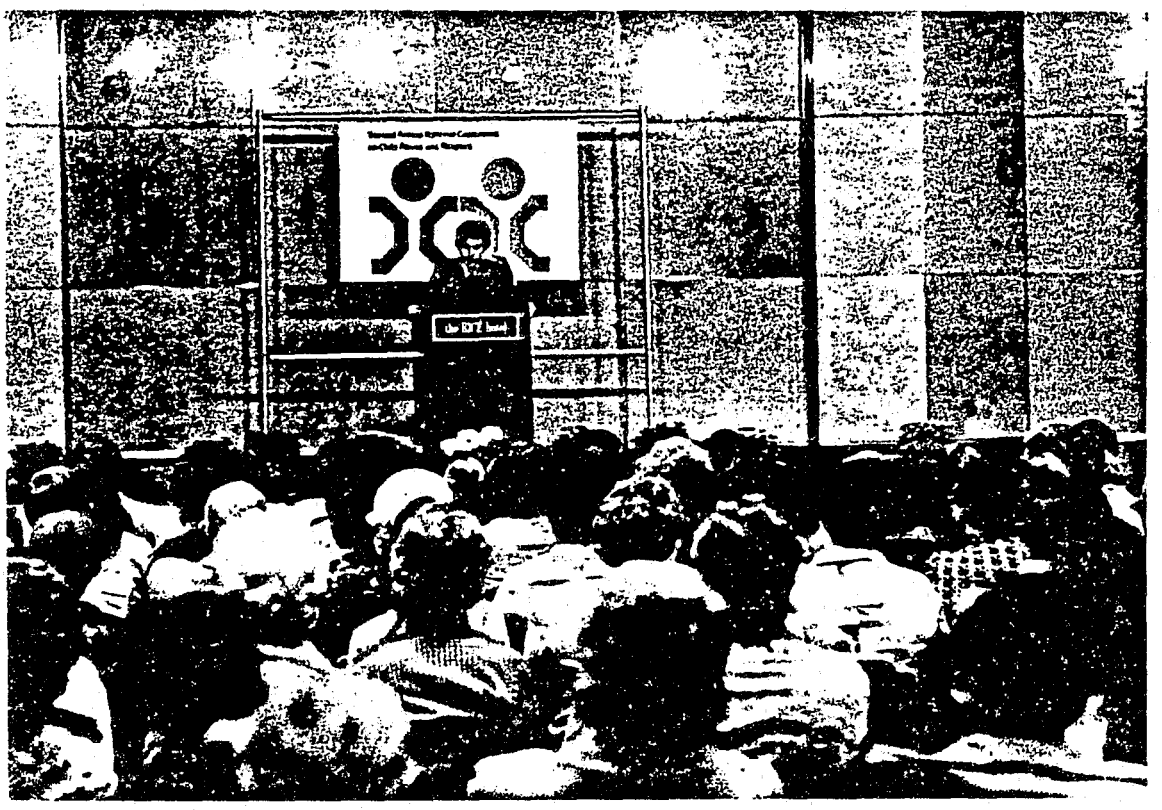

Governor Apodaca addresses a plenary session

C. Henry Kempe

Governor Jerry Apodaca

The Honorable Justine Wise Polier

FOCUS

These papers, all written by leaders in the fields of child abuse and neglect research, social welfare, and government, present an overview of the problem of child abuse and neglect at the social system level. Acknowledging that "child abuse and neglect is by itself not a preeminent concern at the highest levels of government," they discuss the potential of government policies to support and strengthen families and to set goals for the responsible exercise of political power at local, state, and federal levels. These considerations are complemented by overviews of the social, psychological, and cultural ecology of child abuse and neglect as a multidimensional family phenomenon requiring a multidimensional societal response.

Drawing on his experiences growing up in the multi-cultural milieu of southern New Mexico, Governor Jerry Apodaca, one of only two Spanish-surnamed American governors, discusses the role of government in strengthening families, and challenges professionals to achieve their shared goals. Government, while not able to intervene directly with most families, can serve families by creating a nurturing climate of prosperity, equal opportunity, progress, and hope.

T. George Silcott, Executive Director of the Wiltwyck School, presents detailed social and economic data on American families and shows how poverty-level survival relates to the corrosion of family living. Interventions by the child welfare and juvenile justice systems, fragmented and inadequate as they often are, may be more abusive and neglectful than the parents they categorize. A consumer/family and family life preservation model makes specific recommendations to the Federal government for integrated data collection systems, "no fault" social services and income support, community-based services, and a strong policy on full employment.

Dr. C. Henry Kempe, a pioneer in the study of the medical and social aspects of child abuse and neglect, presents an overview of past and present models of the dynamics of child abuse and neglect and their treatment. Social work has traditionally borne the greatest responsibility in dealing with child abuse and neglect, but needs additional supporting resources in the fields of day care, foster care, community-wide programs, and the courts in order to provide services and prevent burn-out. Social work also needs to move toward an autonomous practitioner-consultant model and away from the current restrictive caseworker-supervisor framework.

Discussing the role of the community from the judicial perspective, Judge Justine Wise Polier reviews the history of community response to the problems of child abuse and neglect, from the parent as sovereign to the parent as monster and on to current judicial nonintervention. She urges communities to accept and provide for abusing and neglectful parents; to take an active, vocal role in determining the quality of child care in institutions, including schools; and to make a concerted effort to serve those children who are abused and neglected, not by their parents, but by the negligence and indifference of our social and economic systems.

Raymond Vowell, former Commissioner of the Texas Department of Human Resources, discusses the role of the political process in setting priorities and the importance of informing the public of the needs of children and families and involving them in the decision-making process. Though some legislative progress has been made, and the Department of Human Resources has expanded and refined its services, efforts must be continued to educate governments and communities about their roles and responsibilities toward families.

Douglas Besharov, Director of the National Center on Child Abuse and Neglect, reviews past and present activities of NCCAN and suggests possible future directions for research and demonstration. Based on the premise that the definition of child abuse and neglect influences the response to it, he elaborates a model of the psychosocial ecology of child abuse and neglect, taking into consideration intrapersonal, situational, cultural, and social/institutional effects upon the family system.

Dr. Michael Lauderdale, Principal Investigator of the Region VI Resource Center on Child Abuse and Neglect, presents an overview of child abuse and neglect issues. Focusing on the areas of etiology and professional roles, he notes areas where progress has been made, and contrasts these with other areas which still lack resolution.

The Role of Government in Strengthening the Family

The Honorable Jerry Apodaca
Governor of New Mexico
Santa Fe, New Mexico

It is a great honor for me to open this Second Annual Conference on Child Abuse and Neglect. It is also a pleasure to welcome the conference participants to Houston, Texas, and to the great Southwest. I know all of you come from varied geographic areas of our country, and for some this may be the first visit to the heart of the Sunbelt states. It is indeed heartwarming to see the interest, enthusiasm, and concern that surrounds the opening of this conference.

We have a saying around New Mexico that "Schools are for kids." In spite of our daily hassles about salaries, collective bargaining, bricks and mortar, bond issues, funding, and other issues, we cannot forget, even for an instant, that the schools exist for students, not principals, or administrators, or teachers, or the PTA, and that our only guide should be what's best for the kids. Well, the same spirit permeates this room. We also recognize we are seated in the biggest room in the world—"the room for improvement."

As I prepared this speech I recalled my own childhood and youth on the eastside of Las Cruces, New Mexico, where the Mexican-American families comprised about 98 percent of the population. There, in the dirt-lined streets of Las Cruces, where nearly everyone was related, the American model of the nuclear family was unheard of.

I guess we weren't as advanced as the rest of the country in the forties and fifties. But looking back, I think I was fortunate in growing up in such an environment, with aunts and uncles ready to appear at any street corner, and with *abuelos* and older cousins watching you grow. The sense of community and family ties were both strong. The eastside of Las Cruces, although not wealthy then or now, has produced doctors, lawyers, a Supreme Court justice, priests, teachers, bankers, and even a few counselors and social workers.

I guess we will never be able to return to those days when "family" meant a host of maternal and paternal relations other than those of the immediate nuclear home. Perhaps the American ways of living can never fit the multigenerational household, sharing the responsibilities of child-rearing. But I cannot help feeling that we have lost something.

I don't claim to be an expert on the causes of child abuse. I can't match the years of study and practical experience that you have gained as professionals. But as a father of five, a former teacher, former legislator, and as New Mexico's highest elected official, I can offer you some perspectives on how we, as a people, can reduce some of the elements which lead to neglect and abuse.

One of the current controversies in New Mexico and other western states, and indeed throughout the country, is in the area of corrections—our criminal justice system. Americans have grown increasingly conservative in their approach to crime and criminals, and they don't want to be mugged or robbed by some thug who has an arm's length list of prior arrests. They want stiffer penalties—and more outlaws behind bars. They don't care about rehabilitation as much as they demand self-protection. Citizens don't care how much prisons cost as long as they are filled with criminals. Political officials are responding to this call because we see the public's concern as legitimate. Longer, fixed sentences are going to become the standard, not the exception.

In looking at this current situation, however, I think of the past neglect through which we ignored the immense social problems which inevitably led to our crime problem. Couldn't we have allocated our resources differently to stave off the expenditures of so much greater funds now? Why did we place such a small priority of the national budget on the young people? Now we must pay much higher amounts to repair the damage resulting from our neglect.

In New Mexico, over 75 percent of our state dollar goes to education. It is an expenditure for which I never apologize, even in the face of political criticism, because it is an investment in the future of our state, its people, and our country.

I come to Houston to discuss the role of government in strengthening the family, the individual, and in battling such social problems as child abuse and neglect. I can only give you one man's view, but I can present a challenge that should move all of you for many years to

come. The success of this conference will not and should not be measured at its adjournment. The success of this conference should not be judged on the eloquence or insights of the speakers, or the participation of the registrants, or the originality of the ideas expressed, or even the vitality of the debates and workshops.

No, the success of this conference, indeed of any conference, can only be determined years later by the success you had in returning to your states and achieving the goals you share in common. You are the professionals, the physicians, the psychologists, the social workers, the educators, who deal with the troubled families of America.

You are the ones who can best resolve the problem, and so it is up to you, and nobody else, to fight for sufficient resources to carry out your work. I am not here to say that it is easy, but then again nothing worthwhile ever is. You are the people who can capture the attention of policymakers, you can because you must, for no one else can do it for you.

We in America face an era of changing realities. Some politicians and leaders are meeting this new challenge, but some are not. No longer do we live in an era of abundance. No longer can we say that America is a land of limitless resources, because there appears on the horizons a limit to these resources—land, water, energy—and so we must learn to live with less, to pamper nature, and not ourselves.

Any politician who says we will not have to give up some of our current luxuries, or abandon our conspicuous waste of resources, is doing the country a disservice. Likewise, the spending priorities of our governments—local, state, and federal—will also be subject to change, and this is where you are going to have to fight, and fight very hard. In order to correct the child abuse problem in America, government at all levels must create a positive environment for all citizens.

Authorities believe the overwhelming influence in child abuse and neglect is stress, both in family life and in areas in which government can take action—employment, physical and mental health, income support, housing, education, and child care. Let's face it—these basic human needs are where the bulk of our money should go. If accomplished, we won't be faced so often with the need for much larger expenditures to solve much more complex problems created by our previous stinginess or neglect.

In reading your professional journals, I have learned that child abuse does occur in middle-income homes, although less abuse is reported than actually occurs. The overwhelming evidence points, however, to a strong correlation between poverty, unemployment, and child abuse. One study concluded that reported child abusers are disproportionately represented in the lowest social classes, that there is up to 50 percent unemployment among child abusers, and that nearly 60 percent of the affected families receive some kind of public assistance.

Although we could conclude that poverty is an insufficient cause for child abuse, I think it reasonable to assume that if we, as a nation and a people, reduce family stress by improving economic conditions for our citizens, we also will have gone a long way in reducing the problem of child abuse and neglect. That is why proposals to expand employment opportunities should be encouraged by public and private interests. There is nothing more fundamental to the emotional well-being of a person and to the stability of a family than gainful employment. A person with a job has self-esteem and hope, and a person with hope has everything.

On the other hand, a person without a job loses his identity and self-respect, and soon despairs of both himself and the world around him. That is why federal make-work programs, for all their drawbacks and inefficiencies, accomplish a great deal.

We should realize how essential low unemployment is to the vigor of our country, and that is also why whenever I am asked what my priorities are as Governor I respond with only three words—education, and economic development. With expanded educational and work opportunities, more Americans can enjoy the "good life." These two areas, education and jobs, are the keys to the future. They are the keys to preserving individual capacity to act, and to provide for oneself without depending on government or anybody else.

We spoke before of the need to preserve and protect our natural wealth such as oil, water, and gas. Should we not be as careful and cautious with our human resources? I think it was Franklin Roosevelt who said, "The only real capital of a nation is its natural resources and its human beings. So long as we take care of and make the best of both of them, we shall survive as a strong nation, a successful nation, and a progressive nation." As we begin America's third century, we should not squander any of our resources, natural or human.

I feel it is in creating a climate of prosperity, equality of opportunity, and of progress and hope that government will play its most significant role in promoting the health of the American

family. If we succeed in these efforts, then we need not be so preoccupied in reconstructing already crumbled merchandise..

I happen to be an optimist about the changes government can effect. Government can do great good for many people. I cannot, however, rewrite history, or alter people's attitudes about how they should run their lives. I don't think, for example, that government can do much to lower divorce rates or that it should even try. Nor do I think government can do too much to attract foster families. We can increase foster care board rates, and in New Mexico we have done so over the past years. But we cannot rely solely on the great anticipated surplus of parent-aged men and women to solve our foster parent deficiencies. We can do little to alter the national trend toward smaller families—whether natural or foster.

At the same time, innovations in recruiting foster homes should not be overlooked by either private or public entities. The generation of the post-war baby boom is now starting new households every day, and by all indications they will have sufficient jobs and income to adequately sustain their smaller-sized families. Here again, you will be the key; you must do the convincing; and you will have to scream for public attention, and then hold it. No one is going to do it for you.

Foster care is one area where we need the cooperation of government and private citizens because I think no one relishes the prospect of public institutional care to the point of warehousing children, or the state becoming a substitute parent.

These are challenges you face in the years ahead. They encompass many complex issues on a number of fronts. But that is the human condition. Life would be boring without problems to solve, challenges to meet, and improvements to be made.

More important, all progress must begin with a true assessment of the obstacles ahead. You will encounter many, and that is how it should be. If you talented professionals are not in the front lines of these battles, who will be? Our work is just beginning. Naturally, the challenges you face will result in many long and difficult hours, and I do not envy you.

Child abuse is prevalant today in all parts of our country. It is symptomatic of a society where violence remains too much a part of our national character, a dark spot in our history. We too often view violence as a means of settling disputes, as an easy outlet for frustration, or as the only method of discipline.

Therefore, I urge you to get busy with the work of this conference and the work of your professions. I am aware of the patience you will need and the disappointments you will sometimes meet. I congratulate you on your willingness to assume this kind of work, and in dealing with people—young people especially—who face so many problems, and who sometimes seem so helpless. Your rewards may be a long time coming, but so very worthwhile when once you do see the success story of a family you have helped become contributors to our country's welfare.

Institutionalized Social Bankruptcy Equals Child Abuse, Therefore Today's Challenge: Family Life Preservation

T. George Silcott, Executive Director
The Wiltwyck School
New York, New York

This is the second Annual National Conference on Child Abuse and Neglect. All assembled here, and those who will attend and participate in this conference in the next few days, are deeply concerned about and involved with the problems of child abuse and neglect.

We have friends, co-workers, and family members who are as concerned and disturbed about child abuse and neglect as we are.

The vast majority of federal, state, and local legislators are as concerned about child abuse and neglect as we are. In equal measure, federal, state, and local executives and administrators are concerned and disturbed about this pernicious problem. Business, industry, labor, and agriculture—on all levels—join with the private, non-profit human service industry in their deep-seated concerns about child abuse and neglect. The media, in justifiable indignation, periodically highlight, and focus our attention on, specific incidents of child abuse and neglect.

Were we able to merge and unite all of those who share this deep concern, shock and outrage—were we all to meet as an ocean of concerned citizenry and fill the grounds between the Lincoln Memorial and the Washington Monument, as we did in 1963, our expended efforts would have only marginal impact. We must reshape our thinking, our priorities, our national conscience in such a manner that truly addresses abuse and neglect, or else our agenda for the third annual conference will not be dissimilar to the second annual conference. In truth, we can expect the fifth, the tenth, and the twentieth annual conference agendas merely to reflect our reactions to the intolerable circumstances existing today.

Many of us read about and participate in a wide variety of local, state, and federal "plans for action." On local, state, and federal levels, we have the equivalent of organizations not dissimilar from a citizen's committee for children, joint action committees for children, and various child advocacy organizations.

We have seen and read prestigious national, state, and local studies on the plight and conditions of children, and of the awesome ravages and resultant human waste caused by poverty. Nongovernmental studies and analyses abound concerning the dysfunction and fragmentation of our human service systems.

All this we know. Yet we are assembled here, the cynic and the driven, the idealist and the realist, the conservative and the radical—we, in convocation, are a sampling of the concerned citizenry.

As keynoter, I see my task as one that challenges us to move beyond repetition and inertia. I see my task, beyond rhetoric, to challenge our perceptions of the problem of child abuse and neglect in such a manner that could move us realistically and rationally to basic, meaningful resolutions of this problem.

I see my task to urge us, at this conference, to develop strategies and approaches for our elected and appointed representatives, in high and low office, that lead to quantum, substantive changes in the governmental impact on the human condition, rather than incremental changes in the condition of the victim. I will press for a drastic change in our collective conscience, a change in personal priorities, and the generation of the will (the capacity) to make our rich resources work to improve the condition of children by saving their families.

BASIC ORIENTATION AND REFERENCE POINT

Child abuse and neglect cannot be understood nor effectively addressed in a vacuum. Every abused or neglected child is the result of a multi-dimensional problem, inextricably interrelated with other concerns and issues. When we focus our attention merely on dealing with the abused and neglected child—or on the abuser and neglecter—or when we focus on the narrow category of abuse and neglect—however defined—we have already lost that battle. More grievously, we have distorted and skewed the problem, and have so limited our options that we must fail in our efforts to comprehend the problem.

When we focus on mental illness rather than mental health, we indeed must be labeled crazy before we receive needed mental health services. When we structure and channel the child

welfare system dollar so that services are made available upon the placement of a child, we aid and abet the abuse and neglect of a child and its family in the first instance.

When we enact laws that mandate juveniles accused of committing crimes be tried in adult criminal courts, we do not effectively limit the incidence of serious delinquent acts, but effectively divert our attention from dealing with juvenile delinquency as an expression of our inability to work with children at the preschool age. We certainly avoid the interrelated issues of inadequate schooling, the desert of vocational career building, and the unavailability of employment options. Also, when we make "child abuse" money available for services only after abuse is proven, we encourage and abet child abuse.

Abuse and neglect impacts on a child, a sibling, and a parent. The social, economic, cultural, and ethnic contexts in which these specific occurrences take place are as real as the specific occurrences of abuse. They must be dealt with.

Various discrete pieces of legislation address narrow categories, have specific definitions, and have different eligibility requirements in order to receive services. Class action suits are narrowly defined to address specific categories: the mentally ill, the handicapped individual, the placed child, and the mentally retarded individual. Executive intent and priority point to specific "ills"—specific "problems." Administrative bodies further define and limit the legislative, executive, and judicial actions when they promulgate and issue the necessary rules and regulations in order to carry out their departmental obligations.

Yet, the consumer/family cannot be treated as an abstraction. The child and family living in a given neighborhood are real. What we have been doing in our attempts to deal with disparate, discrete "problems" is to violate, abuse, and neglect the real consumer/family.

The whole child, albeit damaged—the whole family, albeit divorced—the whole family, albeit disorganized and isolated—is put into little compartments. Our current practices and definitions are antagonistic to the whole consumer/family who lives in a given neighborhood.

Because of our laws, because of our piecemeal priorities, because of our current conflicting rules and regulations—we, in effect, mandate that the impact of our efforts be partial, be piecemeal, be arbitrary, be abusive and neglectful of the whole child and the whole family. Intent and good will notwithstanding, we impact on child and family in such a manner that we contribute to the family's deterioration, disorganization, disintegration, and dispersement.

Stated positively and assertively, our national commitment, as its primary priority, must be the preservation of family life. Our policies and efforts must mirror a basic commitment to children and their families. We must reorient and reorganize our efforts and services so that they impact overwhelmingly to preserve family life.

LEGISLATIVE AND ADMINISTRATIVE PERSPECTIVE

As a direct national response to the Great Depression of the thirties, the highest presidential priority spurred the enactment of, and gave the imprint to, much of our welfare system as we know it today, 40 years later.

During this time our welfare system developed in an uncoordinated, sometimes unresponsive, and sometimes dysfunctional fashion. Discrete programs have been added—with no attempt to integrate them with other programs. It is as if programs were piled upon other programs. And once you have a program, you obviously need a discrete administrative agency to monitor and operate the discrete program. Not only do the program gatekeepers promulgate their own rules and regulations with regard to eligibility, etc., but the gatekeepers are responsible to different administrative bodies and different legislative committees—committees which do the essential financial underwriting for the programs.

The April 3, 1977, New York Times commented on a recent library of Congress report that listed 55 separate federal programs that provide government payments of cash or services to various categories of people with limited income. The Times article quotes a landmark study of welfare in 1974 by the Congressional Joint Economic Committee's Subcommittee on Fiscal Policy which describes this witches' brew: "...our income security programs," the subcommittee stated in its report, "are shaped by at least 21 committees of the Congress and by 50 state legislatures, by six cabinet departments and 3 federal agencies, by 54 state and territorial welfare agencies, by more than 1500 county welfare departments, by the U.S. Supreme Court, and by many lesser courts."

The federal phenomenon recurs on the state level. In New York for instance, the Temporary State Commission of Child Welfare reported in its 1975 publication, "The Children of the State, I-A Time for Change in Child Care," that statutes or parts of statutes explicitly

dealing with child welfare laws appear under no less than 22 different volume headings of McKinney's: Administrative Code of the City of New York; Civil Practice Law and Rules; Civil Rights Law; Correction Law; County Law; Criminal Procedure Law; Domestic Relations Law; Education Law; Estates, Powers, and Trusts Law; Executive Law; General Municipal Law; Indian Law; Judiciary Law; Labor Law; Local Finance Law; Mental Hygiene Law; Not for Profit Corporations Law; Penal Law; Public Health Law; Social Services Law; Surrogate's Law; Surrogate's Court Procedure Act; and, Unconsolidated Laws.

The report hastens to add that, "...We make no claim that even this list is exhaustive and concede that, in some cases, the exclusions were more or less arbitrary." New York is by no means unique in this matter.

STATISTICAL PERSPECTIVE

A. Numbers are Suspect

Much can be said about how we have been responding to specific categories of dysfunction and problems. I will highlight only a few of them. The patterns repeat. The cumulative effect is over-whelmingly destructive to the real consumer/family living in a real neighborhood.

I would like to mention one fact that directly affects those of us involved with projects concerned with child abuse and neglect. Congress requires the Office of Child Development (OCD) of the Department of Health, Education, and Welfare (HEW) to provide annually true figures concerning the incidence of child abuse and neglect and to reflect appropriate rates of increase and decrease. The OCD recently authorized a $1.5 million contract just to come up with proper definitions in order to obtain the data Congress requires. As an aside, the New York Times reported last week in a feature article in its Family/Style Section that child abuse occurring in the suburbs (Westchester County, an affluent county in New York) is simply not reported. The article states: "Child abuse, according to experts, has reached epidemic proportions nationally, even after a decade of new laws and educational programs. Still, they say, there is a *reluctance* (my emphasis) to report it, *especially in the middle class* (my emphasis). Private physicians reported only 6 of the 891 cases investigated last year by the child protective services agency in Westchester." The article concludes, "Experts also began to ask whether it was time for a new look at the law mandating the reporting of abuse cases, especially in view of the widespread disregard of that aspect."

B. Relevant Data

I would like to present some statistics I find relevant:

—The difference between a 7.8 percent unemployment rate vs. a 4 percent unemployment rate represents $200 billion in lost wealth (J. D. Straussman—*Society*, March/April 1977);

—The suicide rate has doubled in the last decade among the 15-24 age group. It is one of the 10 leading causes of death and the third leading cause of death among young people; and,

—A study just completed shows that the level of alcohol abuse among junior high school students, in one area of New York City, is double the 1974 rate of alcohol abuse noted among high school students for the same area three years ago.

According to Herbert Bienstock, Regional Commissioner for the U.S. Department of Labor, 15.6 percent of the nation's total unemployment last year (that means one out of every six "officially" unemployed persons in the United States last year) live in New York and New Jersey. New York's "official" unemployed work force is higher than the total work force in 17 other states, a total of 1,390,000 persons registered as out of work. It is more important to note that while nationally the 1975 unemployment rate of 8.5 percent declined to 7.7 percent at the end of 1976, in New York the percentage of the "official" work force without a job climbed from 9.5 percent to 10.3 percent in the same period, and the New Jersey percentage rose from 10.2 percent to 10.4 percent.

A statistic that has special meaning for me is that approximately 28 percent of the all-volunteer Army is Black. Without speculating on the obvious employment reasons for this, I note a pending policy change that is receiving the highest national attention, namely, the need to return to a conscripted army. Among the key reasons offered is that the all-volunteer Army is too costly.

I also point out that as government-sponsored work programs have been announced, poor minority group people (youths and adults) overestimate these opportunities.

COMPARATIVE FAMILY LIFE DATA

A. The Changing Family

To meaningfully relate to the issues of preservation of family living, it is essential we have an overview of the changing family structure. I commend two articles to you:

(1) "The Next Generation of Americans," by Urie Bronfenbrenner, a paper delivered at the 1975 Annual Meeting of the American Association of Advertising Agencies; and,

(2) "The Changing Family," a series of articles published in the Wilson Quarterly, Winter, 1977.

I will use material from both sources and have liberally paraphrased material from the Bronfenbrenner article.

Without defining the parameters of family, it is necessary to state that the American family and family life-style have undergone dramatic changes in the last two decades. Some of the changes are:

—As of 1975, there were 55.7 million families in the United States. Eighty-four percent of these were two-parent families. Thirteen percent are female-headed households and 3 percent male;

—Sixty-eight percent of these female-headed households and 45 percent of the male have children living at home;

—As of March, 1974, among two-parent families with children, 51 percent of married women with children from 6-17 were engaged in or "officially" seeking work. In 1948, this rate was only 26 percent.

—One-third of all married women with children under six were in the labor force in 1974—three times as high as in 1948; and,

—Over the last 25 years, with a sharp increase in the last 10, there has been a marked increase in one-parent families. In 1974, one out of every six children under 18 years of age lived in a single-parent family. This is double the rate of 25 years ago.

In general terms, it is important to note that the majority of parents (80 percent) in single-parent households are also working. In addition:

—The divorce rate has increased 250 percent since 1960;

—The first-marriage rate is approaching in all-time low;

—The remarriage rate is down slightly;

—Close to 130 out of 1,000 infants (13 percent) were born to unwed mothers in 1974. In 1948, the ratio was about 46 per 1,000, or 4.6 percent.

—In 1960, 28 percent of the women between 20 and 24 were single;

—In 1970, 40 percent of the women between 20 and 24 were single;

—Trends consistently show increased divorces among men between the ages of 35 and 44 who have low incomes and low educational attainment. It is important to note, however, that divorce rates across the socioeconomic spectrum are increasing; and,

—In 1974, almost one out of every four parents (approximately 25 percent) under 25 heading a family was without a spouse.

B. Economic Dimensions

Some important economic dimensions must also be added to the equation:

—In 1974, 67 percent of the families with incomes under $4,000 contained only one parent. This represents an increase from 42 percent in 1968, six years earlier;

—Among family heads under 25 with earnings under $4,000, the proportion of single parents was 71 percent for those with all children under six years of age and 86 percent with all children of school age; and,

—There are more than 1.5 million female-headed families under the age of 25 with a median income of $2,800. They constitute one-third of all female-headed families with children under six.

C. Urbanization Dimensions

These are some of the dimensions of urbanization:

—The percentage of single-parent families increases markedly with city size;

—Younger families break up more frequently than older ones in large urban areas;

—In cities with more than three million population, one out of three to four households has a single parent at the head; and

—The most rapid change occurs not in the larger cities but those of medium size. These high levels of family fragmentation, a pattern six years ago confined only to the major metropolitan centers, occur in smaller urban areas as well.

D. Ethnic Dimension

We must also evaluate some racial dimensions of the situation. At the outset, it is important to note that the overwhelming majority of Blacks and whites do not live in similar circumstances:

—In 1974, 50.7 percent of all Black children under 18 lived with two parents, compared with 86.7 percent of the white children;

—In 1974, the percentage of single-parent families with children under 18 was 13 percent for whites and 44 percent for Blacks;

—In 1974, about 6 percent of all white families with children under 18 were living in cities with a population of three million or more, as compared with 21 percent for Blacks, over three and one-half times higher, and this ratio has risen steadily in recent years;

—In 1973, the median family income for an intact white family with children under six was $12,300. It was $6,700 for a Black family; and,

—In 1973, 33 percent of all Black families with children under 18 were classified in the low income bracket, compared to 8 percent of whites—a 4:1 ratio.

E. More Statistics

Further statistical evidence shows that:

—Forty-four percent of white families with children reside in suburbia. Seventy percent live outside the poverty areas and have incomes above the poverty line;

—Black families constitute 14 percent of all American families. Sixty-six percent of all families with children living in poverty areas of central cities with incomes below the poverty line are Black; and,

—Fifty-eight percent of the Black families are concentrated in central cities and half of these, in turn, have incomes below the poverty line. One out of every six (17 percent) Black families with children under 18 are found in the most vulnerable circumstances—low income in poverty areas of a central city, compared with less than 1 percent of all whites.

I can add more statistics, but I believe some generic points must be made.

Nothwithstanding the ethnic dimension with all its racist underpinnings, the American family is undergoing marked changes. For a variety of reasons, there are fewer adults in the home, and there is increased alienation and isolation, both of which are critical precursors to violence. It is almost a truism that families living under similar circumstances tend to be affected in similar ways. The pressure of poverty is perhaps the single most significant element in the growth of juvenile delinquency today.

The ecological disparity between white and Black families in America is a direct consequence of how our society functions. Altered policies, strategies, and practices can change how our society functions.

SYSTEMIC IMPACT ON FAMILY DETERIORATION

The background data just presented was selected in order to present a mosaic of what I consider to be critically interrelated themes that converge and impact on families living under certain stress conditions. While some may argue the validity of direct cause and effect, no one can dispute the high correlation between poverty level survival, and poverty area living, and the corrosion of family living. These conditions exacerbate the already documented changes in family life-style. At the least, they tend to fragment the family unit as we know it and increase the alienation and isolation of family members. Further legislative and bureaucratic fragmentation only serves to exacerbate and hasten family deterioration of the most vulnerable population.

A. Child Welfare and Juvenile Justice Systems

Now let me focus on how the child welfare and juvenile justice systems affect the consumer/family.

During the last eight years, in my role as executive director of the Wiltwyck School, I have been directly involved with the multi-faceted problems that impinge upon children and their families from the ghettos of New York City who have been caught up in the child welfare and juvenile justice systems.

Both systems, underwritten overwhelmingly by the federal, state, and local tax dollar, relate almost entirely to children and youth whose families live under poverty or near-poverty conditions. The documented New York City experience in serving this population varies from the cumulative experience of the various states and their localities only in the degree of its ineffectiveness. Federal, state, and privately sponsored studies of these systems, while in disagreement on various minor points, agree wholeheartedly on one issue—the bankruptcy and

inhumanity of our current approach. Descriptive terms such as "dysfunctional," "non-system," "fragmented," "falling through the cracks," are legion.

The Congressional findings of the gross inadequacies in the various states' juvenile justice systems are directly articulated in the Juvenile Justice and Delinquency Prevention Act of 1974. Innumerable studies have pointed up the confluence of child and family profiles of those caught up in either the child welfare or juvenile justice system. Our experience clearly reveals the inhuman and problem-exacerbating effect of the absence of prompt and appropriate services to a child and his family at an early age.

Our current definition of problems relating to troubled children, youth, and their families makes federal, state, and local monies available only *after* the god-like decision to separate child from family. The allocation of tax levy monies mandated in federal and state statutes for the placement service systems completely overshadows the provision of basic in-own-home/neighborhood-based services. The tax dollar is made available for services only as a concommitant of the labeling process (neglect, abuse, PINS, delinquent, etc.). The youngster, by the very structure of the system, if not by intention, can receive services only when he is clearly on a labeled route. The services brought to bear upon him in the more costly "placement" system, only by chance, may have some relevance to the child's effective return to his family and neighborhood. By statute and service underwriting, this clear-cut division is maintained and sustained. Thus, when and if the "placement system" returns the youngster to family and neighborhood, it all but guarantees his return into placement and ensures continued family failure.

We must ask ourselves: Is the parent the abuser? Is the child the offender? Who abuses whom when the government-sanctioned system abets the destruction of families and the alienation among family members?

B. Child Abuse and Neglect

The Child Abuse Prevention and Treatment Act (Public Law 93-247) was signed into law on January 31, 1974. Under this Act, the secretary of HEW, through the National Center on Child Abuse and Neglect, is authorized to make grants to public agencies or non-profit private organizations to develop demonstration projects for the prevention, identification, and treatment of child abuse and neglect. This was a beginning.

While the Child Abuse Prevention and Treatment Act attempts to move in the direction of a meaningful programmatic response to the shortcomings and gaps in the existing service delivery systems, the avenues required to bring about meaningful change go far beyond the narrow impact of this legislation. To truly effect the necessary changes, we must not approach this drastic turnaround from the narrow vantage point of those youngsters and families who have already been failed by the present system. Rather, we must be concerned with the broad-based community services that involve all the critical delivery systems for youth and their families.

When we merely attempt to redefine the focus of rehabilitative preventive programs for the target population, we tacitly accept the inadequacies of all the other delivery systems (education, health, welfare, housing, employment, etc.)—in short, the current system.

Looking at the problem from a systems approach, therefore, we recognize that imbalances may be created. For example, while we consider the need to develop a new approach to the problem of neglected or abused youngsters, the courts and the child welfare systems face the reality that neighborhood services are not available in their communities to meet their needs. This situation, in practical terms, inevitably leads to a reinforcement of the present "placement" system. And it is the present "placement" system that must be reexamined and reassessed.

Clearly, when we address the issues at hand, we, in fact, respond from a specific ideological view to the basic fabric of our society. It is no accident that neglect, abuse, delinquency, and other definitions of social pathology are found in high proportions in neighborhoods where there is also an accompanying high level of infant mortality, poor educational achievement, low income, and inadequate health services. Also, there is the absence of viable social institutions that can provide the programs and resources that could help families cope with the day-to-day task of surviving in an urban environment.

Clearly, child abuse and neglect, like delinquency, are symptomatic of two closely interrelated problems—family breakdown and the failure of other systems that impinge upon family life. Further compounding the problem is the differential approach used in handling situations of suspected abuse or neglect in inner-city areas as opposed to middle-income areas. The residents of middle-income communities can develop and make use of resources to enhance their survival and consequently do not appear as significant statistics in identifying social pathological behavior. Rarely, if ever, are these families taken to court.

And yet, even when we speak of preventive community services, we face the situation that only protective services are mandated. The predetermined label of abuse is the overwhelming code word for services. The gatekeepers of the service flow, acting under their own administrative and fiscal constraints, continually opt for the need for the pathological designation as a precursor for services to the consumer/family.

Shouldn't we ask: who are the abusers? and, who are they neglecting?

C. Employment/Unemployment Policies

The national policy regarding employment (i.e., 7 percent unemployment to cool inflation) continues the concept of job rationing as a policy alternative to full employment. The unemployment data quoted earlier is a direct consequence of government policy. To be sure, other factors also influence unemployment rates.

We must recognize, however, that national policy defines the status of unemployment. "Discouraged" workers who have been out of work for years—who aren't "actively" returning to the local employment offices—are not included in the statistics. Yet the officially defined unemployed for the poverty areas of urban communities are higher than the rates of unemployment during the Great Depression. Adolescents and young adults who have never worked, who are out of school (or in school, for that matter), and for whom there are no jobs, are not included in the "defined" unemployed. Unskilled mothers, for whom no training programs exist, are not included in the "defined" unemployed category.

The work/welfare programs which favor working mothers help force fathers out of the family household. Job programs for youth, unrelated to jobs for parents, especially for fathers, alienate and demean the adult-parenting figure. Marginally employed fathers leave their families who exist on welfare. If they continue to reside with their families, the resultant welfare cuts would leave their families in worse straits. In a word, our current policies of circumscribed job rationing aid and abet family disintegration, isolation, and alienation.

D. Income Maintenance—Welfare System

Our current system provides incentives for husbands and wives to separate. Studies show it discourages single mothers from marrying. This is because most poor families are ineligible for federal aid as long as the father lives at home. The rules tend to discourage some people who could work from taking jobs, if they could find them. Some eligible families cannot purchase food stamps because they don't have enough ready cash, twice a month, to purchase them. Only 65 percent of the people eligible for food stamps participate in the program.

There are gross inequities between the marginally employed poor and those receiving public assistance. A difference of a few dollars for the marginally employed makes them ineligible for Medicaid, food stamps, or day care. Income maintenance programs, as they currently operate, abet family disorganization and poverty perpetuation.

Title XX funds don't give sufficient weight and sanction to provide the basic human services. Only 2 percent of the revenue-sharing funds have been used for social services.

COMPOSITE IMPACT ON THE CONSUMER/FAMILY IN A POVERTY AREA

The consumer/family requires employment, housing, education, hospitals, social services, day care, recreation, etc. If they need help with special problems that are beyond their human, emotional, physical or economic resources, they need this assistance made available to them where they live. They can depend on extended family, neighbors, and friends for help. In fact, they usually do, but when this is insufficient, they look to the private and public sector for assistance.

When the consumer/family is poor, and their neighbors are poor, and the neighborhoods in which they live are near-disaster areas, the problems multiply. When those requiring aid are already among the most vulnerable at-risk population, and the neighbors share these same vulnerabilities, the burdens on the consumer/family increase geometrically.

When the poverty neighborhoods have problems in receiving any of the basic human services, the problems shift to the other human service systems. When the poverty areas have major shortcomings in all of the human service systems, we openly invite and inflict horrendous man-influenced and inhuman predetermined chaos and suffering.

For example, when a local school deletes its after school recreation program, and there are no other recreation facilities in the neighborhood, we invite street crime and violence. We also can anticipate and ensure the enactment of punitive legislation to protect the elderly who are already isolated and alienated from their families.

When we have no programs that support, as their first purpose, the preservation of family living, we fill the mental, child placement, juvenile justice, and nursing home institutions with

more people. When we attempt to deinstitutionalize these institutions whose residents' ties already have been effectively broken with family and neighborhood, we invite repeated failure and revolving reinstitutionalization.

When we close down day care centers by lowering eligibility requirements, we increase public assistance budgets and increase out-of-home placements.

When we decrease shelter allowances, we force families to move to other streets and buildings in urban areas where fear for life and limb of family members is even more increased—or the consumer/family buys even less for the table. The soup kitchens of the thirties are not an acceptable alternative.

CONSUMER/FAMILY AND FAMILY LIFE PRESERVATION SERVICE MODEL

There must be a mechanism (perhaps a single state public agency with local and regional counterparts) responsible for interfacing and integrating, on the neighborhood level, all human services for families. Such a service system, at its core, must be family-oriented. This public agency must be able to provide services, by contract with the public and/or voluntary sector, to all who need them.

This family life preservation-human service delivery model must be a national program. It should mirror the multiple options that organically grow out of the Black, Puerto Rican, Chicano or poor white family structure. All institutional systems must be programmed to build upon the continuity and integrity of service delivery that accentuates family and neighborhood strengths.

SPECIFIC RECOMMENDATIONS

In order to accomplish this—recognizing that to continue our current dysfunctional nonsystem is unacceptable—we must insist as the highest public policy and priority, that safeguarding and strengthening family life be a cornerstone of our present national commitment in order that this newly affirmed public policy create the building blocks for our future.

This new definition of the family itself must determine social policy and thus can influence the construction of service patterns:

(1) Data collection systems must be devised and designed to obtain integrated and interrelated service-need data that are relevant to the family unit. This data must then be assessed and analyzed within appropriate neighborhood areas;

(2) It follows that social policy must include "no fault" services. Eligibility requirements, labeling, and all impediments to the consumer/family's receiving the basic needed human services must be abolished. Services must be available as a right—just like the right to vote and the right to public education.

(3) Social policy must include "no fault" income. The hodgepodge of income support programs must be merged so that a family is guaranteed a liveable income. This is not beyond our technology or our resources.

(4) Human services must be clustered and made available at the neighborhood level so that the appropriate combination of services would be integrated in such a manner that it truly aids and encourages family life preservation.

(5) Employment policy must support all family members so that the results can truly help raise families out of poverty. Employment policy must be so defined that it can impact on poverty areas in a given neighborhood. Employment policy must be so articulated that it can respond to regional unemployment needs. Employment policy must be so defined that it preserves and strengthens families rather than artificially perpetuating the "welfare syndrome." Employment policy must not be rooted in any given "acceptable" rate of employment, when people are ready and able to work. Our goal must be full employment—a job for everyone able to work.

WHAT WE MUST DO NOW!

(1) President Carter must proclaim, as the highest federal priority, a full program that supports family life preservation. His clear articulation of high policy and need must help define our national purpose so that it addresses those most vulnerable in our society, while including the more fortunate among us.

(2) Congress must initiate legislation, with clearly defined intent, so that rules and regulations that support that intent can be carefully written. The conscious intent of this legislation must be the preservation of family life. States and cities will then follow suit.

MOBILIZATION OF EFFORT

We meet today, April 17, 1977. Soon the White House Conference on the Family will be held. There are literally hundreds upon hundreds of local, state, and national special interest advocacy groups. Most are highly circumscribed. They are "special problem" oriented. Some are more global—the ecologists, the futurists, Common Cause, the women's movement. Some special interest groups are concerned with poverty. Some are concerned with civil liberties, some with the retarded or the handicapped. Some special interest groups are professionally-oriented. Some are business-oriented, others union-oriented. Some are mostly concerned with agriculture, or banking. Throughout all these special interest groups there runs a single common denominator: either explicitly or implicitly, they are concerned with the welfare of their constituents. I suggest that the most basic denominator among them all is the preservation of family life. We must begin today to mobilize these diverse interest groups and enlist their support on the local, state, regional, and federal levels. We have little time to build momentum in order that the White House Conference on the Family become the moment when the humanist spirit of this country will assert its indelible imprint in supporting, nourishing, and nurturing family life preservation for all its residents.

When we leave here, we must develop coalitions of coalitions so that a groundswell of momentum will move this country to a new level of unity—a commitment to save our families for our children. Can it happen? That depends on you.

Child Protective Services: Where Have We Been? Where Are We Now? Where Are We Going?

C. Henry Kempe, MD, Director
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My assigned task is to attempt to describe where I think we have been and where we might be going in the area of child abuse and neglect. To discuss the field of protective services without being a qualified social worker is a hazardous undertaking. Those who assigned the topic must have thought that someone slightly removed from the profession of social work would have some useful comments to make. I have worked very closely with social workers over the past 30 years; they have taught me a great deal and have profoundly influenced the practice of pediatrics in our department. I owe them a great debt. I would hope, therefore, that you would forget that I am a pediatrician, and think of me as another colleague working in the field of protective services.

In our child protection team, now 20 years old, I would challenge anyone who visits to determine who among us is a nurse, social worker, pediatrician, psychiatrist, or a psychologist. We all speak the same language and we each have one vote. Our affection for each other and our mutual support has, without robbing us of our individual discipline and our specific competence, brought us to the point where we truly speak the same language (So I hope that I will speak a common language in this keynote address).

The field of child protective services goes back over one hundred years, but little is gained by talking about the distant past. Rather, let me look at the child protective effort as it was 20 years ago when I first came to know it. When I identify a problem that seems important to me, I will try to do so in the context of what we all can do about it. Instead of a problem list, I hope that you will leave with a list of suggested solutions. I am mindful of the fact that solutions in one part of the country do not necessarily apply to another. Our areas of influence vary enormously from those responsible for small programs in sparsely populated parts of the country to those who are pushed against the wall with hundreds of cases each week in our large metropolitan centers. But basics apply to us all and distant experiences are often easily adapted to our local needs. There are exciting things happening in rural America, in our towns, and even in areas of desperate need in our largest urban centers. Do not fail to see these areas of progress in your dissatisfaction with our societal ills. Regretably, community arousal generally requires one dramatic and tragic death. Does each community need a martyred child to pay meaningful attention to comprehensive protective services?

To those who insist that we do not know enough to be effective in giving helpful services until more research is done, I say that it is easy for academicians or administrators with no direct patient responsibility to order their priorities. We are not so lucky; daily we face the present needs of abused children. While we bless all good research and believe that it must be encouraged and financially supported, we who do deal with child abuse each day must do the best we can, one family at a time. We must use our training, judgment and experience, and we must not think lightly of experience. Our group has, over the years, dealt with over three thousand abusive families from all walks of life, rich and poor, educated and uneducated, and they have been our teachers.

To those in administrative or academic jobs removed from patient responsibility who complain that we cannot define child abuse, I offer the opportunity to spend a day or two with us or in any other city emergency room. They would quickly get a working definition of child abuse, physical and emotional neglect, and the significant physical and sexual abuse that occurs in adolescents. In the last analysis, child abuse and neglect is not what we professionals think it is; child abuse is what the judge says it is. At best, the judge represents the conscience of our communities.

To those who insist that social ills of poverty, housing, and unemployment are the principal causes of child abuse rather than the significant contributing factors, I say that one might remember the abject poverty of the East Side of New York during the waves of immigration prior to World War I. Despite material deprivation, strong family ties led to the kind of family support to be envied. Further, if social ills were the only causal factors, then why is there such a significant amount of very serious child abuse in the military services? Military families have a father and a mother, there is employment, a low but regular income, housing, and

sufficient food, and with all those social basic supports assured, we are devastated by the problems of child abuse we continue to see in that setting.

To those who regard protective services as "Band-Aids on the cancer of poverty," I say that refusal to help now the best we can, because prior social wrongs should first be righted, is like saying that because all children must know how to swim by the age of ten, we will not rescue drowning 12-year-olds.

To those who deride symptomatic improvement, lauding fundamental cures, I say there are indeed some cures and lots of improvements in the field of child abuse and neglect. And, I might add, when those same critics have a sore throat, I never hear them demand a scientific discourse on why we treat them the way we do; all want to feel better, which is symptomatic improvement.

In sum, research, improved practice, and the development of more services all go together. One need not wait for the other; each has a very important contribution to make.

WHERE HAVE WE BEEN?

If we look at the 1955 model of child protective services which had remained virtually unchanged for 30 years, we find the following: Protective service workers had been trained in the image of the kind of individual psychotherapy popular in American psychiatry in the first part of this century. There was emphasis on "professionalism," distance from clients who were not taken out for meals, who didn't have your bedside telephone number and to whom one listened so they could "clarify their situation." Case work was, at least in theory, much listening but little outreach, little advice, little concrete help and few loving gestures such as taking out to coffee or sending birthday cards. There were four requirements for optimal services: (1) that clients should come to our office; (2) on time; (3) motivated; and (4) with the problem clearly formulated. Next, there was the most incredible failure by senior social workers to treat their younger colleagues with the kind of respect of competence and trust that we see in other professional fields at the end of formal training. The social work profession its younger practitioners more than any profession I know by giving supervision or control instead of consultation, often keeping creativity to the minimum and compliance and the party line to the maximum. This lack of freedom exacts a terrible toll in initiative, enthusiasm, and often leads to changing jobs among our best young social workers. Consultation should be a two-way street and often the more experienced of us can greatly benefit from the less experienced.

The 1955 model insisted on a closed system. Professionals other than social workers, such as doctors, nurses, teachers and the police were told that these cases were highly confidential, would be handled only by the people who knew how, and that if their services were needed they would be called. "Don't call us, we will call you." The public was treated even worse, and all attempts by citizens at large to get involved were rebuffed. It would have been unprofessional in those days to look for the development of metropolitan child protection councils, which are organizations of professional and lay people who are brought together out of genuine interest to improve child protective services, or Parents Anonymous, fully supported by the mandated social work agencies.

If there is one overriding and fundamental problem facing all of us who care about young families involved in child abuse and neglect, it would be that protective services, and particularly social workers within those services, are incorrectly perceived by the public as being "against families." They are often called child snatchers because of the pervasive belief that all protective services workers do is take children away from their parents. If you add to this the horror story that often appears in the local press of a child being seriously abused or killed while under the care of the local authorities, perhaps never separated from the parents after an injury, perhaps never adjudicated in the courts, perhaps returned prematurely from foster care, very little is asked about the "whys" but rather there ensues an often hypocritical set of handwringings, accompanied by lots of letters to the editors, all condemning "the system."

Why is it that the work of our child protective services in our 3,300 counties is so poorly understood and so badly supported? In large measure we have ourselves to blame.

How shortsighted we were. We have only recently formed community councils involving enlightened citizens. Would it not have been far better to enlist the help of prominent citizens in defending our budgets with our county commissioners and city councils, in dealing with the press in a way that would enlist their help rather than their sensationalism, sharing in those failures which were preventable and those failures which were not preventable; in short, opting for an open system?

Finally, budgets were prepared each year on the basis of, "Let's have three more homemakers and three more social workers and two more secretaries," when instead we now know how to build a budget from the ground up and should, in fact, start such budget building at every level. Budgets, for example, should be presented in terms of three year plans in such a way that clearly lays out the current state of affairs and the projected needs of protective services in the state. This must be done in a language that paints a clear, easily understood picture to county commissioners, city councils and to legislators.

Having said how bad the 1955 model was, how isolated the social workers in child protection were from other professionals on the one hand and from the public on the other, and how they struggled with inadequate support, the unidisciplinary way of protective services could be very proud of its tradition. What was done was often very good and it was done out of devotion and idealism with little community or other professional support. Despite all these handicaps the social work pioneers made possible what I believe is a new era of child protective services which is now just beginning. I would therefore like on behalf of us all to pay tribute to pioneers such as Dr. Vincent DeFrancis who taught and encouraged and struggled to overcome many of the shortcomings I have just named. He often asked me, "We social workers have been in child protective services for a hundred years and where have you doctors been? And my reply has always been, "We have been nowhere; but now, at least some of some of us are here. And better late than never."

When Dr. Brandt Steele, a psychiatrist, and I started working in the field of child abuse in 1956, pediatricians and psychiatrists were in turn behind pediatric radiologists such as Caffey and Silverman who had described the x-ray findings of the syndrome well. Needless to say, we were dealing with the tip of the iceberg; that is, those children who had suffered multiple fractures, often of a specific and absolutely diagnostic type. We quickly learned that there was an enormous need to acquaint the medical and nursing professions with the facts of life when it came to child abuse and the "failure to thrive" syndrome, that is the failure to adequately gain weight, which is most marked in the first two years of life. There are over 300 causes of the "failure to thrive" syndrome, but the one that accounts for over 60 percent of them is nutritional deprivation, which is generally caused by parental rejection of the child. These are the children who thrive in hospitals, where no child should thrive, and in many hospitals this condition is as common as physical abuse of children. When Dr. Brandt Steele and Bess Davoren and the late Dr. Carl Pollock began their evaluation of our families, they did develop some approaches in treatment which have made it possible to bring about massive changes in approaching the problem on an interdisciplinary basis.

We learned that case work alone, directed to the mother and excluding the father, the abused child, and the siblings, was an inadequate remedy. We learned early that case aides or lay therapists could effectively help extend the work of social workers who would assign suitable families to them for an intensive relationship that might persist for years on end. We found that one social worker could supervise six lay therapists and that the lay therapists would, at the initial moment of crisis, be prepared to give up to 20 hours the first week, then 15, then 10 and then level off at three to five hours a week and be ready to take a second family sometime along the way. By then moving those families into self-help groups, which were then called Families Anonymous, intensive case work could be reserved for those families who were in need of such additional help. We also found that crisis nurseries were of enormous help to the lay therapist in dealing with families whose children had not gone to foster care.

For an attack to occur, four things have to be wrong at the same time: first, there is a family setup which has been well described; second, a child is seen as deserving abuse; third, a crisis, which can be internal or external or both; and finally, an absence of a lifeline or "rescue operation." We cannot do much about the first and the second, but we can do something at once about the third and fourth. The provision of crisis nursery care for children of families in crises made it possible for many lay therapists to see families through crises without resorting to foster care placement.

Another defect of the 1955 model was that case work by a professional, primarily female, often dealt with a mother, only because she was more available, while her husband was working. It rarely involved the case worker with the child in a role other than simply seeing the child, with no skills in evaluating the child's developmental, emotional and physical well-being. This approach of dealing with a mother and leaving out dad and the children came to haunt us in time.

I also knew that unless the father was actively involved, when there was a father in the picture, it was very difficult to make real headway. The old idea that if one could make the mother more competent and happier her marriage would improve, some of that improvement

would rub off on dad, and then trickle down to the children was in retrospect a very naive thought. It was born of necessity because there was little access to the father if he was working and social workers had no training in assessing children. And even if they had the training, they did not have the time, and they still do not.

The traditional and authoritarian protective service departments were unidisciplinary and every employee either was a social worker or a secretary, with an occasional homemaker thrown in.

Professional lines were equally rigid, with a junior worker being supervised by a supervisor, who generally had not been responsible for a case in several years. She was, in turn, supervised by someone else up the line all the way to God, who, as you know, is a social worker not in need of supervision.

To my sorrow, many doctors and nurses to this day are slow to totally involve themselves. But we are proud that there are now many hundred multidisciplinary teams, some hospital based and some community based. They have for the first time brought together social workers, who previously had to work in isolation, with interested others from the fields of law, pediatrics, nursing, the police, and the lay public. This open system has not resulted in loss of confidentiality. Rather it has brought about the sharing of the decision-making process and provision of more comprehensive services to the family. This is one of the great changes since 1955, when traditional departments of social services felt that they could use all the help they could get, but that because they were mandated to decide a treatment plan, they could not share the decision-making process. Nonsense! We in medicine share the decision-making process all the time, and we find it ensures better health care.

WHERE ARE WE NOW?

The interdisciplinary child protection team, whether hospital or community based, is one way the social worker can be a member of a group with similar interests looking at a problem from several points of view and deciding a treatment plan that makes sense for that family in that community. Such a team does not come about overnight, but takes, like having a baby, about nine months, and probably two or three bad cases, in which dubious or wrong decisions are made. The absence of scapegoating, the mutual support, and the feeling that one does one's best since we cannot predict human behavior and all the things that can go wrong—all these have a good deal to do with raising morale of the primary worker.

Is it not frightful when you contemplate that primary workers' turnover in the child protection field in a given department stands at 50 to 100 percent each year? No business could survive with those statistics. We talk at length about training needs and training materials, but what good is it if you wash out all that training at that rate? The usual way that a new worker gets involved in cases, taking over from someone else, is to be handed a stack of files and told: "This is it, Betty Lou." There might then be between 30 and 80 or even more charts which are now hers. Most are not helpful, disorganized and not readable. Behind each file are living and troubled people who have gotten used to being deserted. It is common for some of our abusive parents to tell us the names of eight or ten or 20 social workers whom they have known in their time. There has to be something wrong with a system which on the one hand insists loudly on the sanctity of the case worker-client relationship, only to have it abrogated overnight when the client moves across the county line or the worker decides the job is too emotionally upsetting to stand. It is easier to say, "I've got to go and get a higher degree," than to say, "I'm really worn out dealing with these difficult and insoluble problems. I feel unsupported; I keep giving out and nobody gives to me; I keep worrying every night about what could go wrong with these children whom I have sent home." We all have experienced what might be called the Pontius Pilate maneuver, "Pray God, let me not be the last one holding the football when it drops!"

Clearly, one of our real crises in the child protective field is to keep the turnover down by making the job possible. What would be my suggestion here? First, I would do away with the word "supervisor" and replace it with "team leader." I would provide consultation for workers and also use consultants from within and without the agency: psychiatrists and psychologists and other social workers, to give the kind of mutual support which we have found the members of the child protection teams give so well to each other. The turnover of primary workers should be no more than 15 percent a year. Good primary workers should, within a period of one year, move from a position of requiring supervision to one of using and giving consultation.

Next, I would insist that all such team leaders actually have some families in treatment. I believe it is impossible to be a reasonable consultant to younger workers based on memories of families 20 years in the past. In our unit in Denver all of us are practitioners, every day, every

week, all year long. Families come at us through the hospital and our clinics at a great rate. At Denver General Hospital we have had, since the first of the year, about one child a day and five on weekends, and at Colorado General Hospital, where I work, approximately one-half of that number. Between these hospitals we have lots of decisions to make every day. We make them in conjunction with the respective county welfare department, using a speaker telephone, which is one of the most practical and inexpensive ways to have conferences involving eight or nine different people without any of them having to go to any one place and still share in the decision-making process. It is essential that child protective workers who act as consultants be practitioners. Those who are clearly going to be in administration should be in administration, but unless they can take at least at half a day each week to be in the field, they are not competent to be consultants and there should be nothing wrong in saying so. It is not enough to say, "You are doing fine, Betty Lou," when Betty Lou knows she is not doing fine, either professionally or personally.

To those who teach about child abuse in the schools of social work around the nation, I would suggest that there must be time for some first hand current practice in order to teach competently anything other than someone else's theoretical material. We do not appoint professors of surgery who do not know how to operate. Alternately, close affiliations with local protective service departments, including faculty appointments for practitioners, would help social work students get some realistic view of the field which they so happily enter and so readily depart.

When I urged the Children's Bureau to hold its first conference on a model law for the reporting of child abuse in the early 60s, I did not expect that within three years all states would adopt such laws and that this would result in an enormous increase in the number of children and families brought to the attention of protective service departments. But reporting has never been an end unto itself. Reporting, per se, has done nothing but bring the child's plight to the attention of the helping society. But you must see that if a crisis is needed for abuse to occur initially, and that the injury to the child is a second very important crisis for most parents, then you must also see that the reporting of the inflicted injury is a third and frightening crisis to the parents. We have seen children killed simply because reporting led to investigation, but it did not lead to prompt family rescue.

Implementing a huge television campaign, as was done in Florida or as we are currently doing through private and public agencies, is a serious matter which requires giving careful thought to the provision of services. Service must be immediate and at the least must involve the use of emergency hotlines with a live voice on the other end instead of a tape recording. This can be lifesaving. There must then follow some meaningful and immediate helpful intervention using a variety of modalities that make sense for that particular family in that particular community.

Why is it that social workers in protective services are the only public servants expected to have a perfect batting record when such performance is not expected of other public servants such as those in the police or fire departments?

Public servants, such as policemen and firemen, have certain standards and will adjust the number of employees to the load fairly rapidly through direct confrontation with the city council or the county commissioner. Why is it that social workers on the other hand have been expected to adjust their services to their load without any regard to their professional standards, feeling that the only means of protest they have when stretched too thin is to leave the job? Perfectly wonderful, devoted, competent workers find themselves unable to do any of the things that they know how to do because they have only enough time to manage the most obvious crises in their case load and cannot do their professional job at all. They are spending all of their time investigating and evaluating and virtually none of their time treating clients. When we talk to them about treating children, they just laugh.

Clearly, it is not possible for a department to work alone doing all evaluation, all short-term and long-term treatment while dealing with prevention, child therapy, community support, and courts as well.

The needed public relations effort to involve private citizens' groups such as the Junior League, the service clubs, the League of Women Voters, and the various metropolitan and child protection councils takes time. It is important simply to decide that this activity will be done on behalf of the needy families by someone outside the department.

The same is true of the defense of the yearly budget. Social workers must become far more militant regarding the formulation of a realistic budget. A single protective service worker has approximately 1,310 hours in a year to devote to direct service delivery. Therefore, one

worker cannot adequately handle any more than 22 family situations in protective services at any time. Any community or county approaching 100,000 population needs a full time attorney in the area of protective services who must be accessible to the staff and housed within the agency. That also is true for a part-time staff pediatrician and part-time psychologist or psychiatrist. For a population of 200,000 an average case load of child protective services is 600. Approximately 50 positions and a budget of not less than 1.2 million dollars are required.

DAY CARE

Day care is an under-utilized alternative to foster care in child protection. In many ways it is the least disruptive to the family, provided the family is simultaneously receiving direct help. Homemakers and visiting nurses can provide other alternatives in the treatment plan, and many good departments use some or all of these modalities.

The use of lay therapists for family aides, crisis nurseries, small family learning centers, group therapy, self-help groups such as Parents Anonymous, hotlines, and others all have worked well—often in combination. Assessment shows that, provided the family is treatable in the first place, all modalities of treatment work at least to prevent reabuse, but they do not ensure a loving home environment. We also know that abused children and their siblings need supplemental, empathic and loving parenting from other adults if they are to avoid the devastating emotional and intellectual effects of living in a hostile or unloving family. This normal emotional growth and development is our goal. Protective services must do more than prevent a child from being killed or reinjured.

FOSTER CARE

The foster care problem in the United States represents a national scandal, one which will have to be addressed by the Congress and by each of our state legislatures. There are over 370,000 children in foster care today, one-third because of child abuse and neglect. In one department which was pretty well staffed, foster care stay in that category averaged less than three months. Because of funding cutbacks, that same department three years later has had to extend the average time in foster care to 15 months. The cost is phenomenal. New York City spends $24 million a year on foster care alone. Those departments of social services which feel that children receive therapy in foster care because they are in foster care could not be more mistaken. There are, happily, some therapeutic foster homes, but each of you knows that while you are lucky to have a few of those, there are many others which are, by and large, simply a place to park a child. In fact I believe much of our foster care system is institutional abuse of a kind which, in time, will have to be challenged in the courts on a child-by-child basis.

Lest one think that Denver does well, within the last two years a juvenile court judge had to deputize several volunteers to review the status of all the children under his jurisdiction in foster care, many of whom were lost in the system. To his dismay, the judge found many of these children were in categories where parental rights could have been terminated and the children adopted. In fact, children's cases had not been reviewed by the court in several years. It is now widely accepted that in all foster home placements a careful review by the court should be initiated by the responsible department at least every three to six months, with the intent of providing either permanent placement or termination with a view to adoption or subsidized adoption or return to the home with special services.

Some foster homes are abusive and/or neglectful. One must realize that many foster parents do not ever want to see abusive parents. One then must picture a judge incorrectly expecting a short-term separation in foster care and parents who will have access to their child for one hour a week. The worker picks up the child at the foster home and picks up the mother for a one hour reunion in the welfare department, from which the father, if he works, is excluded. Watch this continue 15 months and try to understand if weakly bonded families are likely to be better bonded after such a period of time when the child has, of necessity, built new bonds to someone who to him is "mother." It is not surprising that we see so many failures in the eventual reuniting of such brutalized families who are victimized by our inhumane institutional system.

Foster care can be therapeutic, and it should be. If we made a national effort to discover therapeutic foster parents by giving that profession high societal status, perhaps through a presidential proclamation or by designating a Sunday in May for each church to devote its sermons to the ideals of foster care, we would influence more families to see abusive parents as needing parenting themselves. These families could then provide many of the same services that our lay therapists provide our families. Examples of this approach do exist, but they are all too

few because they require care in the recruitment, selection, and supervision of foster parents which means money and someone's time. This effort will require social support from the population and particularly from our opinion makers, which is lacking because they have not been asked for their support. This new approach will also require early development of a treatment plan in which foster care is one of several short-term therapeutic modalities employed when the family cannot be together.

ADVANCES IN TREATMENT OF INCEST

Protective service departments are beginning to work in group sessions with preadolescent and adolescent girls involved in incestuous relationships with a father, stepfather, or brother. Not everybody can lead such a group or give individual care. It is impressive to see the lessening of guilt and rediscovery of a sense of personal worth in the child and family improvements when the cessation of incest is accompanied by outreach services to parents as well as to sexually exploited youngsters. This, too, must be a part of up-to-date protective services.

EDUCATIONAL NEEDS

One of the great unmet needs is the provision of educational background provided by schools of social work, medical schools, nursing schools, law schools, and police academies. None of these fields is adequately committed to the field of child abuse and neglect, with the further result that every practitioner seems to start from point zero.

DEVELOPMENT OF COMMUNITY-WIDE COMPREHENSIVE PROGRAMS

One of the first gambits of those not wanting to do anything is to delay development of a program by the "let's do a survey" routine. The temptation is to apply for federal funds and to await their arrival before developing a program. Money coming into an untrusting and unorganized community can be devastating. Too much money coming in at once can be detrimental, and no money is equally devastating. It has been our experience that communities who joined efforts in applying for federal funds and who failed to receive the money have done a better job in many instances. Having learned that the various components of a community-wide program are staffed by reasonable people, many of the initial fears have disappeared, and community-wide programs are moving forward.

The overall goal is to achieve community coordination, building of trust, and cooperation—the willingness to include just about everyone who is competent or who can be brought to the required level of competence. In recent years, many adoption agencies have willingly moved into the field of child abuse, but if you share, through contracts, any of the long-term treatment, then the receiving agency must not refuse cases they consider "too tough," leaving the constituted agencies with all the unsolvable problems. Once contracted, there should be no further "intake which doesn't take in." County department social workers are entitled to work with some "treatable" families as well.

The modern, comprehensive, community child protection system has the following components: (1) multidisciplinary review teams who provide a realistic treatment plan; (2) awareness and provision of treatment needs of children as well as parents, and resources for child therapy; (3) a strong emphasis on the value of the therapy program; (4) the availability of a crisis nursery; (5) the availability of a 24-hour a day, seven-day a week hotline referral system for the management of crisis situations; (6) the encouragement of active support for self-help groups such as Parents Anonymous; (7) strong working agreements in contractual form with both private and public agencies to provide a greater variety of service, and broaden the alternatives to families for treatment; (8) active involvement of community programs, and development of community support to broaden treatment modalities; and (9) a viable, mutually respectful relationship to the court system, and consultants and collaborators in the health care system, the schools, the police, and the law.

THE BURN-OUT PROBLEM

One of the problems in any child protection team is the tremendous physical and emotional fatigue that overcomes the worker after he spends one or two years in the front lines. This is most true of protective service social workers since other team members are either part-time, or can divert their emotional stress by performing other duties within their discipline. In that sense, physicians, nurses, and lawyers have it particularly easy. Protective service workers, however, eventually wash out unless very careful attention is paid to this problem.

One of the great advantages of a child-protection team approach is that decision-making in some life and death situations can be shared by the group, and emotional stress diminishes. When mistakes are made, there is increased mutual support rather than scapegoating, and the worker knows that whatever lack of foresight was evident, it was shared by all.

It is interesting to note that even though the armed forces offer rest and recreation programs for soldiers under fire, we provide no such service for our front-line workers.

We recommend all protective service workers have a block of time every four to six weeks in which no new cases are assigned to them. Lasting at least two to three weeks per quarter, possibly longer, this would allow workers to catch up on old cases, build community relations, speak at local schools, help train new workers, etc. Whatever the cost, this will decrease the enormous worker turnover which is the single most important drain on money and talent in our system. It is impossible to function well as an acute care worker in a child protection group without extended time regularly allotted for other activities.

NEGLECT

The addition of neglect to our reporting laws poses many problems. Unlike objective findings in physical abuse, with neglect we must assess so many subjective values of social setting, community customs, and individual variation of life-style that there is real danger that the efforts of social agencies will be diffused without having accomplished much.

In the past, we encountered no problem in including serious neglect, which was directly reflected in the child's physical, developmental, and emotional health, under abuse. I prefer returning to that definition.

We are concerned that in study after study, middle-class and upper-class families are excluded simply because they do not currently enter the system in large numbers. This leads to the widespread belief, even among professionals, that abusers are poor people mostly from minority groups. In fact, two careful studies in this area show that whites are overrepresented in child abuse. Furthermore, in Denver we have had opportunity over the last 20 years and over 3,000 cases to see our share of rich and middle-class families, and although middle-class and rich families can cope with external crises because they have money, internal crises do not differ much between rich and poor. Remember, millions of very poor people are perfectly marvelous parents and in our own experience with one of these groups, seasonal migrant workers in Colorado, we have been impressed again and again by the relative absence of child abuse, although there exists what in a middle-class community might be considered neglect born of circumstances.

EMOTIONAL ABUSE

The problems of serious emotional abuse are gaining increased attention. Many courts now view emotional abuse from a somewhat different point of view than in the past. Having learned that growth failure due to malnutrition (which is easily corrected by rapid weight gain in a hospital setting) proves the human environment dangerous to a child's health, courts increasingly look for evidence that an emotionally deprived child can make enormous, documented, emotional and developmental change in reasonably short time in a supportive setting. Emphasis lies on two words, "documented change." It is absolutely essential a pediatrician and/or child psychologist or psychiatrist conduct a careful initial evaluation of the child's developmental and emotional status, and a reevaluation after the child has lived in a changed environment that provides warm parenting, to determine if any dramatic gains have been made. This will distinguish children who clearly need help from those who are either beyond help or who have an underlying neurological or psychiatric disease not amenable to environmental change. In a recent Wisconsin case, a judge removed two children from the care of their parents. The children, who were preparing to enter school, could speak only swear words and were therefore judged incapable of succeeding in any social setting. In this case, which was upheld by the state supreme court, the judge held that the children were as endangered by their hostile environment as if they had been physically abused.

THE COURT

For a community to have an effective protective service system, it is essential there be a good working relationship between local agencies and the juvenile court. One cannot operate well without the other. Developing a relationship with the court may take years, and it can begin by having regular meetings with court personnel including judges and referees. These meetings between the two agencies (i.e., the department of social services or the local multidisciplinary team and the court) can serve as a means to identify problems and approaches to problems, and

to better communication and trust. The court and other agencies may never agree on all matters, nor should they. However, what is important is that there is ongoing dialogue, respect, and a means by which to solve problems.

A competent and concerned county attorney can also build effective relations with the juvenile court. In order for cases to be properly prepared, protective service workers must have access to their attorney prior to a hearing. The county attorney, in many respects, becomes a liaison with the court. He must, therefore, be respected by the court and the social workers for his competence and vigor.

Agencies need protocols and guidelines concerning all aspects of a court (i.e., the filing of petitions, court reports, testifying, etc.). We cannot expect the court to make good decisions without adequate data. In order to understand the problems, consider options, and make decisions a judge needs information which is nontechnical and concisely written.

A guardian ad litem can often help in acquiring court-sanctioned family evaluation not previously volunteered to the social worker but essential for developing a treatment plan or the recommendation for termination of parental rights.

PREVENTION

Last year we presented the results of a prospective predictive study which showed it was possible to prevent all injuries requiring hospitalization in the first two years of life by outreach service using lay health visitors. In terms of money saved, we showed that the $12,000 outlay in health visitors' time prevented $1 million of serious injury costs, an amount Colorado is now paying for the health care of those injured children whom early intervention would have saved, since no serious injuries occurred in our outreach group. The University of North Carolina conducted another predictive study involving high risk and premature infants. It clearly is possible to identify during and shortly after delivery families who need extra services. We are now prepared to consider ways to intervene before serious injury or malnutrition occurs. Parents, by the way, have not resented this early intervention and, as it turns out, it is unnecessary to use invasive techniques or questionnaires. Rather, we incorporate into routine nursing and medical care during labor, delivery, and nursery stay those parts of nursing and medicine which are becoming standard observations, not dissimilar to the standards of a physical examination and the taking of blood pressure.

All communities should develop grass roots programs from neighborhood to neighborhood, reaching out to all young families and babies and then gauging the need of frequency of outreach to the needs of the family. This would eliminate the current paradox of providing excellent obstetric and neonatal care and then upon discharge of the mother and child from the hospital, having the baby disappear from society's view until he enters school six years later. All of us would much rather prevent child abuse than treat it.

Furthermore, we now know that young parents, as a cry for help, often appear with nonexistent complaints about their own physical or emotional health and that of the child they are about to abuse. We must anticipate this need.

CONCLUSIONS

Finally, we should consider some recommendations.

Office of Child Development, Department of Health, Education, and Welfare

National guidelines should be flexible enough to allow local county departments to develop diverse and responsive treatment programs relevant to local needs. This requires commitment and emphasis from the Office of Child Development for preventive aspects and the diverse modes of treatment of child abuse and neglect.

State Departments of Welfare

1. In support of budget requests, each state should provide leadership to develop a sound data base system to present to local legislators. Budget requests should be made based on a state-supported work load standard for social workers and on cost effectiveness data.
2. Protective services should be a priority in each state.
3. State departments should assume the responsibility of providing the media and public with information that would educate the community on programs, services, and problems, and thus improve the image of county departments.

County Departments of Protective Services

1. Have a commitment to the concept of an "open system," (i.e., the use of multidisciplinary teams);
2. Develop written contracts with local public and private agencies;
3. Develop internal review committees of children in foster care;
4. Place greater emphasis on recruiting, training, and supporting foster parents. Licensing should be contingent on training and experience with different levels of licensing (e.g., License 1, 2, 3, with a more disturbed child going into a level 3 home).
5. Review the "rules" by which they operate. The criteria to review these rules should be based on what is best for the child and his family. We suggest flexible guidelines rather than rigid rules be used in county departments. For example, it is not uncommon for a child not to see his parents for two weeks following placement in a foster home. Who is this rule for? It certainly is not for the child or his parents; and
6. Recognize that some families cannot be reunited or that improvement in parental functioning is just not possible in the foreseeable future. For too long, county departments have carried too silently the responsibility of trying to improve such hopeless situations. County departments must feel free to speak out loudly and clearly on this issue and seek termination of parental rights to free the child for early adoption.

It is precisely because society mandates all protective services to keep families united whenever possible that social workers are so beset by serious conflicts. On the one hand workers are under pressure to reunite the family as soon as possible. Likewise, workers feel pressured not to allow a child under their care to be reinjured through premature return from foster care. Most states must do more work, and good legislation should better define the criteria of termination of the parent-child relationship.

RECOMMENDATIONS FOR OTHER AGENCIES

One of the themes of this talk has been to recommend that all mental health centers, hospitals, law enforcement agencies, schools, private agencies, etc., recognize they play a part in concert with the department of social services in combating child abuse and neglect. Child abuse and neglect is clearly a community problem and must be recognized as such.

Finally, we now know the great length of time treatment must be offered to many of our families. We recognize that changes often cannot be accomplished even in one year of intensive treatment. Child abuse cases are really never closed. This fact, more than ever, emphasizes the need for community agencies to work together in sharing responsibility for treating the abused child and his family.

I am very optimistic about continued rapid progress in the understanding and treatment of child abuse and neglect, but I am particularly optimistic in the area of prediction and prevention on the one hand and the effective treatment of the emotional needs of the abused child and his siblings on the other. Prevention of child abuse and treatment of the child are the cutting edges of progress in this field in the future. Together with all the other knowledge that has been accumulated from so many professions, it should be possible to engage the best minds and hearts of our young people in the great endeavor to strengthen and make happier the lives of many families. All of us are dedicated to this goal.

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Child Abuse: The Role of Community

Judge Justine Wise Polier
Children's Defense Fund
New York, New York

This is a critical time to consider the role of the community in preventing or ameliorating the abuse or neglect of children. Conflicting concepts and resulting forces join as they seek to extend or narrow when or how communities should intervene on behalf of children in any collective fashion.

Statutes are criticized as too vague and unfair because they fail to specify the limits of acceptable parental conduct or what resulting harms warrant court intervention.[1] There is equal confusion, and even more uncertainty, as to the limits of acceptable conduct on the part of agencies, institutions, or governmental bodies exercising power over the lives of children. Finally, there is greatest uncertainty and hesitancy in fixing responsibility for correcting social conditions which produce or contribute to the neglect or abuse of children by either individuals or social institutions, which together make up the community.

Originally, social or communal intervention on behalf of a child, except in crisis situations, was regarded as conflicting with two basic American traditions: the ideal of rugged individualism and the idea that a man's home is his castle. Bolstered by the ancient tradition that a child is the property of parents, the doctrine of the natural rights of biological parents supported a hands-off policy, even in cases of harsh physical abuse. In my own state, New York, legislative action to create a Society for the Prevention of Cruelty to Children in 1874 followed by ten years the establishment of the Society to Prevent Cruelty to Animals.

Since Kempe and his colleagues first presented the picture of the battered child syndrome, concepts about and responses to child abuse and neglect have suffered sea changes. At first, there was disbelief. I shall never forget the judge who told me he could not believe that any woman who had carried a child for nine months of pregnancy could abuse her child. Unhappily, his dismissal of the case preceded the death of that child, and the judge, a decent man, became a saddened and wiser one. With a 180 degree swing, abusing parents were pictured next as individual monsters from whom children must be snatched for salvation. During both periods, clinical services that could help parents, protect children, and prevent separation were slow to be considered, and were implemented at only a snail's pace.

Today, there is wider consensus that children are persons and must not be regarded or treated as the property of their parents. Legislation and court decisions are seeking increasingly to define the rights of children as persons. Laws providing for the termination of parental rights, subsidizing adoptive placements, as well as assuring constitutional requirements for due process, reflect this change in attitudes. Yet the traditional adherence to the rights of biological parents continues, and is reflected in laws and court decisions that give priority to the rights of parents even where they are clearly in conflict with their children's.

Apart from theoretical or legal differences, a vast discrepancy also exists between the stages at which communities actually function in regard to child abuse and neglect. Like the content given to the Eighth Amendment of the Bill of Rights, prohibiting cruel and unusual punishment, the content given to laws against the abuse or neglect of children is determined, to a large extent, by what is regarded at a particular time and place as "abhorrent to the sensitivities of the general public."[2]

For reasons articulated as far different from the traditional adherence to the natural rights theory, some knowledgeable and concerned child advocates now seek to avoid judicial intervention or coercive community action wherever possible. They are disillusioned about the quality of judicial action, the consequences of decisions, and the lack of appropriate community resources. They urge that continuity in the life of a child is of such importance that inadequate and neglectful biological parents present less risk to healthy development than removal of a child to the limbo of endless and changing foster care with its consequent denial of identity and the sense of belonging needed for healthy child development.

Such advocates also urge that the community shall not use coercion to intervene or remove a child unless the child has suffered, or is in imminent danger of suffering, serious physical harm at the hands of the biological parents. Emotional neglect is held to be beyond the competence of courts to evaluate, except in extreme cases where resulting harm is evident. Distrust or loss of faith that court intervention can be more helpful than harmful to children has

led to overlooking the consequences for children of emotional neglect except in extreme cases. The steady erosion of a child's spirit from lack of emotional nurturing, which can be more deadening than physical hurt, is not weighed sufficiently in the attack on harmful state coercion in family life or in the opposition to mental health services as part of the current denigration of the so-called "medical model."

Unhappily, in the absence of a vital community role or alternative community resources, the proposed reform of reducing the role of courts in neglect and abuse cases has largely led to transferring decision making powers from the malnourished courts to even more starved child welfare departments.

Trained and untrained workers in protective service divisions are given awesome responsibilities in cases where suspicion of abuse is reported. With heavy caseloads and without benefit of adequate diagnostic help or clinical services, they decide whether or not to leave children with parents charged with abuse or neglect. Later, they must also decide whether or not to accept plea bargains from parents who agree to "voluntary" placement of their children in exchange for not being charged with abuse or neglect. While the latter seems a kindly and time-saving procedure, it means that parents can demand their children returned at any time, and that there has been no judicial determination of what happened in the past to guide either welfare departments or courts as to whether or not children can be safely returned to the biological parents. Such decisions and procedures reflect both the failure of communities to provide adequate protective services for abused children and the current widespread support for diversion of children and families from the courts without requirements for adequate protective services.

In sharpest contrast to efforts to narrow the grounds for court intervention, the joining in statutes or programs of child abuse and neglect without adequate definition or differentiation has all but simultaneously enlarged the area for various kinds of community concern and state intervention. Those working with children are aware of the vast difference between pathological parents who strike out against their children, and those whose ability to function as parents is worn thin by unremitting economic, social, and emotional burdens. There is danger that statutes and procedures which obscure the differences between abusive actions and neglect will too likely lead to a failure to distinguish the problems of parents and the risks to children.

What communities see as their role in meeting or preventing child abuse and neglect varies not only in law and in practice, but from community to community. Confusion and conflict abound. In discussing the community role in child abuse and neglect, I believe it is necessary for communities to consider where they are and where they should move to counter such harms, and whether these problems result from parental conduct, the administration of agencies or institutions, or from basic conditions for which the whole community must accept responsibility.[3]

INDIVIDUAL ABUSE BY A PARENT OR CUSTODIAN—THE COMMUNITY ROLE

After the initial period when willful abuse by a parent was regarded as inconceivable, legislators and even judges, spurred by horror stories, finally responded to some of the harsh realities of child abuse. But their methods of response present another question. While legislators established central registries and hotlines to aid in the detection of abuse, communities failed to secure adequate manning of the hotlines, careful screening of reports of suspicion, or protection of the confidentiality of those whose names were entered in swiftly growing computerized registers. Communities also failed to require that the scientific light or clinical enlightenment available be used to protect children, help parents, or prevent unecessary separations of children from parents.

In the area of individual child abuse cases, the role of the community seesaws. It accepts the traditional American child rearing philosophy based on the right of parents (more recently renamed "family autonomy") to do as they see fit, including approval of the use of force. At the same time, communities are ready to punish parents whose actions are so extreme as to be repugnant. I am reminded of the wisdom of Jeremy Bentham who challenged the principles that guided the fixing of penalities on the basis of emotional response to offenses. He wrote:

> In looking over the catalogue of human actions in order to determine which of them are to be marked with the seal of disapprobation you need but to take counsel of your feelings: whatever you find in yourself a propensity to condemn, is wrong for that very reason. For the same reason it is also meet for punishment...If you hate much, punish much; if you hate little, punish little; punish as you hate...[4]

No more accurate description could be drawn of community responses to child abuse by individual parents. Communities, repelled by abusing parents, have failed to recognize the extent to which the actions of such parents reflect harms resulting from past personal and community antipathy and alienation. Communities thus avoid seeing abusive parents as part of the larger community family.

Community hostility and avoidance of responsibility have not been confronted by what seem to be the cheap short cuts of punishment through removal of a child. Antipathy too often dominates, while sympathy remains quite minimal, except where a few clinicians like Kempe, Helfer, and Steele have won understanding for the needs and potential of individual abusers and of their children. They have challenged concern for parents, who are themselves strangers within the community. Here, the role of the community is determined by its readiness to respond to such teachings: to embrace rather than ostracize, to help rather than cast off, and to provide direct services to offending parents.

INSTITUTIONAL ABUSE—THE COMMUNITY ROLE

When persons or institutions have authority to care for children outside their homes, the community role has thus far been minimal, except as it has responded to specific cases of serious institutional abuse presented by child advocates. Two factors seem to play a significant part in the unwillingness of the community to challenge child abuse when schools, foster care agencies, hospitals, mental institutions, or correctional institutions have authority over the lives of children.

As in the reluctance to interfere with parental control, there is widespread community approval at all levels of the use of physical force in American society. Only a few states (including Massachusetts and New Jersey) have recently prohibited corporal punishment by institutions. How much physical or corporal punishment may be applied to children in schools remains a subject of controversy among educators as well as in the courts. When I chaired a committee two years ago to investigate charges of harsh physical punishment of school children by the use of a three-foot wooden paddle, the community was divided on the issue. Even parents were divided between criticism and approval of the administrator who introduced and used the paddle. The school was located in a poor and largely minority group area. Some parents became outraged by the corporal punishment of their children. Often, parental objections were directed more to the absence of their consent than to the use of corporal punishment. Some parents who supported the use of school paddling expressed fear that without such discipline their children would not study, be truant, engage in delinquent conduct, and therefore not get ahead in life. To them, and to some teachers, maintaining order in the schools was of primary importance. Underneath the acceptance of corporal punishment in the school was the parents' assumption of their right to administer corporal punishment at home.

The second factor in allowing abuse of children outside their homes has different roots. It stems from unreadiness by communities to question existing institutions, especially when these institutions are under the auspices of powerful establishments. This is true especially when establishments are administered by religious or charitable agencies, long regarded as above reproach. It is also true when establishments are administered by government. Although the community pays for the care of children in these agencies in various ways (from tax exemptions to 100 percent purchase of care), the community role in their operation has been practically nonexistent. Communities act as if they are outsiders, unaware and not responsible for the quality of care or service rendered by those they regard as untouchable experts. The old attitude that the recipients of charity should be grateful for whatever they receive, and ask no questions, is not unrelated to the attitude that the community should not question established institutions charged with rendering services to children.

The alienation of communities from a role in child caring institutions is compounded by the limitations of the state agencies charged with supervision. State bureaucracies charged with setting standards in public and private institutions are rarely given enough staff to adequately monitor how children actually fare. Licensing is largely a ceremonial act. Even when abuse or neglect is found by a supervisory agency, "gentlemen's agreements" provide cover-ups that prevent the communities from knowing or acting, even if they might have the will to do so. When information services are set up, anonymity, in regard to what the computer finds, is promised to individual agencies although no such anonymity is assured to individual families who are tracked.

The non-role of communities has necessitated class actions to challenge institutional abuse of children. In addition to benefiting some children directly, such actions have stirred

communities to learn more about what is happening to children and to reexamine what their role should be. Unfortunately, the present Supreme Court, known as the Burger Court, has moved recently to make federal courts increasingly less accessible and responsive when misconduct or mistreatment is charged against governmental or private agencies. Only time and a change of judges on the Court can restore the promise of securing constitutional rights for children against institutional abuses advanced by the Warren court.[5]

Despite all obstructive factors, the basic responsibility rests with the community for acting against abuse of children placed away from home. Community concern, expressed through fact finding and action, will ultimately determine the rate at which such abuses and neglect of children will be challenged and ended.

COMMUNITY ABUSE AND NEGLECT—THE COMMUNITY ROLE

As Gil found in his national study of child abuse, the widespread neglect affecting millions of children living in poverty imposes "severe deprivations (and) much more serious problems than abusive acts toward children committed by individual caretakers."[6] Both societal acts and the failure of communities to correct conditions in which healthy child development is at greatest risk are responsible. Without burdening you with statistics, a simple illustration can be found in the report that "there are more than seven million needy children in family day care homes who could be receiving through federally supported institutions three meals a day, and yet only some 15,000 do so... The children of the working poor are almost entirely ignored."[7] In a recent study of children referred for preventive services in the hope of avoiding placement, it was found that 75 percent came from single-parent families, 80 percent depended on public assistance, and 35 percent lived in areas regarded as too dangerous to allow social workers to visit the homes.[8]

In addition to the amoral absence of a positive community role to protect those children most burdened by multiple deprivations, communities assume moralistic attitudes toward the poor based on a double standard. They tolerate, if not impose, violations of privacy and confidentiality on recipients of welfare or Medicaid. They allow and approve spying on the indigent. They demand information on the personal and sexual lives of recipients that would never be tolerated by middle-class families. Such "big brotherism" has been accompanied all too often by ignoring neglect and abuse of children on welfare caseloads. In the case of one battered child, the casework record showed a long history of neglect. When I asked the worker why she had not intervened sooner, she shrugged her shoulders and replied, "This is the culture of poverty."

The community role should include a determination to end practices involving unjustified snooping or the imposition of moral standards not applied to all citizens. At the same time, it must bend its efforts to overcome calloused, prejudiced, or indifferent attitudes that deny adequate services to children and families because they are poor.

No single prescription for the community role is possible. But, to be significant, it must embrace preventive services that strengthen families through economic and clinical supports. It must oppose the use of force or violence against children, whether practiced within or outside their own homes. It must challenge societal neglect wherever found. And, it must assume the difficult and unpopular role of insisting that communities provide needed resources essential to providing the foundation on which decent family life can be built, even though this means higher taxation.

In abuse and neglect there is more sympathy for the individual infant whose failure to thrive can be attributed to a parent than for the many children whose failure to thrive is neither identified nor recognized as attributable to society's negligence or indifference. The community role has focused therefore on the individual parent and on reducing intervention by the state, except where the injury is actually or potentially dangerous to life or limb. New forms of benign neglect of children in their own homes have been invoked in the name of parental rights and distrust of state intervention. Once more the underlying causes of parental limitations and childhood deprivations have been avoided. The higher incidence of abuse among deprived families is presented but not confronted.

Some years ago the English historian, Arnold Toynbee, defined a monstrosity as an institution that dabbles in symptoms but fails to deal with underlying problems. To avoid becoming one more monstrosity, the community role in child abuse and neglect therefore requires it do more than dabble with symptoms. It must go beyond individual and even institutional abuse, neglect, or deviant behavior, and seek out the underlying problems that threaten the lives, the full development, and the well-being of children wherever they live.

FOOTNOTES

[1]For discussion of unfairness to parents when too much discretion is allowed to judges see, "In the Child's Best Interests: Rights of the Natural Parents in Child Placement Proceedings." Comment, *New York University Law Review*, Vol. 51, Jan. 1976, pp. 446-464.

[2]State v. Killory, 243 N.W., 2d 475 (Wis. 1979).

[3]Gil, David. *Violence Against Children*. Cambridge, Mass.: Harvard University Press, 1973.

[4]Bentham, Jeremy. *The Principles of Morals and Legislation*. Hafner Press, 1948, Principles XIII, XIV, 16-17.

[5]Statement of the Board of Governors, Society of American Law Teachers, *The Burger Court's Efforts to Close the Federal Courthouse to Public Interest Litigation*, Oct. 10, 1976.

[6]Supra, fn. 3, Preface, p. vii.

[7]Bode, Barbara. Director of Children's Foundation, in a report to the Field Foundation, Jan. 14, 1977.

[8]Report by Hannah Nakhshab, Supervisor, Preventive Services, Louise Wise Services, March 2, 1977.

Child Abuse Prevention: The Role of the Political Process

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It is difficult to make a more precise statement about the role of politics in preventing child abuse than is stated in the preface of the program of this conference. It says, "We must recognize that child abuse and neglect is by itself not a preeminent concern at the highest levels of government."

That is sad but true. There is no compelling concern about child abuse and neglect among those occupying the hallowed halls of government. We have watched men walk on the moon, but we have not seen our children walk with equal pride upon our land. We are rich, yet millions of children are deprived of adequate nutrition, physical care, and wholesome homes and environment.

Nearly 50 years ago at the opening of the 1930 White House Conference on Children's Health and Protection, President Hoover said, "If we could have but one generation of properly born, trained, educated and healthy children, a thousand other problems of government would vanish." We still wait for that proper generation.

In June, 1934, President Franklin D. Roosevelt sent a message to Congress concerning the Depression. It announced the creation of a Committee of Economic Security. He spoke for "men, women, and children against several of the great disturbing factors of life—especially those relating to unemployment and old age." Not a word was mentioned about child health. Many of you remember well the tragedies of World War II. From Pearl Harbor to VJ Day, 281,000 Americans died in action. During that same period, 430,000 babies in the United States died before the age of one—that is, three babies for every two soldiers killed in the War.

America remains a long way from fulfilling the hope embodied in our children. The Preamble to our Constitution begins, "We the people." We assume that includes children. We proclaim ourselves a nation devoted to its young. Yet America, the richest of all world powers, has no united national commitment to its children and youth. It is a fantasy to claim we are a child-centered society, and that we look to the young for tomorrow's leaders. In replying to a question asked by Ann Landers, 70 percent of her readers responding said that if they had it to do over again, they would not have children.

Our words are made meaningless by a lack of national, community, and personal investment in maintaining the health and development of our young. The Texas Constitution says all free men have equal rights that shall not be denied or abridged because of sex, color, creed, or national origin. Nothing is said about age. Our children today, therefore, essentially are minus a bill of rights. We believe in family structure. We look to families to nurture their young, yet fail to assist them in child care until a child is badly disturbed or disruptive to the community.

The discontent, apathy, and violence of today are warnings that society has not assumed its responsibility to create an environment providing the best care for its children. We must stop believing that parenting is a natural phenomenon. It is not; it has to be taught. Usually, child abuse results from the parent's inability to "mother" or "father." Good parenting is learned from good parents. Therefore, the family can't be allowed to withstand alone the enormous social and educational pressures we impose on it. Beginning drivers today receive more education than beginning parents. Within the community some mechanism must be created to assume responsibility for providing the supports children and families need. This is vital. A child's greatest need is a loving and caring family. This is the greatest single influence on a child.

I believe permissiveness has damaged an entire generation of young people. If the good Lord had favored permissiveness, He would have handed Moses "10 Suggestions."

Family life today suffers many problems. Ten million children are reared in one-parent families. Many are raised in families where step parents are present, largely because of earlier divorces and remarriages. One-fourth of our young people marry before 20, thereby greatly increasing the risk of later breakdown. All family members face the stresses of our modern, automated, and depersonalized society. One-fourth of all families live near poverty, with an income of about $5,000 per year. About one-fifth of the nation's families move each year. Mobility is high, particularly among young, nonwhite, and low income families. In times of crisis, there are few services that aid our highly mobile, isolated, and fragmented families.

What about education? Have we hit the mark of that "proper generation" sought by the 1930 White House conference? Education has inflicted the "sputnik syndrome." After the awesome experience of man in space, society decreed everyone needed a college education. This is absurd! Only one in five jobs open in the next five years will require a college degree. Yet four of five high school students are studying a precollege curriculum. One obvious result is the high dropout rate: seven percent in Texas, or 59,000 high school students per year.

Another statistic shows the annual cost of vandalism to schools totals almost $600 million, an amount equal to the cost of textbooks in recent years. The hickory stick is gone, but the use of suspension in public schools has reached mammoth proportions. Figures also show that in a recent school year, school districts with a little over one-half of the student population in this country suspended more than one million children. These suspensions represented a loss of more than four million school days and 22,000 school years.

We also see an unprecedented number of teachers showing signs of battle fatigue, the same stress soldiers suffer in war. Only two out of five persons continue teaching after five years. There also were 75,000 assaults on teachers by students in 1975. These assaults range from a slap on the face, being stabbed with ice picks, or being shot in the classroom with a Saturday night special. This semester, a college coed completing her student teaching in a public school in East Texas was asked for sexual favors by a fifth grader. Dreadful commentary, isn't it?

Yet suspension of students is self-defeating. Instead of improving the situation, it removes students from facilities where they should be learning. This usually destines them to slums, poverty, possible early parenthood, and, in Texas, an almost assured acquaintance with the Department of Corrections. Ninety percent of this state's prison population is comprised of school dropouts. Seventy-five percent come from broken homes, and most have been in juvenile trouble or county jails. Many fail while assigned to probation, and all this occurs before the person is sentenced finally to prison.

Having recited the book of lamentations on child concerns, I must draw some conclusions: (1) the home failed; (2) church, community, and civil groups failed; and, (3) public education failed. Therefore, federal and state governments find themselves assuming responsibility for child care. Faced with this responsibility, government needs more research into the causes and effects of child abuse, and information on how to provide care for those requiring it. The needs of our children must be determined, and commitments made to meet those needs. Unfortunately, this is not happening. The public simply fails to show a concern about child abuse and neglect even though it nears epidemic proportions.

I again return to our program statement which claims child abuse and neglect is not a preeminent concern at the highest levels of government. If we are to effectively cope with child maltreatment, we must change people's attitudes. There must be more than healing and mending—there must be prevention.

Most of all, however, there must be grass roots support for ending mistreatment of children. Only this kind of leverage will change the mind of one Texas legislator who believes children are the property of their parents who can do to them whatever they want. Something must bring realism to other Texas legislators who deny child abuse and neglect exists in their districts. While in Austin, perhaps they should visit the city hospital and see an abused child. The Legislature also must create laws that penalize abusing parents more than abusers of pets, or smokers of pot.

Something must change public attitudes that resist even minimum standards of care offered by child care facilities. Somebody should explain why the Department of Public Welfare is authorized state funds by the Legislature to support an annual $234 million nursing home program for 56,000 people whose lives are largely behind them, while granting only $30 million a year for child abuse protection. Or, why does the department pay as little as $4 a day to protect a child in a foster home, but grants as much as $38 a day for a mentally retarded person in an institution? It costs about as much to board a dog in a kennel as is paid foster parents to care for children.

The public needs to know that malnutrition and illiteracy are widespread in Texas, the state containing more poor people than any other. Not much is done about it. Somebody should ask why medical residents in teaching hospitals see so much child abuse, yet receive no training in prevention or education.

Why does no one complain about the failure of our juvenile criminal justice system, a system that affects children too late? By age 15, behavior patterns are often difficult or impossible to change, and many of these patterns result from early parental abuse or neglect.

Juvenile judges should involve themselves in all matters concerning children, especially those involving parental abuse. The abused and neglected child, we must remember, becomes the juvenile delinquent, the prostitute, the alcoholic, the drug abuser, and, most ironically, the child abuser of the future.

We should ask the broadcast industry why it endures continuing criticism about program violence, yet refuses to use public service slides that increase awareness of the extent of sexual abuse of children.

In short, public and government leaders see the potholes in the road caused by winter ice, but not the potholes of indifference that deprive children of education and parental care. We have let our children down. We have not done enough to prevent child abuse, and it is doubtful if even a fraction of the excesses that occur are reported. Some officials estimate we find as few as six percent of all child abuse cases.

I am convinced every parent is capable of violence. I am also convinced society causes us to treat children as less than human. If a man hits his wife, he is a wife beater. If he spanks his kid, he is a good disciplinarian. The trouble is that some people cannot stop with a couple of swats on the fanny.

For more than five million American children, parental punishment at home has meant being shot, stabbed, kicked, beaten, burned, and bitten. While often parents express concern about violence on television, many of them should worry, instead, about how violence in the home affects their children.

We do not concern ourselves with child abuse until a child dies. This happened in 1973 in a Texas child care facility. The uproar was instant, and the highest elected officials of Texas made inspections of the facility. They and the legislature demanded safeguards to prevent a recurrence. So the Texas Department of Public Welfare spent thousands of man-hours compiling guidelines designed to safeguard children from institutional abuse or neglect. In all, 14 recommendations were presented. Today, four years later, two of the recommendations have been adopted.

Meanwhile, the department pushes ahead with its child protective services designed to aid troubled families, protect children, and help parents to cope and love better. The department's child abuse hotline plays an important role in the identification and prevention of abuse and neglect in Texas. Operators on duty 24 hours a day, seven days a week, receive an average of 600 calls per month. Approximately 37 percent of these are related directly to abuse or neglect. Ten percent concern emergency or life threatening situations.

The Texas Legislature did make failure to report suspected child abuse or neglect a criminal offense. It also has helped uncover child mistreatment, but we feel the number of reports has peaked, and that we now receive as many as we are likely to get.

The department has other effective programs combatting the mistreatment of children. We are working with the Councils of Government to coordinate services to children. We have a program aimed at preventing child abuse in military families where unusual stresses prevail. We work with Parents Anonymous, the police, and medical communities in identifying abusers. We attempt to use medical schools and law schools as educational vehicles for recognizing and coping with child abuse. We co-sponsor family counseling centers with the National Council of Jewish Women. We contracted the Baylor Medical School of Houston to prepare video tapes on parenting for presentation in junior high schools, recognizing that more than 40 percent of children born out of wedlock have mothers age 18 or under. Many are 13 and 14, and some 14-year-old mothers are having their second babies.

We recognize a new concern in Washington for the abused child. Under Title IV-B of the Social Security Act of 1935, Congress was authorized to spend $266 million per year on child welfare services. They have been spending about $50 million, but a study is now underway to expand this amount. The Title XX amendment to the Social Security Act appropriates funds to help remedy child abuse and neglect. The foster care program is being scrutinized and may be improved. Let us hope so.

Parents and children have reciprocal rights that go back to the Bible. It is our job to find the least damaging way of preserving the family unit. But regardless of economic and cultural conditions, the child born in Texas is likely to have parents who had minimal opportunities to learn about parenting. They learn as the child grows. Little is done to help men and women be e better fathers and mothers.

There is a juvenile court building on which these words are engraved, words on which we should reflect: "Through the guiding light of wisdom and understanding shall the family endure and the children grow strong in the security of the home, for they are the hope of the future."

The Psychosocial Ecology of Child Abuse and Neglect*

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Washington, D.C.

My purpose today is to share with you, as one important aspect of our field, the National Center on Child Abuse and Neglect's planning framework and our future direction. As many of you know, when the National Center was established in 1973 it authorized a series of grants in the areas of research, demonstration treatment, demonstration resource, and a series of contract activities. Basically, we initiated a single wave of new activities, and in the past three years we have not awarded any new, major contracts. We are now in a one to two year process of digesting all the new ideas, findings, and impressions generated by both our grantees and the other field agencies we have funded. As we organize what we learn, we see the need for a policy or planning framework. We need to pigeonhole our findings about parental self-help, counseling, and prevention. We find that communication and understanding in the field suffered because people used the same words to talk about different things and different words to talk about the same things. What I am going to do today is describe our tentative—and it is tentative—sense of what concepts you hold about child abuse and neglect, prevention, and treatment. We have tried to reflect what we see developing from the field, and I think that after I am finished talking it will make sense to you. As I reveiwed what I have heard in the last three days here, many, if not all, of the contents of the plenary sessions and the workshops fit within the concepts I am going to describe and the relationships I will outline.

NCCAN FUNCTIONS

HELP GENERATE KNOWLEDGE/
HELP OTHERS APPLY KNOWLEDGE

- Research
- Demonstration Projects
- Evaluation

HELP OTHERS APPLY KNOWLEDGE

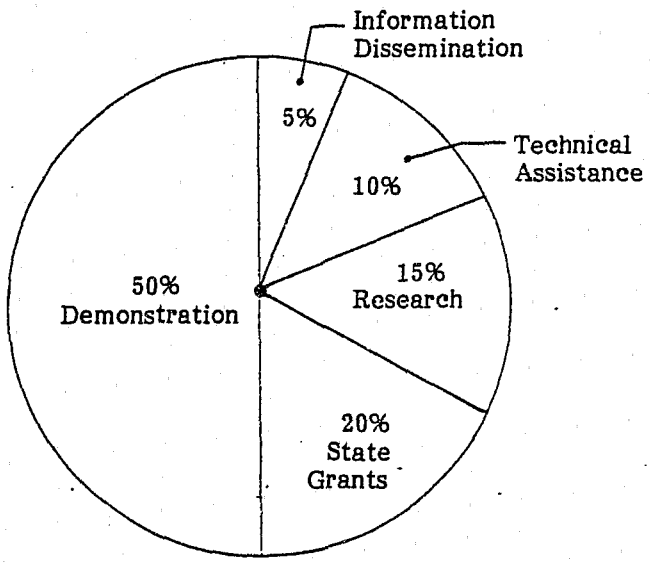
- Advocacy
- Information Dissemination and Referral
- Training
- Technical Assistance
- State Grants
- Federal Coordination

*Informal remarks

I want to start by describing the role of the National Center. We are a small federal program. We have limited ability, in terms of staff time and finances. Our yearly appropriation is $18.9 million. Title XX of the Social Security Act, which funds the bulk of local and state child protective activities, appropriates about $200-250 million a year for these activities, and there are many other specific and nonspecific federal programs that pay the salaries for you and your colleagues. I cannot say, "We at the National Center are in charge of improving the system." All we try to do is help—help you and help others. We try to do this in two broad areas of activities. We try to generate new knowledge about effective treatment and preventive techniques, and because we are not in a direct service role, we try to help others use that knowledge. In helping generate new knowledge, we fund the implementation and evaluation of various research demonstration projects. With permission from and the cooperation of public child protection agencies, we are also considering funding the evaluation of various public service programs in order to learn their strengths, their weaknesses, and what makes them work. In helping others apply knowledge, we serve as an advocate, an information disseminator, and provide training, technical assistance, some state grants, and federal coordination.

I want to share with you the percentage of our budget we devote to these activities. Budget guidelines were established by the same legislation that created the National Center. Each year we spend 50 percent of our budget on demonstration projects, treatment projects, resource projects, demonstration training programs, and state agencies. That percentage was established by Public Law 93-247. Each year we allocate 20 percent of our budget to state grants. We have not used all of this amount, however, because the number of states eligible for grants has not been that high until this year. Thirty states are now eligible, and we expect about forty by the end of this fiscal year. We actually spend about 12-15 percent of our budget for state grants. Regional branches of the Office for Child Development (OCD) transmit appropriations from our office to various field agencies. In each region we have at least one regional child abuse and neglect specialist within the OCD. We disseminate publications, operate the Clearinghouse, and accomplish other dissemination activities.

NCCAN BUDGET



In speaking of our approach to child abuse and neglect, I need to define that phrase. First, let me propose what we think we see and what we think happens. I think we agree that child abuse is merely a statement of what point on a continuum of parent-child interactions we place that line dividing "abuse" and "nonabuse." In other words, depending on their point of view, their cultural orientation, their values, and their sense of history and community, different people define different amounts of corporal punishment as child abuse. Some say any form of corporal punishment is abusive. Others claim child abuse occurs only when there has been a serious and

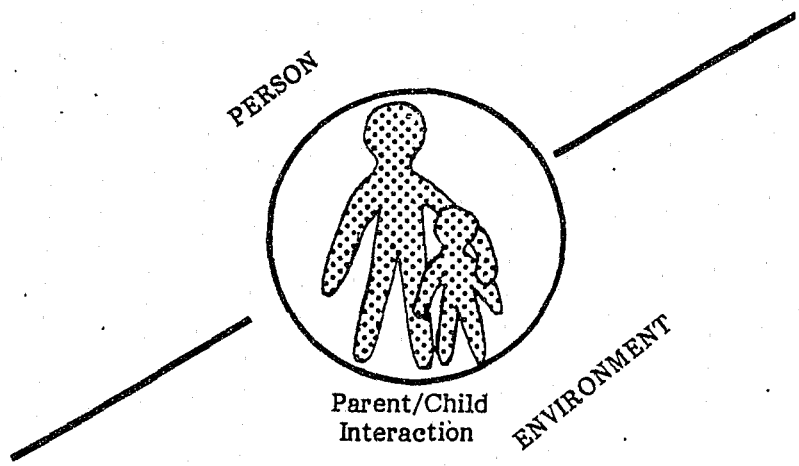
permanent disfigurement. The same principle applies in terms of emotional abuse. Some argue that any deprivation of needed love and care is emotionally abusive. Others say only serious and permanent actions are abusive, and so forth. It is clear, therefore, that when we talk about child abuse and neglect we are trying to define what point on the continuum of parent-child interactions justifies society's intervention. We also find, and can demonstrate with statistics, that there is also a gray area. This is an area in which people disagree. At one end of the continuum almost all would agree a child is not abused. At the other end we would all say that a brutally attacked or murdered child has definitely suffered abuse. It is in the middle of the continuum that we disagree. As a result of our research, we now have some very clear statistical documentation as to how one's profession helps to determine the way a person views this gray area. A policeman, a physician, and a social worker may all hold different views. These attitudes may be determined by a persons' cultural values, racial prejudice, the views one holds toward people who preceded him, past life experiences, and a host of other issues. What we are saying is that no clear line exists which everyone would agree represents the demarcation point between what is and is not child abuse. With this in mind let me add that to think only in terms of one continuum and one gray area is to take only a snapshot in time. People and behaviors change over time. Someone who is at one point on the continuum, or in one family at a given time, may move to another point a week, month, or year later. This may be due to treatment, a new job, or any one of several other factors. What we are saying is that the concept of child abuse and neglect as a static condition may be true when applied to specific families. Other families, however, and we are gathering statistical evidence on this through the demonstration and research projects we have funded, move back and forth in their ability to cope, protect, and care for children. If this is true, then there are some interesting concepts that we must apply to ongoing research and treatment. When researching, we tend to look at a family at one point on the continuum, then look at it at another point, and assume that the passage of time from one point to another implies that the family progressed in a straight line. We tend to forget the clinical wisdom that a family experiences a lot of ups and downs in this process. We may well be correct when we assume that the ongoing service program is responsible for moving the family forward, but how do we explain the other ups and downs?

There is no one single set of parent-child interactions. In other words, to say that there is only one single unitary improper or antisocial behavior called child abuse and neglect is to grossly oversimplify a very complex set of differing behaviors. We can no more talk about child abuse and child neglect as unitary functions than we can talk about kidney ailments as one type of problem. The treatment depends on the kidney ailment. The type of treatment for different kinds of criminal behavior depends upon the kind of behavior we are discussing. We deal with murders differently than with pickpockets or burglars because we make a statement, an assumption, about the forces at work, and about the most effective treatment and intervention for these situations. The same is true about child abuse. Remembering that all this is tentative, let me suggest one way that we are trying to delineate these differences. From the experience of our project, we hope to give you some names to these lines within the next year. But for now, let me suggest some possible names for these differences. One can be called the "battered child syndrome." This concept concerns not only injury to a child, but also the factors of intent, personal problems, and time. In other words, think about the richness of the notion of "syndrome" and "the battered child syndrome." This syndrome does not apply to just one day. It means that over a period of time the family's behavior has been such that the child has been injured repeatedly. Another syndrome can be called "sexual interaction," or maybe we will separate it and deal with one called "sexual misuse" (a concept growing in attention), and another, "incest." And maybe we will deal with one called "unreasonable corporal punishment," and say that the dynamics of this concept differ from those of "unprovoked physical attacks," because we see in our research projects different kinds of people in these different categories. A person who wantonly picks up an infant and throws him against the wall for no particular reason is extremely different from someone who abuses an adolescent for disobedience. We must bring out the differences between the two.

I will now discuss the factors that result in child abuse and neglect, and those that help prevent it. First, we say nothing new when we claim there are certain psychological and social forces that influence the family. In fact, we feel strongly enough about the interaction of these forces in relation to the family and its environment to use the term "psychosocial ecology" to describe the environment in which the family finds itself. We also say that parent-child interactions are a function of person, or personality, of the individuals involved, and the environment in which they exist. Then we add a formula many of you know, it is a truism, and

one we ought to say and remember and apply to our treatment, our interventions or prevention, and our concepts of our place in society. The formula states that behavior is a function of the person and the person's environment, and is written B = f(P, E).

PSYCHO-SOCIAL ECOLOGY OF
CHILD ABUSE AND NEGLECT



Behavior is a Function of Person and Environment

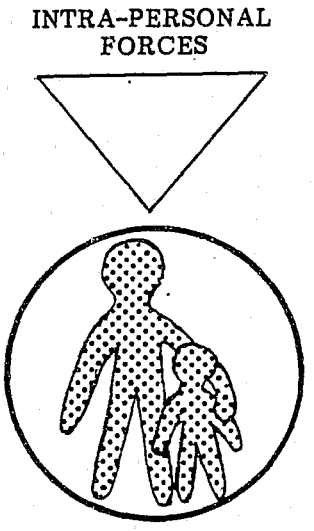
$B = F(p,e)$

Let me describe how we define those personal and environmental factors, to categorize them so that we can then share our understandings about them. The first is intrapersonal forces. Some people do not like the term "intrapersonal." I hope, however, in coming years we will use words everyone can understand and accept. Nevertheless, we are saying there exists a set of forces that influence the family. Intrapersonal forces act within a person, and they involve the mental and physical health, education, intelligence, and past life experiences of the individual. Now, let me deal with past life experience. We talk a lot about failure, improper bonding, or being abused as a child. That becomes relevant in terms of later behavior, if it has been internalized or incorporated within the individual. We call that history: the history about the individuals and the family, or past life experience.

We also recognize that the internal things are not the only things that make people tick, so we divide environment into three sections. One section, and maybe we are not happy with the term, is specific life situation forces. Where do people find themselves today, this week, this month? Where do they live, what do they do? We label these forces, but this is not a complete list. That is why we perform research and demonstrations. We try to fill these lists, and we try to read the literature and get more information about what would go on the list. Marital situation, job situation, extended family, characteristics of the child, housing, financial status, and degree of contact or isolation with others are just a few.

It is appropriate for me to make a point here. I have tried very hard not to talk in terms of stresses, not to talk in terms of negative forces, because if our view makes sense it is appropriate to think of these forces as both positive and negative. A happy and gratifying job situation, should, we hypothesize, make it easier for people to function in family situations, as well as others. If you have money in your pocket you are not supposed to experience financial stress. Being broke is probably a negative stress, but having some money "ought" to be positive (There are those of us, however, who do not always feel that way). So we are talking about positives as well as negatives.

INTRA-PERSONAL FORCES

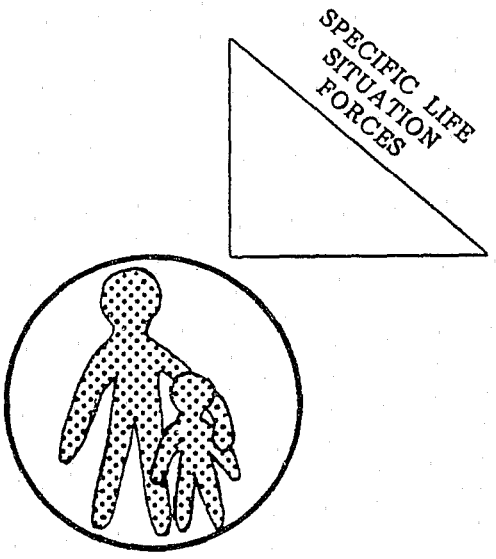


Parent/Child
Interaction

- Mental Health
- Physical Health
- Education
- Intelligence
- Past Life Experience

We also make a distinction here between chronic and acute, because some of the forces acting on individuals have been with them for years, or lifetimes. Others are immediate, and in the future, not only do we want to look at the difference between chronic and immediate, but we want to see their different effects. We have talked about family crisis but we have never, in a systematic way, explored the implications of how we deal specifically with crisis vs. chronic situations. That is not to say people have not worked on it, or that in clinical practice we do not deal with it everyday, but remember we are an "R and D" shop, and we like to do a little research and demonstration.

SPECIFIC LIFE SITUATION FORCES



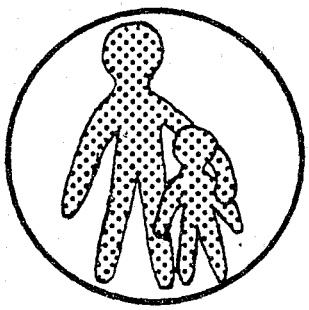
Parent/Child
Interaction

CHRONIC/ACUTE

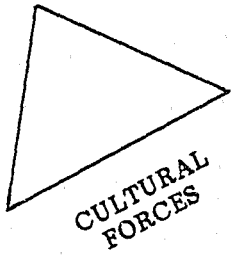
- Marital Situation
- Job Situation
- Extended Family Situation
- Characteristics of Child (REN)
- Housing Situation
- Financial Situation
- Degree of Contact/Isolation with Others

Again, although obvious, we think it is worth stating and making an equal part of this equation that cultural forces shape the way we live and behave. Cultural forces shape the way we drive our cars, the way we function in our jobs, and the way we raise our children. There is no doubt that attitudes toward children have a real relationship to whether they are abused or neglected. To what degree are children prized commodities? To what extent are they valued as individuals in a society? Has child care any prestige in a society that increasingly questions the validity of staying home all day, that defines staying home as not having a career, not "working"? That attitude must create tension in those women who want to stay home and do, or don't want to, and do anyway. Attitudes towards violence, corporal punishment, economic or social competition, mobility of families, racism, religion—all these societal forces influence the way we live and act.

CULTURAL FORCES



Parent/Child Interaction



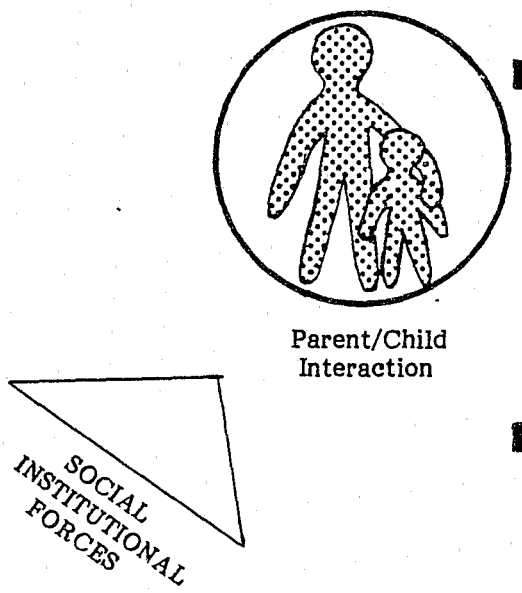
- Attitudes Toward Children
- Prestige of Child Care
- Changing Family Roles
- Attitudes Toward Violence
- Attitudes Toward Corporal Punishment of Children
- Economic and Social Competition
- Mobility
- Racism
- Religion

The last set of forces we will categorize—again, we are not trying to discover but just categorize these forces—is what we call, for now, social institutional forces. The purists among us wanted to call them institutional forces, but the communicators thought institutional forces would cause people to think about buildings and prisons. We are talking, instead, about the institutions of society, and let me start with the most general of them—the community institutions, or community-wide institutions. Each of them, and we have only a partial list, shapes the way we live by the way we interact with them, by the way they shape our immediate or specific life situation, and by the way they shape our cultural values, mores, and attitudes. The media offer an excellent example. We also include the family, police, schools, and day care as community institutions that shape the way we think and live.

We also want to describe other separate social institutions that we call problem-oriented agencies. These are the agencies that provide, as Dr. Kempe said, services for people or families

with special needs: mental health, self-help groups, foster care, job counseling, and any kind of specialized helping services. We also list another section called child-protective agencies. Our classification is functional, so police, for example, would show up twice, once under child-protective and once under community institutions. If the police receive reports and investigate them in order to provide immediate protection to children, we call them, for the purpose of this model, a child-protective agency. If police perform only their general duties such as patrolling and traffic direction they function as community institutions.

SOCIAL INSTITUTIONAL FORCES



CHILD PROTECTIVE AGENCIES

- CPS
- Police
- Courts

PROBLEM ORIENTED AGENCIES

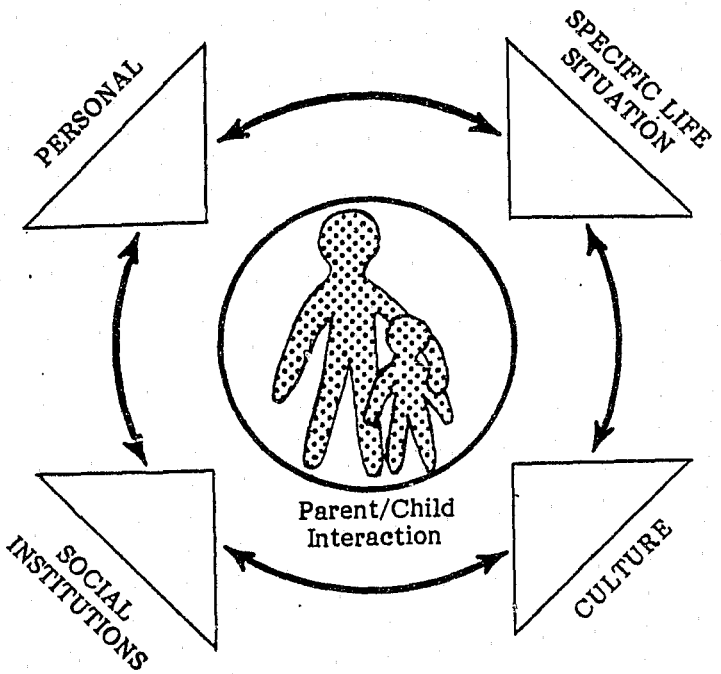
- Mental Health
- Self-Help Groups
- Foster Care
- Drug/Alcohol Programs
- Job Counseling/Training
- Therapeutic Day Care
- Special Education for Children
- Public Assistance
- Unemployment Benefits
- Various Helping Professions

COMMUNITY INSTITUTIONS

- Schools
- Day Care
- Police
- Fire Department
- Family
- Recreational Facilities
- Church
- Community (Block Associations, etc.)
- Business
- Social/Fraternal Organizations
- Media (Television)

Overall, we divide person and environment into four categories: personal forces that influence a family, specific life and situation forces, cultural forces, and social institutions. These forces can push down and detract from the ability of a family to care for its own. But just as important, they can push up. My wife is a social worker and after reading her social work and psychoanalytic literature I see that we deal not only with negatives, but also with the positives. This is the most promising thing about our jobs, the uplift.

These forces not only interact directly with the family, but they also interact with each other and then with the family, and then back and forth again. The point is that they are interdependent variables. It means you cannot say that one particular factor leads to one particular behavior. Even if we know everything about an individual and then offer him a vanilla ice cream cone and a chocolate ice cream cone we still cannot predict which ice cream cone he will take. I cannot promise you that in four years we will sort out all these factors for you and explain why each parent neglects or abuses his children. But we will try to identify these factors, discover new ones, and explore their interactions and relationships, because we as researchers and as practitioners think a few ideas can help go a long way.



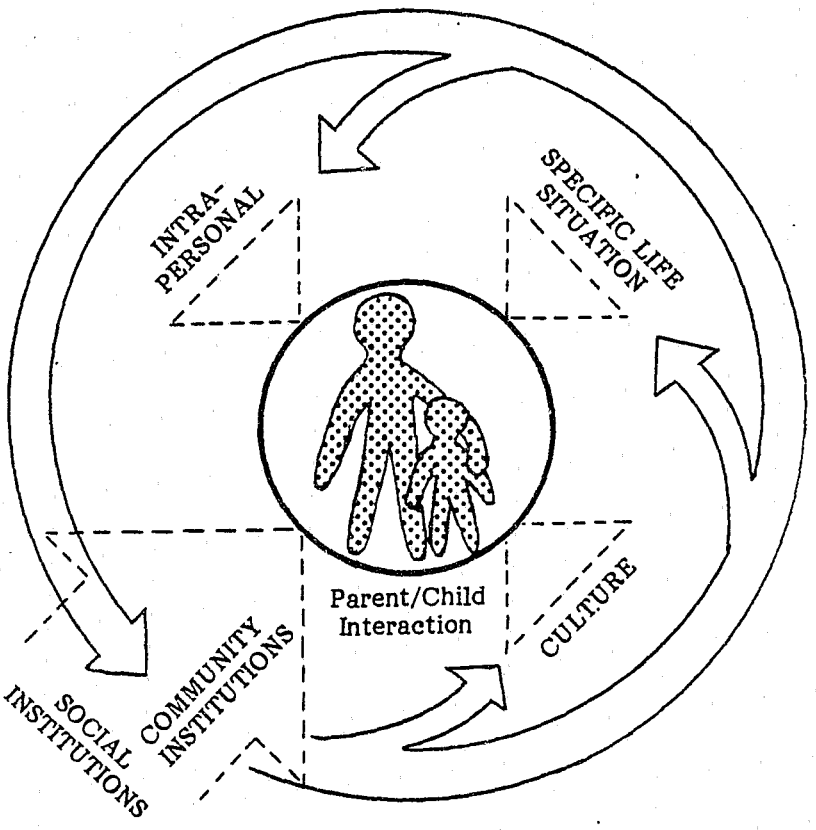
We also have a theory on how we can do something about this problem (here is where I am most concerned about what I am going to say. If you disagree, write me a letter.) Of all these forces, we can directly intervene in only one category—social institutions. We cannot get inside the personal life, the psyche, the specific life situation of people, or the culture. The only way we can deal with these factors is through social institutions. Whether those social institutions are schools, communities, the family, or specific helping organizations such as day care and child protective services, we operate through institutions in our society. Even when we want to shape values and norms we do it through the institutions of television, radio, and newspapers. We say, for the purposes of this construct at least, that change agents work through institutions. We know, and better remember, that we are change agents. Sometimes we do not change things for the better, and sometimes we hurt people by trying to help. That is of deep concern to us at the National Center—it is great to want to help people, but as we look at our programs we never assume a program helps people. We look at it and try, to the best of our limited ability, to measure its effect. Does it have a positive or negative effect on people? I will talk about that in a moment.

I will use the words "primary prevention", "secondary prevention", and "treatment". Let me propose definitions of these terms, ones that combine social work ideas and the concepts that I just mentioned. Let us start with a definition of "primary prevention", something we all want to accomplish. Primary prevention deals with those cultural and institutional forces which affect the specific life situation and intrapersonal forces within all individuals in the community. Primary prevention is not targeted at specific (high-risk) subgroups; it is for everyone. We all need a little primary prevention.

Secondary prevention deals with those institutional, specific life situation, and intrapersonal forces within families with special needs who might, but for these services, abuse or neglect their children. And treatment, which is sometimes called tertiary prevention (meaning preventing a recurrence), deals with those institutional, specific life situation, and intrapersonal forces within families who have abused or neglected their children, and attempts to prevent recurrences of the abuse. We say social institutions do all this, but we could be wrong. We say that social institutions, by affecting culture, lifestyles, beliefs, specific life situations, intrapersonal situations and forces, and by interacting with themselves, can perform primary prevention. Let me take a few minutes to describe how some projects, only a few of which we fund, do all this. I will give a specific example for each.

In terms of primary prevention, a number of our projects serve special populations whose cultural heritage, history, attitudes, and mores differ from the majority culture. Especially within the treatment demonstrations that we have funded for Indian populations, we see a very clear desire to emphasize those elements of cultural heritage that strengthen individuals. We refer to them as treatment projects, but their major focus is primary prevention. In Alaska, for example, they take all the Native American families that come into town, not just the "high risk," and provide them with the cultural supports they need at a time of stress and dissonance. They emphasize cultural strengths through pot luck dinners, pow wows and a whole series of events that say, "Look, we've got ourselves a legitimate culture here. Let's not be ashamed of it. Let's emphasize it. Let's grow within it." They do not have to have an intake or a caseload. We call that primary prevention, and that is why we fund it.

DYNAMICS OF PRIMARY PREVENTION

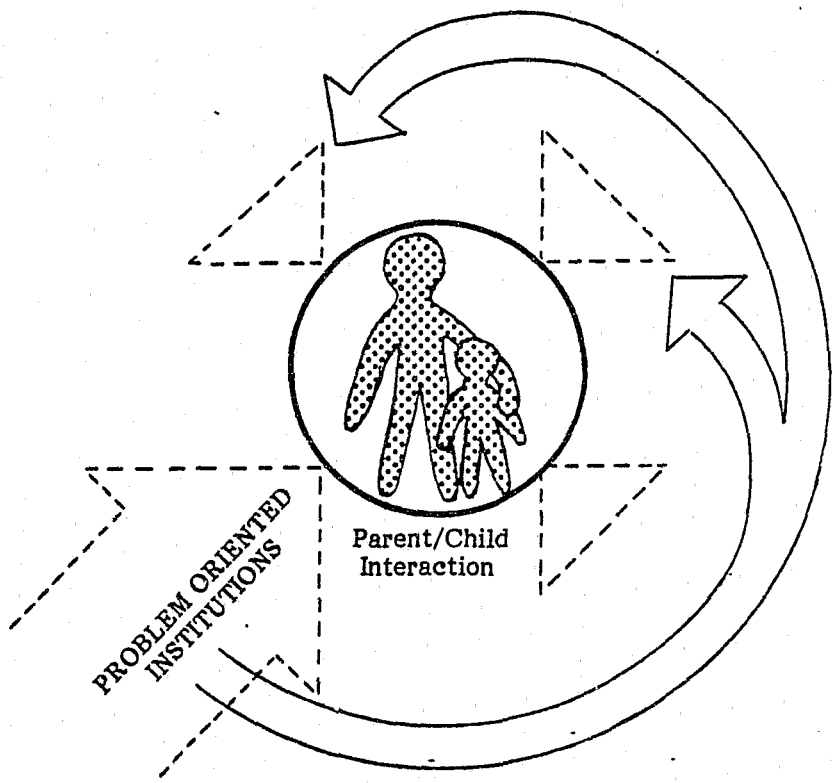


We are learning a lot, and not just about Indians. We are learning a lot about the notion of supporting families who experience dissonance with their culture. I mentioned our Alaskan project, but I could also relate this notion to middle-class life in the suburbs. Our Alaskan project welcomes every newcomer to town in much the same-way those of us living in the suburbs receive a "welcome wagon." The project says, "Welcome to the community. What can we do to help you?" Since it is offered to everyone we call it primary prevention. It is difficult to give examples of primary prevention because a lot of it is not labeled "child abuse programs," and much of it does not happen. But there is no question that programs which, for example, emphasize the nutritional needs of children and adults—programs which ensure children and adults of a square meal—have a lot to do with the intrapersonal forces that shape our lives. Also, institutions can work with institutions to make other institutions positive forces in terms of care and protection of children. So researchers and theoreticians, for example, work with hospitals and labor and delivery room staffs to make childbirth a special experience. If we forget these few special moments, what do we do during that lifetime of stress? That is the time to start the bonding process. That is another form of primary prevention.

Let us talk about the dynamics of secondary prevention. When we talk about secondary prevention we do not hit culture. We are talking about specific interventions with specific families in relation to specific life situation forces. Earlier, we identified parental stress. Parents Anonymous or the San Diego YMCA Project, for example, both in different ways, emphasize the importance of self-recognition of parental stresses and of seeking self-help. These two, and half a dozen other projects, some of which we fund, run parental hot lines, stress lines, and bring people into a nonthreatening, non-child abuse atmosphere to deal with that underlying force—parental stress. In San Diego we have found that many problems stem from marital stress, and by dealing with that problem practitioners help relieve the pressures on the parent-child interaction.

I want to mention another response of problem-oriented institutions for secondary prevention, interpersonal forces. Many projects identify families where there exists a high risk of child abuse or neglect. Special care, in the form of attention, education, a visiting nurse, or perhaps Dr. Kempe's "home visitor," is given to the family in the hospital, newborn clinic, or at home. This care is offered the family if it is believed they will have particular problems in dealing with the child. This is another example of what we call secondary prevention.

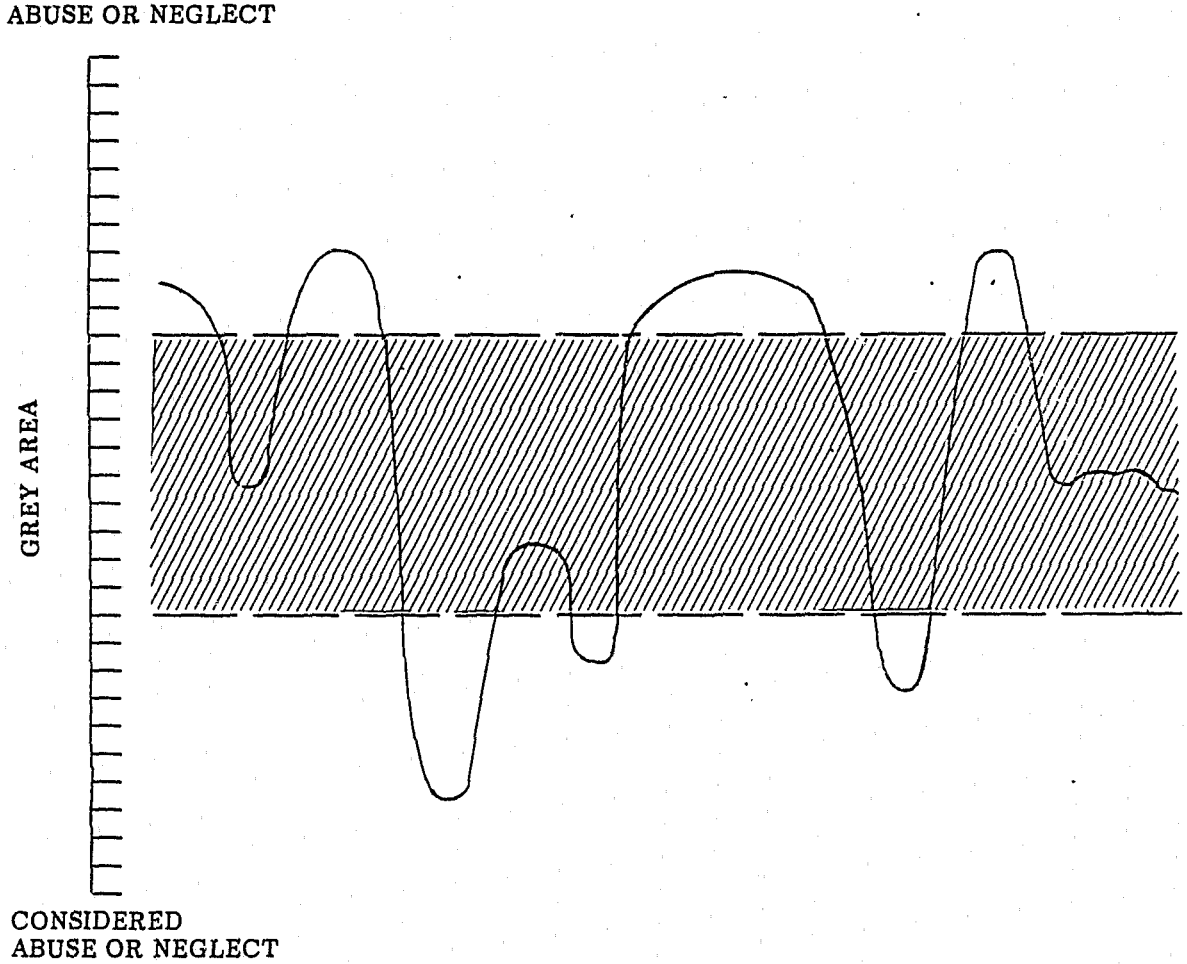
DYNAMICS OF SECONDARY PREVENTION



In treatment, we find the same general situation. You do not treat a family by fighting its culture. You can fight the culture—that may at times be a valid thing to do—but we do not think that is going to help the particular family in question. What do you do with the family in front of you? You begin by trying to deal with their immediate life situation and with their interpersonal forces. Let me cite two examples. We all know homemaker care is a nice servide to provide families. But what kind of homemaker care, how elaborate, how well-trained should the homemaker be? What kinds of supports should there be? Should these supports entail merely cleaning the house? Should they be emotional supports? Should they be cultural supports? Should they deal with racial issues in communities suffering from racial discrimination and

isolation? We are looking at this issue in a couple of our projects. This means adding a person to a specific situation. We are also considering pulling people out of their environment. An example of this is our program in Hawaii which has a special shelter in which the entire family—minus the father (who usually precipitated the problem)—can live during times of personal stress. We are radically altering the specific life situation. In future years we hope to determine the meaning of this: Is it valuable? Does it work?

DEFINITION OF
CHILD ABUSE AND NEGLECT



Let me now share with you the most tentative aspect of what we are learning from our treatment projects. We think it is dreadfully important and significant, but let me present it to you as something to discuss and consider in coming years. If you remember the continuum we spoke of earlier and the gray area in which we tend to disagree about what is or is not abuse and neglect, let us now attempt to define what is secondary prevention and what is treatment. Now remember the difference: treatment occurs when parents have already abused or neglected their children, and secondary prevention occurs prior to abuse and neglect. The theoretical construct would be that above the gray area is secondary prevention, and below it is treatment. But notice that since the position of this gray line depends on how you define child abuse, if you redefine

some action and this line shifts, you have re-labeled the service without ever having changed the family. In other words, if a cop thinks a kid is being abused, then when you serve the family you are treating them. But if a physician says, "No, that's not abuse; that's close to it but the real line is over here," then suddenly that service you provided the family is labeled secondary prevention.

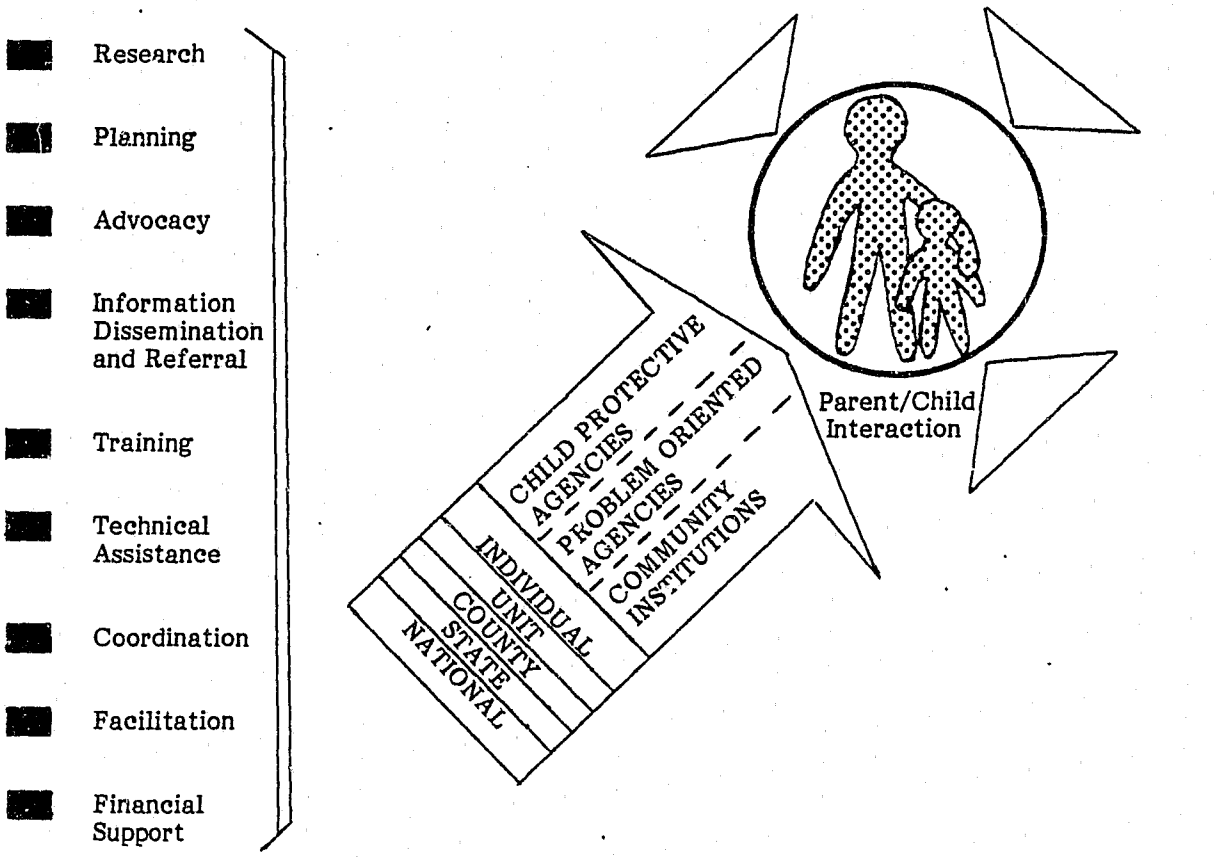
The label placed on the service depends on the label placed on the family. I think that the fact that we do this is significant. Does the service itself differ for the families above the line and below the line? We know it seldom does. We provide services to families whether or not the parents abuse and neglect their children. We either give them homemaker care or advise them of their need for it. We offer them job counseling and housing services. We give them personal counseling services because they have a problem.

Let us look at this from a slightly different perspective. Remember, we said families change over time; therefore, one month a family may be in secondary prevention and the next month it may be in treatment. What I am suggesting is that if there is a lesson be be learned from the treatment demonstrations that were funded both before and after PL 93-247, it is that helping projects that are not constrained by income eligibility requirements, that are not concerned about reporting law requirements, tend not to make a distinction in the cases they see between actual and potential abusive and neglectful families. They tend to treat families in need as just that—families in need. But, there are always exceptions. We do not know how extensive the exceptions are, but that is one reason we evaluate the demonstration projects and do research. It is also very clear that there exists a set of families, and I shun to term them "hard core," but do not know how to describe them, nor how to characterize them. We do not know how many there are, but there is a set of families whose parent-child interaction curve is such that we cannot place them into the other broader service category. And those are the families that must be serviced five to ten years, perhaps permanently, and given a permanent crutch. We want to look at programs around the country and see real progress in the development, maintenance, and strengthening of secondary prevention and treatment programs when they deal with these general social problems, because they have a source of funding. There are day care funds, mental health funds, and others. But there is no categorical federal program that will support, over a ten year period, a family with a permanent disabling problem. We do not know the significance of this except that those are the cases you hate to let go, the ones that remain in agencies for years and years. Those are the cases that, unless we do something, consign those children to the constant risk of abuse and neglect.

Problem-oriented agencies and several community institutions are responsible for the identification of child abuse and neglect. In terms of secondary prevention and treatment, we know that problem-oriented agencies, child-protective services, and some community institutions can perform secondary prevention and treatment.

In terms of intervention and referral, we must remember that some cases of child abuse and neglect, as well as other forms of improper parenting, are not referred to child-protective agencies but to other special treatment programs in the community. We say for the purposes of this construct that intervention and referral occurs not only in child-protective agencies but also in problem-oriented agencies.

Until now I have talked about the dynamics of direct services or treatment in families and children. The other half of our job involves trying to improve these services, and when I say "we" I do not mean just the National Center, I mean all of us. For our purposes we call that process "resource enhancement." You can call it advocacy, coordination, or planning, but we call it resource enhancement because we are hoping to include those other specific activities within it. In terms of the institutions that can affect the other forces, there are the same three: community institutions, problem-oriented agencies, and child-protective services. There are several key activities or elements within each. There are individuals, units, county organizations, and sometimes a state or a national element. And we can also list activities that enhance resources: research, planning, advocacy, information dissemination, referral, training, technical assistance, coordination, facilitation, and financial support. Not only is that a statement of what we believe the role and mission of the National Center are, it is also the role and mission of most of the regional and state resource projects that we fund. It is also the role and function of many child advocacy groups in this country, and in part, the role and function of many treatment organizations. The best example is the National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver, which is both a treatment organization and a resource project. Other appropriate examples are the special training, technical assistance, and services provided by child protective services agencies, by our treatment demonstrations, by



anyone in treatment who is called upon to give a community lecture, or someone who is invited to a hospital to explain the handling of child abuse cases.

Let me give some examples of what our projects are doing in relation to specific client agencies, and the levels within the agencies and these activities. For example, one resource project decided its activities could be better used to strenghten problem-oriented agencies, which will help prevent cases from being reported, than to improve child-protective agencies. So they, through technical assistance and coordination at the state and county levels, help problem-oriented agencies accept more cases before they are labeled child abuse and neglect, and urge agencies to work with more families before referring them to child-protective agencies. Another resource project provides training to the whole range of individuals across these situations. The stated purpose of training is to teach individuals how to better identify child abuse and neglect, to be aware of the problem, and to be sensitive to the needs of parents. The other unstated, but equally effective, purpose is to develop coalitions of conerned professionals and citizens across the nation so that these coalitions can advocate for improved and expanded services.

To conclude, I wanted to present a specific list of the projects and grants, contracts, and other efforts that we plan to initiate in the future. But there are three reasons why I cannot do that. First, we do not know under what legislation we will operate. Second, we have not fully digested the information from our existing projects; that will take another year or year and one-half. And third, since we will not start funding until next March, April, May, June, or July, we are not ready to start planning. However, I want to share with you some of the underlying concerns of the National Center, and I think you can assume that our funding and activities will follow these concerns.

- Psycho-Social Ecology of CA/N
- Nature, Extent, and Effects of CA/N
- Dynamics of Prevention, Identification, & Treatment
  - — Direct Service
  - — Resource Enhancement
- How Best To Apply This Knowledge
- Helping Others Apply This Knowledge

To summarize the points I've made here, let's first consider the nature, extent, and effects of child abuse and neglect. We have said the definition of child abuse and neglect lies on a continuum. We have said there are gray areas. We have said behavior is kinetic. We have said there are different types of abuse and neglect, and I have suggested that we are probably looking at various syndromes: the battered child, the apathy/futility, the maltreatment, and any number of other syndromes. As we look at these different forms of abuse, we will probably perform research and demonstrations to bring out the different manifestations of parent-child interaction. What places one set of parents in one situation, and a second set in another? We will probably try to determine if there is a geographic distribution of these syndromes in terms of incidence. For example, we have an emerging sense that the apathy/futility syndrome may be limited to the southeastern and southwestern United States, and that it is probably a result of the weather in those regions.

In terms of the psychosocial ecology of child abuse and neglect we recognized the truism that behavior is a function of the person and the environment. We also noted that the only way you change that is through social institutions. In the future we will look to research and demonstrations that take into account the psychosocial ecology of the family, trying to understand and manipulate it. We will seek to determine what forms of intervention and institutions are most effective at preventing and treating child abuse and neglect. We will also begin the long process of exploring the interrelationships between these various forces or factors.

In terms of the dynamics of prevention, identification, and treatment, we believe there are definable and identifiable strategies. Based on our experience in treatment demonstrations we have funded during the last four years, we will be able to say these strategies work, or should at least be attempted. We will look at them from a variety of research and demonstration activities. As we identify these institutions' specific strategies—the positive and negative roles and responsibilities they play in society—and as we identify the best methods for applying this knowledge, we hope to shout it from the rooftops. If providing welfare in a demeaning or demoralizing way is a negative force on family life, we want to say it. If school responsibility for teaching parenting is a positive force, which it seems to be, we want to push forward with it. We will do this with all the limited resources at our disposal such as our technical assistance activities and our small, but important, state grant activities. We hope the way we work with other federal agencies will evolve around our understanding of the dynamics of prevention and treatment, the best strategies of prevention and treatment, and the positive and negative roles specific societal institutions can play in that psychosocial ecology.

Let me say that as a field, we have a handle on a fair amount of both research and practical wisdom. During the last three days that wisdom has been expressed in a variety of ways. We hope in the next two years to focus that wisdom's impact in order to facilitate better communication with each other. Only if we share our experiences, our successes, and our failures can we learn from the experience of others. Last year I said that the most striking thing

about our field was the way we seemed to be reinventing the wheel, and a square one at that. Through you, however, we are beginning to develop a framework to focus society's attention on the best methods for the prevention and treatment of child abuse and neglect. To the extend that you develop that framework, and to the extent that we can help you frame it and use it, we will.

Individual Tragedy and Social Response

Michael L. Lauderdale, PhD
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Child abuse or neglect is a tragedy for the victimized child, and the consequences may stay with the individual as an indelible pain throughout a lifetime. Though there is gathering momentum for social action to correct the situation, the phenomenon of child abuse and neglect is so complex that the selection of the appropriate social response is proving to be a frustrating and tortuous process. To understand the tragedy requires a delineation between child abuse and child neglect coupled with the understanding that abuse and neglect vary in severity, frequency, and intensity from incident to incident.

Much of our familiarity with child abuse is physical and consists of seeing children with broken bones, severe cuts, burns, bruises, and abrasions. These battered children are a visible and pathetic manifestation of the tragedy and evoke strong reactions from everyone who encounters the situation. These batterings are often life-threatening and, moreover, can produce serious psychological consequences for the child. These consequences include timidness, withdrawal, aggressive behavior, and other such ill-timed or ill-chosen responses to social situations. Some investigators fear that such experiences in childhood may be replicated by the child when he or she becomes a parent. Such generation-after-generation occurrences suggest for some researchers an epidemic that passes unimpeded from parent to child and enlarges and intensifies with each generation.

Child neglect, like abuse, has its physical and psychological consequences that often are more difficult to diagnose and relate to specific adults. Physical neglect is perhaps most often noted in the "failure-to-thrive" syndrome in which a child fails to maintain the normal development in size, weight, and motor skills relative to his or her age, sex, and racial peers. Psychological neglect may produce retarding consequences for the child intellectually and emotionally, but frequently is not as severe or dramatic in impact as child battering. Though emotional abuse and neglect is seen increasingly as an important concern, its occurrence is often difficult to detect. Little can be said definitively of what kind or degree of emotional mistreatment damages the child, nor in what ways, although we can be reasonably sure that the damage is done. Overly aggressive adults, parents who are cold and punitive, persons who callously manipulate and abuse others may well be the results of this damage.

Much of the complications of understanding the tragedy of abuse and neglect, and knowing what the proper social response is, derives from our lack of definitions of proper care and parenting for the child. We are much closer to good workable definitions in the area of physical care where we can describe safe environments for children, warn against excessively strong physical punishment, and pinpoint neglectful diets and improper hygiene. Adequate emotional care is a much more debatable issue, and involves what must be labeled "catch words" such as genuine love, empathy, permissiveness, firmness, and character-building. What one parent may consider being firm with a child may border on abuse for another, and what one parent may call love and free expression another may call over-permissiveness and indulgence. Pediatricians, educators, and psychologists have vacilated over the last forty years on such issues as whether or not a crying baby should be held, what to do when a child has a temper-tantrum, or if only positive reinforcement should be used to shape a child's behavior. Even the choice of language is debated, with some authorities arguing that the words "shaping a child's behavior" imply manipulation rather than the provision of an environment of freedom, warmth, and support. There are hundreds of books available on how best to raise your child, and there is more than a little disagreement among them on these issues. If the hypothetical middle-class parent or professional is confused by this, then social class and cultural differences make it even more complex. It has been suggested that setting unrealistically high goals, or goals too easily attained, may limit the child's development as well as his or her future ability to succeed in an achievement-oriented world. Should the inclusion of the traditional machismo concept for the Mexican-American boy be viewed as a special instance of neglect producing a man ill-suited for modern marriage? Or is the strict authoritarian model of the single Black mother a subtle form of child abuse? Does television advertising on the Saturday morning cartoons represent exploitation of children? Are American Indian children abused when our educational system

demands that an oral tradition in a native tongue be foresaken for written English and formal mathematics? The lack of clear answers to hundreds of questions like these precludes an appropriate social response to countless potential neglect and abuse situations. The battered child, in a way, presents the easy problem, but the vast majority of cases are less easy to define and prescribe for.

Promoting the cognitive development of the child presents similar problems of defining proper care to be manifested by parents or other caregivers. We do know that critical stimulation as early as the first few weeks of life is crucially important for the development of language, physical, and social concepts. The extent to which parents are able to provide critical stimulation, and do, is an area of some disagreement. Head Start, day-care, television, the pediatrician's waiting room all are additional places where environments could be improved to facilitate the conceptual development of the child. How such environments can support parenting, and what should be the role of each to the other, is not well known.

DEFINING CHILDREN AND CHILDHOOD

The answers to the proper care and parenting of children are embedded within the larger question of the social and psychological definition of the child, and the proper processes of socialization and control of children. There are at least four separate working definitions of what the child is with respect to his or her inherent capability. One definition stresses the view of the child as a small adult capable of doing most things that adults do, limited only by size, strength, and experience, and heir to the same rights and prerogatives of the adult. In some cases such a view might lead to permissive circumstances, and for others it might lead to exploitation such as child labor. A second definition depicts the child as a willful and untamed savage. This view has strong roots in traditional psychiatry through the Freudian framework, and requires that considerable control be directed toward children in order to humanize them. It suggests that parents and institutions must act to control and mold behavior if adults are to be safe, and if tamed replacements are to be available in every new generation. A third concept portrays the child as being an angelic creature unsullied by the greed, envy, and perversity of adulthood and the world. Here the child is perenially the hope of the future, perfect society. The fourth definition, and probably the most accurate, is that coming from modern developmental works such as those of Piaget. This view stresses that the child is a being who operates with different conceptual and emotional properties from adults, and during the maturing process passes through several stages of thinking and emotionality distinct from adulthood. Such a viewpoint may lay particular emphasis upon certain learning experiences at critical periods so that development may proceed to the next level. For example, visual experiences may be necessary from years three to four to prepare cognitive processes for reading that will begin to develop at age six. It is this fourth definition of the child that lays the basis of the need for a thorough understanding of every step in the developmental process to ensure that child neglect does not occur.

Quite simply, how we define the child determines how the child is cared for and treated. The psychoanalytic definition of childhood prescribes different care from the prescription coming from Piaget's work.

The definition of childhood is culturally relative. The laws and informal codes of every society define the rights, prerogatives, and responsibilities of children and families differently. In many parts of the world children possess few rights within the society and have no access to property, but rather are defined themselves as chattel. In some cases the child is under the control of a large and extended family, and in other cases a single parent is identified as possessor of the child. In other areas, or other times in history, children at a very early age are assumed to be adults and may engage in many of the transactions of adults including marriage, work, and procreation. In the United States we are experiencing confusion in these social codes and are simultaneously moving to extend rights to children on many fronts such as: the right to legal counsel apart from parents or the state in cases of child abuse and neglect; earlier voting privileges by lowering the voting age from 21 to 18 years of age; and the right to independent sexual activity through the provision of contraceptive materials without parental consent. All of these social codes imply earlier adulthood. In contradiction, not too many years ago, we were providing different kinds of rights for children by forbidding them to enter into the labor force before a certain age, and protecting them from labor exploitation by requiring that they be paid the same wage rates as adults. We have encouraged the deferment of adulthood by extending the years of mandatory schooling, and by the creation of special legal codes and juvenile courts to handle children differently from adults. Conversely, children are encouraged early to act as adult consumers. Entire businesses such as the recording industry are almost exclusively

dependent upon the purchasing power of children. Much of the leisure and entertainment industry is built around youth, and part of the message of this industry is freedom and autonomy for youth. Yet today a number of authorities feel that unwanted teenage pregnancies and youth crime in the city are at least partially a consequence of the decline of adult control over the actions of children. At best we can say that we know very little about what should be the relationship between children and adults in our society where our legal codes have moved in seemingly contradictory directions, and that this ambiguity is creating urgent and compelling questions.

THE ETIOLOGY OF ABUSE AND NEGLECT

Careful investigation of the etiology of abuse and neglect is only now beginning. There are many areas that seem to suggest answers, and include the possibility of brain, neurological, or endocrine dysfunction wherein certain adults may be more prone to volcanic-like outbursts when under stress and frustration, and may be more likely to abuse children. We do know that within the limbic or recticular formation of the forebrain are certain structures that seem to control selective awareness, fighting and fear responses, and may be the sources of the violent behavior manifested by some parents. Evidence indicates there are clearly psychotic individuals who cannot relate or perform in a parental role, though we suspect that such individuals are but a small minority of those adults engaged in child abuse. Psychoses in the order of schizophrenia or severe character disorders are inimical to the parenting role. Some persons, because of problems of physical health such as diabetes, immaturity, or environmental factors such as demanding occupations, may be under too much stress to be always in control of their behavior and consequently be potentially included to abusive and neglectful actions. Some families may indeed develop dysfunctional patterns of interpersonal relations in dealing with children and pass them from generation to generation. The care of children among humans, unlike infant care among other animal species, is heavily dependent upon learning, and when a dysfunctional pattern occurs, it may well be transmitted from generation to generation. When families become nighly mobile as they are today, and when neighbors, relatives, and friends are less likely to be available for assistance, the prospects of others assisting in modifying dysfunctional patterns are reduced. Our entire culture, in fact, may be so stressful and so oriented toward individual autonomy and satisfaction that dysfunctional conditions for children are created. Some other countries, such as Sweden and Japan, have much lower rates of child abuse, infant mortality, and neglect. This results not only from better health and educational programs for children, but also seems a consequence of a society that is more orderly, integrated, and less fluid and violent in its arts, entertainment, and interpersonal relations.

We have been aware of child abuse and neglect since the late 1800's and have done much to reduce the systematic exploitation of children in industry. Diseases such as smallpox or rubella that yield to a simple epidemiological causation model have been our earliest and best achievements in improving the well-being of children, but now we face the residual problems that do not yield to simple cause and effect models. In all likelihood, these remaining problems for children come from a variety of causes and require a systems orientation for their explanation and control.

Many of the crippling diseases of childhood, poliomyelitis, smallpox, diptheria, and rubella have been controlled or eliminated. In child health, viral infections that yield to immunizations or antibiotics have provided some of our most brilliant successes. In large measure such successes have been with a particular kind of problem, those problems that are caused by a single agent operating in a relatively simple and direct causal sequence. Polio, for example, was eliminated by assisting the existing immune-defense systems through triggering antibody production by injecting dead or weakened polio viruses into the body. Such problems permit solutions of either eliminating the source of the problem, in this case the viruses, or activating the body's ordinary defenses. Closer inspection of this situation reveals a single entity or a small number of closely related entities that cause the disease. Moreover, the problem follows a predictable and largely invariable sequence with the description of the disease entity and the operation of the body's ordinary defenses being well-known and understood in biomedical research for many years. Solving these kinds of health problems follows a familiar and well-known procedure of describing the presenting symptoms and the path of development of the problem, isolating the causative agent and then either eliminating the agent, the mode of transmission, or activating existing defenses against the agent.

What now can be understood about child abuse and neglect indicates that it is not the kind of problem characterized by the previous descriptions as presented in the example of

poliomyelitis. Actually the concept of child abuse and neglect covers a large range of conditions from severe battering to cultural deprivation. For some conditions the sequence of the progression of the condition is well known, but this is not usually true. The specific causative agent or agents are not known, nor is there much evidence for routine bodily defenses. For child abuse and neglect, it appears that the use of the traditional medical model of explanation confuses, rather than assists, the understanding of the problem. It seems that interventions based upon medical models or the use of medical terms such as "epidemics" or "syndromes" are of dubious utility other than arousing public concern. Raising public concern, though, may even worsen conditions in some instances. Before substantial progress can be made in child abuse and neglect, the complex conditions must be understood in their own right rather than depending upon misleading medical analogies.

THE ROLE OF THE STATE

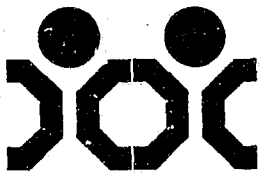
Every society must evince concern for the rearing and development of children, for the strength and continuation of the society is contingent upon these activities. In most instances, the informal family held these responsibilities and if the responsibilities were poorly handled the society was weakened. Modern societies, though, have increased the involvement of government in the care and protection of children. All states have codes dealing with the education, health, and protection of children. The institution and profession having the greatest initial contact with the parent and infant is the field of health. With the rare exception of those persons belonging to a health maintenance organization (HMO), routine pre- and post-natal care is difficult to obtain. Moreover, the typical physician or pediatrician is not prepared to diagnose many cases of child abuse and neglect, and in many instances may prove to be reluctant to report such instances when they are identified because of perceived role conflicts as well as the fear of court involvement, loss of clientele, or financial damage to the practice. The only other uniform and generalized institution involved in contact and care of children is the public school system. In most states the involvement with the school begins in the fifth or sixth year of childhood, but teachers, like physicians, are not well prepared to detect child abuse or neglect, particularly in its subtle manifestations. Our society depends upon individuals being able to detect health or legal problems themselves and then choosing whether or not to seek assistance. The individual is routinely expected to pay for services. Two problems exist from the perspective of the child when abuse and/or neglect occurs. The first problem is that there is almost no way to detect abuse or neglect until the child reaches school. For a variety of reasons the abusive or neglectful parent may choose not to recognize the problem or seek to hide it. Occasional visits to physicians do not raise significantly the probability of detection, and if the family does not have a regular physician the chances of detection are lessened. Most states now have mandatory reporting laws that require professionals, neighbors, relatives, and others to report suspected child abuse. However, many cases go undetected and often reporting occurs only after severe damage has been done. Prevention and early treatment seem unlikely as long as uniform health or educational services are unavailable for the preschool child. A national health program for children or universal daycare beginning with infants (a much more sophisticated level of daycare than we currently have) would be a vehicle to remedy the early social isolation of the child and the family, but such developments are some years away.

Child welfare or protective services are seen often as organizations that could prevent child abuse and neglect, but mostly protective services become involved only after abuse or neglect has occurred. Protective services must depend upon media, physicians, church groups, and schools to do primary prevention, which means teaching how to care for children. Typically protective services do not get involved until primary prevention fails. When protective services do get involved, their usual charge is to protect the safety of the child and conduct some form of investigative proceeding. Other things being equal, if the case is severe, a thorough investigation will be done. Given caseload sizes in most communities, less than severe cases receive much less attention. Most protective services personnel like to think of themselves as being able to treat and remediate some psychological disabilities in children who have been victims of child abuse, and to be able to improve the parents' capability to care for the child. There is much more hope here than actual accomplishment. Most protective services personnel are not adequately trained to provide successful therapy for abusive and neglectful parents, and there is still very little known about how this is done anyway. Again, most caseloads are far too large to permit intensive therapy with abusive clients. Protective services, then, mostly become involved in investigations of suspected abuse, struggling with the courts, trying to locate foster homes, and

hoping for an adequate referral service for treatment. Protective services workers tend to be overworked and frustrated, and, especially in recent years, move into other kinds of work.

SUMMARY

The more we discover about child abuse and neglect, the more aware we become of the complexity of the issue. Data increasingly indicate that there are alarmingly high levels of abuse and neglect, and that these levels have continued to rise in recent years. We have many more single-parent families today and disconcerting increases in teenage pregnancies. Teenagers who become mothers know little about parenting and possess few reserves for family support. Our laws and our social norms regarding children are contradictory. The etiology of abuse and neglect is frighteningly complex, and our protective services systems are overburdened and designed to be stopgap measures rather than prevention and treatment systems. However, it is not an impossible state of affairs. Since many other industrialized countries are plagued much less by these issues than we are, one might conclude that progress can be made. To rectify the situation, though, some means of greater early contact with parents and young children is required. Uniform medical services must be made available to children regardless of parents' intentions or inclinations. Protective services delivery systems must become thorough and coherently functioning organizations rather than the irregular patchwork systems that they are today. Abuse and neglect will not yield to one-shot solutions; rather a complex of changes must occur within the society with the complex being carefully orchestrated for the basic providers of care, the parents.



CONTEXTUAL ISSUES

Child abuse and neglect, like any other social phenomena, do not exist in a vacuum. Cultural norms and values, social institutions, environmental situations, and the characteristics and attitudes of the families and individuals involved all share in influencing the nature, severity, and outcome of child abuse and neglect. The definition of child abuse and neglect which we use not only determines its legal and sociological presence or absence, but can also influence the affective responses of the community, the protective services worker, and the family itself to the label/diagnosis/assessment/charge of child abuse or neglect.

There is clear agreement that the structure and role expectations within *family systems* have changed. The question remains what the function of the family will be, and where the supports and assistance necessary to allow families to move from realistic expectations to their maximum potentials will come from. One option, as the MOTHERS organization demonstrates, is from cooperative self-help.

The *cultural and cross-cultural perspectives* presented demonstrate most clearly how many of the issues of child abuse and neglect are the same, not different, across cultures, but also reinforce the necessity of delivering services within the socio-cultural context of the family. Other social phenomena—corporal punishment in schools and juvenile delinquency—appear to be related to child abuse and to each other, as well.

Research activity can play a reciprocal role in defining the context of child abuse and neglect. Our view of the problem influences the kind of research we will engage in and support, while data from the research feeds back into our perceptions of the phenomenon. The potential for a single-minded positive feedback loop is obvious. The challenges of research in child abuse and neglect include how to study service delivery without disrupting it; how to study a private, low-frequency event; and how to make findings useable by policy makers, other researchers, and practitioners.

Emotional abuse and neglect is perhaps the knottiest problem in the area of child maltreatment. Merely defining it in a way acceptable to mental health, welfare, and the law has not yet been fully accomplished; a two-level diagnosis seems to be necessary, with considerations of parental intent and cooperation key indicators for intervention.

Neglect is obviously a poor cousin to abuse in terms of research, program development, and intervention, even though neglect affects—in incidence and fatalities—many more children. The reasons for this are seen to lie in the more dramatic nature of abuse and the comparatively lower cost of intervention with abusive parents, as well as in political and organizational issues.

Two approaches to the *prevention* of child abuse and neglect are represented. One, which might be called secondary prevention, uses behavioral, demographic, or other types of indicators to identify families at high risk, and then applies direct interventions with the child, the parents, or the total family system. The other, referred to as primary prevention, assumes that in our mobile, changing society all families are at risk, and stresses educational and social policy interventions designed to lessen the impact of environmental stresses on families.

A campaign to develop accurate, comprehensive *public awareness* of child abuse and neglect can have several benefits: increased community support in terms of legislation and resource allocation, increased reporting, and even an increase in self-referrals. But service delivery must keep pace with expanded expectations, or clients and the community as a whole face disillusionment.

Although *reporting systems* and central registries pose significant privacy and parental rights issues, their use is generally seen as an important aspect of protective services, aiding in identification, epidemiology, and research on the social context of child abuse and neglect. The danger arises when practitioners use registry information as a substitute for direct observation and assessment.

Vincent De Francis

Leila Whiting

The panel on prevention; left to right: George Starbuck, Brian Grodner, Lawrence Brown, David Williams, C. Henry Kempe

James Cameron

Wayne Holtzman

Ray Castle

Family Systems in Society

The Child and Family in Society: Realistic Expectations of Maximum Potential

Edward T. Weaver, Executive Director
American Public Welfare Association
Washington, D.C.

The story is told of a talented painter who was frequently visited in his studio by an enthusiastic and admiring neighbor. On one occasion, as the visitor hovered over the artist's shoulder watching a masterpiece take shape under his very eyes, he exclaimed, "Isn't there any way I can help?"

"Yes," the painter replied. "Stand out of my light."

All the painter needed was an environment of positive opportunity; he could handle it from there. The analogy may be crude, but that is exactly what families need—a relatively free and positive environment in which to grow and achieve.

However, we see the child, the family, and the community interacting within different and sometimes conflicting expectations, and all this overlaid with an urgency to pursue their "maximum potential."

I offer no analysis of the topic assigned to this panel, except to say that as I tried to understand its meaning, I was struck by the notion that the topic carried overtones of pressure that tend to create individual and family dysfunction. The topic flows naturally from our high achiever-oriented society. But before I am marked as one who advocates a laissez-faire attitude toward realization of family or individual potential, I will state my thesis and briefly elaborate on it. My thesis is simply this:

> Family and individual goals and expectations are developed within the family's or individual's perception of realistic opportunity.

To elaborate further, I will discuss three questions and then briefly relate these ideas to the problem of child abuse.

WHO SETS THE GOALS?

We should have learned long ago that "we" cannot set goals for "them." What we can do is relieve the external pressure as the first step toward creating positive opportunity for the individual or family to identify how they want to live and relate to each other and the community. Freedom to choose from among the options should not be usurped by helping professionals.

I assume that when we talk about goals we mean the tangible, defined expression by a family or individual of their aspirations. Goals may include not only specific material or financial achievements toward which to work, but should be framed within and deduced from a recognized "quality of life" that a family deems most desirable and needful for its own best functioning. The quality of relationships among family members, the development of mutual support within the family and community, plans to enrich life through pursuit of religious affiliation, education, or cultural activities are appropriate areas within which to select goals.

We know that not all choices will be the best that could be made—nor will they inevitably lead to achievement of maximum potential. The professional role is to prevent undue hurt as families and individuals learn to direct their own lives in a social environment. Some will choose not to vigorously pursue "maximum potential," perceiving the pressures of such pursuit as being too severe and thus actually damaging themselves as a family or as individuals let alone as "goal achievers."

A child crawls before he walks. Should we expect a family to set its first sights on its "maximum potential?"

The important thing is that each opportunity offered should be just that—and not an option forced upon a family nor one that, if selected, would be allowed to retard progress toward self-selected, self-fulfilling and socially responsible goals.

Selection of optimal goals for individuals and families is the prerogative of the people involved. Society's goals for development of families and children should focus on environmental and opportunity considerations. It is inappropriate for society to usurp the individual's personal choice of goals, except to set standards for protection from injury.

WHAT ARE APPROPRIATE GOALS?

You may already question this approach because to this point no acknowledgement has been made that inappropriate choices and actions by individuals and families all too frequently result in wasted potential or injury to one or more of its members. That fact exists—I do acknowledge it—but I submit that it has little to do with goals. Rather, such injury signifies a breakdown, a frustration, entirely aside from goal selection itself.

Children are seldom abused because the caregiver decides he or she wants to abuse them. The abuse derives from a collapse in the caregiver's coping ability in a stressful situation.

Appropriate goals obviously would embrace those achievements or states of being which are fulfilling to the people involved and which contribute to the social goal of family and community. Few people would knowingly choose otherwise.

The appropriateness of goals selected and pursued is enhanced by the environment of positive opportunity. When opportunity exists and is perceived, aspirations rise up to capture it—especially if optimistic support and encouragement are present in family and community.

HOW DO WE IMPACT ON OPPORTUNITY?

Perhaps it is true that we create our own opportunity; that is the American way. But some of our fellow citizens are discouraged, and with good cause. Unemployment, crowded living conditions, friction between family members, scattered and unavailable extended family members and other stress-produced conditions distract us. Even when opportunity is there, we may not see it, or may not believe it exists.

The professional role, then, is best directed at stimulating the social environment to produce real opportunity and to direct the discouraged toward it. Sometimes all that is needed is a facilitating and connecting type of service. When the discouraged family member experiences the opportunity as real, a new level of expectation and aspiration is born. Maximum potential, or self-fulfillment at whatever level, is achieved one step and one success at a time.

RELATIONSHIP TO CHILD ABUSE

Thus far, my comments have been general and conceptual rather than concrete and practical. To attempt to balance that let me relate these ideas to the problem of child abuse and neglect.

In my judgment, no environmental condition or lack of opportunity absolves anyone of responsibility for violence against another person, especially a defenseless child. I have purposefully focused on the necessity and value of a positive opportunity environment. Achievement of individual goals and exploitation of individual potential is best enhanced when options are available to choose from and persons capable of extending practical help offer optimistic support and encouragement. Equally important is the need for intervention and help at crisis points to prevent injury or to protect from further injury. Perhaps I am cautiously searching for a strategy which is preventative in a true sense, a strategy which nurtures and capitalizes on the substantial strengths of the family and its individual members.

When thinking of the importance of the family, I am reminded of a quote from James Reston in a column titled, "Family Life—the Last Refuge," in the Minneapolis Tribune.

> If preachers are not to be believed, and politicians are not to be trusted, and society as a whole is a jumble of lies and tricks, then the family may still be the best bet available, maybe even better than being liberated into loneliness.

It is time to "rediscover" the family as having great potential for self-help and nurture of its members. With this in mind, the family should be strengthened as an alternative to expanding institutional helping agents.

Undeniably, child abuse and neglect is the result of an act, or failure to act, by some specific responsible person. But the causal factors are frequently very complex. Studies have given evidence that the episode of abuse is strongly related to: immaturity of the abuser, recent birth of another child, an abuser who once was an abused child, and unemployment of the family head. The abusing environment apparently has at least two aspects: (1) there is a condition (a cause or trigger situation) which puts the caregiver in a stressful situation; and, (2) the caregiver is unable to cope with stress in a nondestructive manner; the caregiver loses control of his own actions.

To illustrate the impact of impaired opportunity and the result of failure to achieve expectations, I present the following observations from American Families: Trends, Pressures and Recommendations, a Preliminary Report to Governor Jimmy Carter by Joseph A. Califano, Jr.:

> When unemployment reached 20 percent in Flint, Michigan, Flint became the city with the highest rate of alcoholism in the country, drug abuse treatment centers had caseloads twice what was projected and the incidence of child abuse soared. Recent research suggests that the variable that most frequently relates to child abuse is the father's unemployment.

This is but one example of a negative opportunity environment. But the point is made: an effective preventative strategy must address such large environmental factors.

As a society, as a community, and as helping professionals, we are obligated to look beyond the individual case and examine the environmental factors which provoke or create the problem. When we do, the quality of life and the realization of human potential can be enhanced for all.

Child and Family in Society: Realistic Expectations or Maximum Potential?

Diane Broadhurst, Education Consultant
HELP Resource Project
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The title and sweeping theme of this panel, "Realistic Expectations or Maximum Potential," alarms me. I find myself wanting to define terms, to find some common ground, to understand where we are headed. I think it is well to set some limits whenever a national conference discusses policy issues.

Our topic falls naturally into three areas: (1) realistic expectations vs. maximum potential; (2) when, if, and at what point should separation occur; and (3) what resources are available for helping families at risk.

Should realistic expectations or maximum potential be regarded as an either-or situation? Does one preclude or negate the other? If we settle for realistic expectations, must we assume that maximum potential is not, or cannot be, achieved? If maximum potential is achieved, is that unreal or beyond what should be expected?

Perhaps our title and theme should instead be realistic expectations of maximum potential.

Just what is meant by maximum potential? Who defines it, and how? How does one measure another's potential, much less delimit it? Realistically, do we foresee a committee formed to determine each individual's potential and to set an arbitrary limit upon it? Are we in some measure already doing this with, or to, abusive and neglectful families?

Whenever we talk about maximum anything we are by definition setting a limit, and this will not work with people. People have a way of evading the arbitrary limits which society devises. In practical terms, setting a maximum potential for an individual could mean discouraging excellence, or disregarding that person's dreams and hopes for a better life. Shall we depress a family's hope to someday, somewhere find a better life? It can become a self-fulfilling prophecy; by not expecting very much, we get just that—not very much, although so much more might have been achieved.

There are mountains of evidence to prove that children early labeled slow, poor learners, etc., usually turn out that way. If we label an abusive or neglectful family as having the potential to reach number six on a scale of ten, perhaps we condemn them to go no higher.

Let us examine a brief case history of a young man. The child, age three, and his mother were abandoned by the father. His mother was an alcoholic, and he had a congenital malformation which left one foot crippled. As a boy he was severely physically abused by his mother, who also emotionally abused him by taunting him about his defect and regarding him as something less than human. Before the age of ten he was sexually assaulted by a nurse, an experience that had a profound impact on his later sexual activities, which included marked proclivities for young boys and an incestuous relationship with his half-sister.

What would we say were the realistic expectations for this young man? What would we say was his maximum potential, and what might we expect him to achieve? Predictably, his marriage was unhappy, his relationships with others disturbed, and his life chaotic.

But unpredictably, he was also one of the greatest figures of his age. Although he died at age 35, he had already written *Manfred, The Corsair, Don Juan,* and *Childe Harold's Pilgrimage.* I refer, of course, to George Gordon, Lord Byron.

When we speak of expectations, whose expectations are they? The family's for itself, or society's for the family? If not the family's for itself, we had better look closely at a few important points. First, have these expectations of society been set in consultation with the family, or have they merely been imposed from without? Has anyone ever asked the family where they want to go, and how? And if *society* is setting the expectations, what is the social distance between it and the family? Are we at the point of eliminating individuality in favor of having everyone alike, everyone at the same level or standard, everyone doing and being what one or two of us has decided is right and proper?

To go a step farther, how shall we determine what is realistic, especially in a world that changes as fast as ours does. What was fantasy yesterday happens today, and is history tomorrow. We can no longer be so certain about things as we once were. Things change, people

change, and society changes. Clearly, our expectations must change too. But do they? As Henry Kempe said, "Once a year we should ask ourselves, why are we still doing this?"

We must learn to view abusive and neglectful families as individuals, not as the sort of homogeneous group they are often considered to be. To be realistic, our expectations must take into account what each family is willing to achieve, and we must avoid setting some arbitrary limit, whether high or low, for maximum potential.

James Hyde has said that of the hundreds of abusing families with whom he has worked, not one was without some strengths. That is a critically important point. Too often all we see in individuals and families are the weaknesses; we cannot see the strengths. Yet we must, for it is upon these strengths that treatment must be built. Even in families where separation of parent and child must occur, there can be strengths. Perhaps they are the kinds of strengths which can be built upon so that the separation need not be a permanent one. Or perhaps the strengths are the kind that will allow a parent to say, "I can't do this job of parenting very well. It will be best for my child if someone else looks after him."

We were asked to consider what families require in order to stay together. In my opinion we have gotten hold of the wrong end of the microscope. The question is not at what point are families able to remain together—number six on that ten-point scale, perhaps—but at what point must they be separated. In my view separation should occur only under extraordinary circumstances, such as when a child is in clear and present danger at home or (and this is often overlooked) when the parents sincerely request voluntary separation. When parents request separation we had better be prepared to listen. Rarely are such requests frivolous, and to disregard them may have tragic consequences. A note of caution: removing a child only under extraordinary circumstances does *not* preclude making removal a first resort as sometimes it clearly must be.

As an example I'd like to describe a case that happened recently in a mid-Atlantic state. A 2½ month old child was brought to a hospital with massive head injuries, contusions, and fractures. There was not much question the child was a classically battered baby, and extensive cranial surgery was required to repair the damage. The child was returned home as soon as he was well enough to leave the hospital.

If we are to speak in terms of our theme, this family had a maximum potential for violence: the parents were unmarried, the mother young, the father on drugs, known for his violent temper, and unemployed. A realistic expectation might have been that trouble would recur. It did.

Within two weeks the child was back, this time with multiple fractures. Again he was hospitalized and again returned. Two months later, after a third incident and a third hospital admission, he was dead.

Here removal to a safe environment should have been a first resort, considering the age of the child, the severity of the injuries, and the home situation. But removal was not the first resort, nor tragically, was it the second or third resort.

I believe we need better standards to tell us when families should be separated. Some standards exist, it is true, but they are far from universally applied. I do not suggest that there can be a formula to state at what point, under which precise circumstances separation must occur. So many factors must be taken into account; the peculiarities of each case require individual consideration. Some factors may be considered common to all situations in a given community. Chief among them is the question: what are the real alternatives to separation, or to leaving the child at home?

If a community has no shelter care facilities, or none available, and no medical facility willing to house a well but endangered child at least temporarily, the child may well be left at home regardless of the danger, simply because there is nowhere else to put him. On the other hand, a community which has a few treatment resources geared for abusive or neglectful families may regard removal as "treatment," even when it is not indicated. Resorting to removal becomes the only alternative to doing nothing.

The matter of resources for abusive and neglectful families is a critical one; we are all aware of that. But many communities have resources that are not being used simply because they are not thought of as resources for abusive and neglectful families. Prime among them are schools, and the variety of volunteer groups found in any community.

I would like to point out why schools are not, but should be, more actively involved than they are.

Schools are where children are; that is a fact of life. Children are in school every day, nine months of the year, for twelve critical years. The school is generally the only place a child

is seen daily by those trained to observe children. Where parents are not advocates for their children, as may be true in child abuse and neglect, the community must take on the advocate role. The school, as part of the community, must be willing to do its part. Indeed, the schools already stand in loco parentis in many circumstances. Speaking out, reaching out, to the abused or neglected child is merely a natural extension of that function.

In the past, many educators have been reluctant to become involved in cases of child abuse and neglect, fearing the results of involvement with angry parents, lawsuits, etc. However, as more and more schools have become involved—safely—much of this reluctance has begun to disappear. More and more educators have come to understand their immunities and now realize that good can come out of reporting abuse and neglect.

A new problem is emerging, and it is one we are going to have to address if we want to count on schools as a resource in the future. This problem is the reaction, I might say resistance, schools are encountering from social agencies when they do get involved. Sometimes school reports are discounted, even though they are made by experienced professionals who know what they are talking about. Such a reporter, turned off by the reception he receives is unlikely to want to report again. Here is an example:

A school counselor reported a case of sexual abuse which had been revealed to her by an adolescent girl. The girl had been raped several times by her step-father, most recently, the morning of the report. She sought out the counselor, asking for help, and she was clearly frightened. When the counselor called the proper agency she was met with indifference. The agency simply was not very interested, although the situation was serious. The counselor pressed for action. Reluctantly the agency offered to make a home visit—to see if the girl "is enjoying this."

If this counselor is reluctant to report again, will it be any wonder? Another case history will illustrate how a school willing to take an active part in child protection can be turned off by being told to mind its own business.

This school, which had reported several cases of suspected child abuse, all with good cause, received a letter from the local social services agency stating that they had been overreporting. They were requested to confine themselves to cases that were serious. The letter made it clear that in the agency's opinion bruises were neither indicative of serious injury, nor capable of causing a child pain.

I call this the "give me blood syndrome." Far from using the schools as a means of early identification and detection, this agency is encouraging the schools to wait until things are really bad.

If we want to make better, more extensive use of the schools as a resource, we had better make them welcome and a part of the team. We had better treat school staff as the competent, experienced observers of children that they are.

My last point has to do with the use of volunteers as a resource in the broad area of child abuse and neglect management. Recently I have seen several instances where enthusiastic volunteer groups, ready to commit time, money, and resources, have been told that they are not needed, that the field is for professionals only, and that they are not wanted. What a waste! There are so many things volunteers can do, often better than paid staff. They can be a vital part of any overall community program to detect and prevent child abuse and neglect. In some communities, volunteer groups are doing just that, and in a variety of very imaginative ways.

In one city a therapeutic nursery for abused children is staffed in large part by Junior League volunteers. In another city an all-day training program on child abuse for mental health workers is being underwritten by the local Exchange Club. Another training program in a different city was jointly funded by the Chamber of Commerce, the Junior League, and the American Association of University Women. These groups also handled all the arrangements, publicity, and ground work.

In some communities volunteers sponsor Parents Anonymous groups, direct hotlines, operate speakers' bureaus—all jobs that are time-consuming, but must be done. Agency personnel cannot do these jobs unless they stop doing their assigned jobs. Clearly what is needed is a partnership.

If it is really true that child abuse and neglect is a community problem, a problem for all of us, then it is going to take all of us and all the resources we can muster to solve it. We cannot afford to turn away, or to turn off, anyone. To paraphrase Pogo, I have met Society, and it is us.

I'd like to leave you with one more case history to think about in terms of maximum potential and realistic expectations. This is a man born to a syphilitic mother, who died when he was young. His father was a brutal man who abused the boy. In addition, the siblings did not get

along; this was a multi-problem family. Our study subject eventually became deaf. By all accounts he was irascible and difficult to live with, an expectation we might have predicted. In assessing his maximum potential, however, would we have guessed he was Beethoven?

Changing Family Roles and Structures: Impact on Child Abuse and Neglect?

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What is happening to families today? Statistical data offer interesting commentary as a focus for the current crossroads of family life. Statistics can do more than measure facts; they can jar us into putting our beliefs and assumptions into new perspectives; they can demonstrate how the world has changed and how we can act upon those changes.

Recent Department of Labor statistics point to a shattering fact about today's families. Only 7 percent of American families fall into the category of the "traditional" family structure, i.e., the two-parent family, in which the husband works full-time, the wife stays home and maintains the house and cares for the two or three children. Ninety-three percent of all families do not follow this pattern. Clearly, the structure of the nuclear family is changing.

According to HEW, in its publication, *The Status of Children* (1975), some 12 million of the 70 million children in this country, or almost 20 percent, do not live with both parents; there are now 1.3 million of these children living in single-parent families headed by men. In 1975, over 47 percent of all married women were in the labor force. Breaking these figures down more specifically by age of child we find the following: 32 percent of all mothers with children under age three were working; 35 percent of mothers with children between three and six were working; and 54 percent of mothers with children over age six were working.

These figures are thought provoking. Today it is a necessity for many husbands and wives to work to maintain a middle-class standard of living, to achieve the goals of home ownership, and to secure college educations for the children. Clearly, both the structure of who is included in the family unit and the family's style of life have changed. In addition to these changes, new attitudes are developing about women and their roles in the home and work force.

We are still reeling from the impact of the new family unit, the changing work force, and the women's movement, and their effects on family life and societal values and priorities.

The women's movement has generated controversy regarding its effect on the development of children within the family. One point of view suggests it is the women's movement that has created the major upheaval in family life. Despite the effects produced by the smaller, mobile, nuclear family, and the economic pressures forcing women into the labor market, there is a school of thought that holds the women's movement responsible for the upheaval in the roles, traditions, and rituals of structured family life. This, according to psychiatrist Edward Levine (1972), has led to disruption of family stability, gender identity problems, and less satisfying and enduring marriages. All of which points the way to increased stress on families and more difficulties in the rearing of children. Many experts in the field of child neglect and abuse point to high stress as a factor for the existence of child abuse and neglect. Conclusion: The women's movement is a contributing factor to the ever increasing problem of neglected and abused children.

On the other side, there are psychologists, feminists, and physicians who view the women's movement as being positive and in the long range a deterrent to child neglect and abuse. Kempe and Helfer in *The Battered Child* (1968), point out that the child abuser's attitude toward his or her child is that the child exists to satisfy parental needs, and when such needs are not met punishment of the child ensues. Such facts illustrate the necessity for options for need fulfillment. For many women this has come to mean self-development, aside from the wife and mother role.

The second positive element of the women's movement has been better education of women in preventing and planning pregnancies. Traditionally, birth control and planned parenthood were not practiced. Couples (that is to say, women) had children as they came—unplanned, and often unwanted—while being unprepared for the responsibilities of parenthood. Today, this pattern can be changed. As women can consciously decide about bearing children, there is less possibility of an unwanted or unneeded child, thus decreasing the stress on the family as a result of the birth of that child. Both parent and child can start out on a more positive course.

According to Patricia Keith-Spiegel (1974), there are specific goals of the women's movement which, when achieved, may simultaneously reduce the incidence of child abuse. These include:

1. Education about self, marriage, parenthood and family from a non-sexist point of view;
2. The creation of multiple life options for women besides motherhood;
3. Knowledge of and safe accessibility to proper contraceptive devices;
4. The liberation of men from their "aggressive" and "non-child oriented" role models;
5. Establishment of programs to allow mothers extended life activities; and
6. The raising of females to be more resourceful, self-confident, and less dependent, so that life's problems and obstacles can be handled in a constructive manner.

The trade-off of what has been lost and what can be gained by the women's movement with respect to the incidence of child neglect and abuse will continue to be debated. In my own mind, the long-range consequences point to increased benefits for children and families. The major barrier now is for our society to lay to rest the myth that today's families are living or can live in the traditional structure and roles in which they were once cast.

Where does the family go from here? Clearly, there is no going back. Society has changed too drastically; technological advances, an urban-industrialized culture, the economic structure, the sociological patterns—all exist today in a vastly different world than that of society 50 or 100 years ago. Thus, the family structure will be shaped by the societal patterns around it. The future success of the family—and hence, for the children of the future—will depend on what support systems the family demands and society takes responsibility for: support systems which will strengthen the family and allow it to continue to provide the nurturing climate for the growth of healthy children.

What kind of support systems must be developed for the family of the future to survive? These can be discussed in three categories: (1) family-to-family support systems; (2) family-to-social community support systems; and (3) family-to-work community support systems. Today's highly mobile family has lost the support provided by yesterday's extended family. This has left the small nuclear unit to fend for itself in meeting the daily demands placed on it. In family-to-family support systems, families band together with other families to share the burdens created by nuclear family isolation, and develop creative means of solving the problems of stress. Examples are: babysitting co-ops, parent hotlines, communal living arrangements, and a blending of roles and tasks in equal partnership. More and more of today's young families are taking these initiatives, and in the proper communities neighborhoods can become an extended family. There is a sense of trying to find togetherness as a means of survival.

Today's family is isolated in many respects, while being less self-sufficient than ever before. It is highly dependent on the social and economic community around it for its existence and growth. Family-to-social community support systems are those which contribute to the workings of the family. Schools, churches, health facilities, government services, etc., are examples. Today's family needs these systems to recognize the current plight of family life, patterns, and structure, and to respond to these needs.

We cannot afford for our families to be ignorant of what parenthood is, demands, and requires. Education for parenthood must begin at an early age and continue to adulthood. Schools, colleges, and churches must play their part. Adult education programs should be offered. Parenting programs and parenting groups for new families ought to be available and encouraged. The social community must bear the responsibility for providing the opportunities for activity, counsel, resources, and sharing, through increased development of community centers that speak to the family of today. They need community centers in schools, churches, and neighborhoods that provide extended life activities beyond home and job and offer both social activity for children and adults and emergency assistance to families in crisis. The issue of substitute child care—meaningful and appropriate child care—must be faced squarely. The federal government's pronouncements and actions in this area during the past ten years point to the crossroads we are at and the dilemma we are facing. Women with children are working in record numbers. Substitute child care is a problem faced by all families where the parents (or the single parent) works. It is still largely an individual struggle for each family to work out a child care arrangement. The United States, more than any other industrialized nation, still has not come to grips with this situation. The result is hit-or-miss child care plans: constant changes for children; the ever-increasing numbers of "latch-key" children, left to fend for

themselves between the end of the school day and the much later end of the work day; and children neglected and/or abused in the child care setting. We must begin to ask certain questions more seriously and come up with some answers. For instance:

1. How are children between ages 4-14 to be cared for between 3 p.m. and 6 p.m. daily?
2. How long should the school day be?
3. Should schooling be utilized as both an educational and a child care experience?
4. What kind of supplemental programs do we need to cover the present gap in services?
5. What should be the program content for such supplemental programs?
6. What are to be society's and families' standards for such programs?
7. How should child care programs be financed?

Answering these questions is the first order of business in preparing the way for stronger family life in the future. Certainly, child care outside the home has become a major enterprise in the last decade. The problem is—as the latest federal attempt at "reforming" the tax laws for the deduction of child care expenses indicates—American society has not yet come to grips with the fact that substitute/alternative child day care arrangements are the necessary order of the day, and not a threat to the continued well-being of family structure and way of life.

Finally, the family-to-work community support systems will play an important role in the future direction of family life. The structure, time, and orientation of work has revolved around the traditional family structure. Although women with families have flooded the labor market during the last decade, the work sector has resisted most attempts aimed at changing the outmoded premises on which it operates. The family of the future may depend heavily on the public and private economic community's willingness to recognize its role in the strengthening of the family and to begin to respond accordingly. What can the working community do? There are certainly many alternatives, ideas, and programs with which to experiment. These are a few examples:

1. Take leadership in the day care area, particularly for very young children. Day care centers attached to large enterprises, factories, manufacturing plants, etc. can most easily develop programs so that a parent can bring his or her child to a child care center at the work location, see the child at lunch time, know that the child is well-cared for, and be able to take the child directly home after work. Possibilities for after school activities programs also should be considered;
2. Respond to the problems of the working parents by encouraging more flexible work schedules with respect to daily hours, number of days per week, holiday and vacation schedules, etc., so that obstacles to maintaining a stable family life can be reduced and stress (about problems faced in this area) can be minimized;
3. Recognize the serious consequences for families being constantly uprooted by transfers, promotions, and job opportunities, and realize that the more quickly a family becomes integrated into the social community, the more stable and productive the employee is going to be. Businesses, government agencies, and corporations can ease the trauma of a family's move to a new and unknown community by providing assistance before and after a move. How? By offering resources, information, and helpful hints regarding schools, churches, shopping, recreational facilities, health care, etc.; by being honest about the problems families might face in the new community; by offering social events, get-togethers where families can get to know one another; and by utilizing the Welcome Wagon or Big Brother concepts to offer a supportive arm in assisting families establish themselves; and
4. Stop penalizing working women for becoming pregnant, bearing children, taking time for physical and emotional recovery from having a child, and taking time to become acquainted with their child and with being a parent. Women should be rewarded for these efforts rather than punished, if society is serious about wanting to continue to procreate and maintain the nuclear family structure as the foundation for the healthy upbringing of its children.

These are just some of the possible means by which society can develop support systems to strengthen its families. To do so, however, certainly will require the full commitment of the professional community which works with families and children to act as constant advocates for the changes that are needed and to point to directions for change. Those of us who have seen the disastrous effects of the breakdown of family life in our work with abused and neglected children know all too well the consequences of continuing this pattern. As we daily try to rehabilitate individual families with our Band-aid approach, we must also keep in mind the larger picture, and focus some of our energies in the advocacy arena for all our children and families. Only by nurturing the positive aspects of families and bolstering them with support systems which make sense in today's world will we make a dent in the overall societal problem of child neglect and abuse.

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Family Change and Child Abuse

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There is widespread agreement among scholars in the field that the American family is a changing institution (e.g., Clayton, 1975; Nye and Berardo, 1973). For example, the average number of children per nuclear family has decreased dramatically over the years, while at the same time a relatively greater emphasis has been placed on the social-emotional functions of the home, when compared to traditional economic and educational tasks. Since physical child abuse--which is the problem this paper addresses--usually occurs within the home (Gil, 1970), it seems reasonable to explore the possible impact family change might have on the mistreatment of children.

Since the issue of family change is so complex, involving both outside pressures as well as naturally occurring events common to the life cycle of all families, any attempt to understand possible relationships between such change and child abuse is, necessarily, somewhat speculative in nature. Indeed, at least three major issues will slow our progress in this area. At the outset, it is clear that evolution in family structure may increase, decrease, or simply have no influence on the probability that an abusive event will occur. In addition, it seems reasonable to assume that changes in family form or function may impact on punitive childrearing only indirectly, or in combination with other factors. For example, in general it is assumed that decreasing parental support from extended families may increase the risk of abuse; however, relatives who approve of severe punishment may add to the problem. Thus, not only must we locate areas of family change which affect abuse, but we must also specify the other social processes which help explain any such relationships.

Finally, in order to clarify how evolution in the family influences parental behaviors, we will need to examine how rapidly changing life circumstances in general influence human performance. That is, the evolution of the family is only one of many varying situations with which a parent must cope. The stress produced by too many events changing too quickly may have similar effects whether the changes involve family relationships or not.

When faced with enormously complex phenomena, the usual practice of the social scientist is to simplify the situation, often much to the distraction or disbelief of those faced with the demanding role thrust upon them as clinicians. However, simplification is a tried method for reconstructing reality so that at least a rudimentary understanding of complex events can develop. Therefore, rather than speculate too quickly on the broadest issues, I will take the last problem first and examine what we know about the association between rapid life change in general and child abuse. Within the context of available data, particular life change events will be related to roles and structures in the family. The final step in the process will be to explore how other factors basic to human behavior might combine with family change to produce an abusive event.

LIFE CHANGE AND CHILD ABUSE

Results from two studies are available which directly examine the association between life change (life crisis) and child abuse (Conger, Burgess and Barrett, 1977; Justice and Duncan, 1976). Both of these research projects used the Social Readjustment Rating Scale, developed by Holmes and Rahe, to measure life change (Holmes and Rahe, 1967). Table 1 shows that questions in the scale are weighed by event, going from eleven life change units (LCU) for a minor violation of the law to one hundred LCU for the death of a spouse. Previous research has shown that the questionnaire is predictive not only of ill health or physical injury but also of behavioral performance deficits (Rahe, Biersner, Ryman and Arthur, 1972).

In their recent study, Justice and Duncan (1976) have suggested that most major theories of child abuse place a strong emphasis on stressful events experienced by parents. Stress, according to those theories, is seen as a cumulation of aversive experiences, e.g., job loss or marital problems, which occur more frequently in abusive homes than others. As an alternative to this view, Justice and Duncan conceive of stress as "a situation which requires adaptation or coping behavior by the affected person, whether that situation is experienced as pleasant or unpleasant" (p. 112). Thus, the emphasis for these authors is not necessarily stress in a punitive

sense, but rather changes which occur so rapidly in the life of an individual that major efforts are required to cope with them.

Table 1

LIFE CHANGE ITEMS IN THE SCHEDULE OF RECENT EXPERIENCE

No.		Life Change Unit Value
1.	Marriage	50
2.	Troubles with boss	23
3.	Detention in jail or other institution	63
4.	Death of spouse	100
5.	Major change in sleeping habits	16
6.	Death of a close family member	63
7.	Major change in eating habits	15
8.	Foreclosure on a mortgage or loan	30
9.	Revision of personal habits	24
10.	Death of a close friend	37
11.	Minor violations of the law	11
12.	Outstanding personal achievement	28
13.	Pregnancy	40
14.	Change in health of family member	44
15.	Sexual difficulties	39
16.	Trouble with in-laws	29
17.	Change in number of family get-togethers	15
18.	Change in financial state	38
19.	Gain of new family member	39
20.	Change in residence	20
21.	Son or daughter leaving home	29
22.	Marital separation	65
23.	Change in church activities	19
24.	Marital reconciliation	45
25.	Fired at work	47
26.	Divorce	73
27.	Change to different line of work	36
28.	Change in number of arguments with spouse	35
29.	Change in responsibilities at work	29
30.	Begin or stop work outside of home	26
31.	Change in work hours or conditions	20
32.	Change in recreation	19
33.	Mortgage over $10,000	31
34.	Mortgage or loan less than $10,000	17
35.	Personal injury or illness	53
36.	Business readjustment	39
37.	Change in social activities	18
38.	Change in living conditions	25
39.	Retirement from work	45
40.	Vacation	13
41.	Change in schools	20
42.	Begin or end school	26

As Table 1 shows, both welcome events, e.g., item 25 "outstanding personal achievement," as well as unhappy situations, e.g., item 3 "jail term," are included on the Social Readjustment Rating Scale. According to Justice and Duncan (1976), the more rapidly life change occurs, the greater are the number of adaptations a parent must make. When required coping responses become too great, there is a loss of personal control and the chance of an abusive act increases. In this first study, scores for life change computed for 35 abusive parents and 35 matched controls showed a mean of 233.63 LCU for the first group, and a mean of 123.62 LCU for

controls ($p<.001$). On the average, the abuse parents were experiencing moderate life crisis during the year before the abusive incident, while the controls were not.

From their results, Justice and Duncan conclude that rapid life change, whether aversive or not, contributes to child abuse. However, they do not feel that changing life circumstances are directly related to abuse, but rather, that life "crisis...does appear to be an important predisposing factor..." (p. 112). Moreover, given our society's demonstrated trend toward "greater change in less time," the study of life change influences on childrearing becomes particularly important. We will return to another finding of this study later when changes in family roles are discussed.

The second study of life change and child abuse was done by my colleagues and me as part of a child abuse and neglect research project in Central Pennsylvania (Conger et al, 1977). Using the same scale as Justice and Duncan, we found a mean life change score of 340.2 LCU for an initial 18 abuse parents which contrasts with an average of 244.4 LCU for a set of 20 matched controls ($p<.025$). The probable cause for our higher scores compared to the earlier work is the method of computation. We cumulated life change units back from the date of the abuse event for three years, while a one year time frame was employed by Justice and Duncan.

LIFE CHANGE AND FAMILY STRUCTURE

These studies are quite consistent in their findings. In some fashion, rapidly changing life circumstances apparently create conditions amenable to child abuse. The question remains, how might we relate these findings to specific changes in families? Two aspects of change in families have been suggested as important. First, we have been asked to consider family structural change and then changes in role relationships. The two, of course, are closely related. For example, a change in structure from a two-parent to a one-parent family has tremendous impact on family roles since, in most cases, the single mother must now assume a substantial number of the responsibilities usually expected of the father. Given the extreme interdependence of role and structure, then, the focus here will be on changing social roles.

Social roles are essentially expectations or rules about what one ought to do when occupying a certain position located in a social network. For example, mothers and fathers traditionally have been expected, within broad limits, to engage in activities special to their roles. Equally important, however, are the expectations an individual develops about how he or she should be treated once ensconced in a particular role. These expectations, although enjoying great consensus, are variable and must develop through a process of learning. In fact, "expectation," as used here, is not intended to imply a mental state. Rather, it is used as a short-hand descriptor of the learning history unique to a given individual. Learning experiences can be direct or vicarious, i.e., by observing others.

When one assumes that occupying a position holds certain privileges, then what Homans (1974) calls "distributive justice" is maintained only when particular rewards are forthcoming to those holding a certain role. Once our inputs, e.g., assuming a particular role, fail to garner what we feel are just outcomes, we will experience an emotional reaction. Gelles (1974) has illustrated the idea in his description of a birthday party in a family where the husband had beaten his wife. At the party, the wife offered the first piece of cake to a guest. The husband, having learned that a husband ought always to be served first, stomped out of the house enraged. Equity failed, but as always justice is, to a large extent, in the eye of the beholder.

The importance of this discourse on role expectations and justice lies in the emotional reaction which many have when their expectations are not realized. Current trends suggest that almost one in every two marriages will end in divorce (Hetherington, Cox, and Cox, 1977). This finding implies that many role expectations, e.g., those assuming a unified, suburban family with strong parent figures, will increasingly fail to be met. Moreover, the trend toward larger numbers of working wives, many times from economic necessity, means that many women desiring to stay home as part of their mother role will not. In addition, some working wives will achieve more occupational prestige than their husbands, contrary to traditional norms. Indeed, Gelles (1974) has found that such a reversal of expectations contributes to violence between spouses which, in turn, correlates with child abuse.

Thus, as more women work and as the single-parent family becomes more common, at least for some period of time in the life cycle of most families, traditional role expectations may increasingly fail to hold and a great deal of emotional behavior may result. Importantly, aggression is not the only reaction which emotionally charged situations may produce. For example, many upset people may simply withdraw quietly from irritating situations. We will have to ask eventually what produces such differential responding.

Certain individual items on the Social Readjustment Rating Scale help tap a dimension of failure in role expectations. For example, Justice and Duncan found that "sex difficulties," i.e., problems in meeting marital role expectations, were more prevalent among abuse than control families. We also found the same result in the Pennsylvania study. Additionally, we found evidence that men in control families were more likely than abuse fathers to experience changes consistent with our traditional views of the male role. For example, control fathers were more likely to report important personal achievements, school completion or job advancement than their abusive counterparts. On the other hand, abuse fathers were more likely to experience changes inconsistent with the male role. For example, they reported a higher incidence of illness and trouble with the law. Moreover, abusive families were more likely to report major changes which may require dramatic shifts in role responsibilities, e.g., health problems, death of a family member, a son or daughter leaving home, or pregnancy. It is interesting to note that Gelles (1974) found a dramatic relationship between this last item, pregnancy, and family violence.

To outline the argument thus far, it has been suggested that failure to meet role expectations may lead to feelings of unjust treatment and emotional behavior. Some items on the Social Readjustment Rating Scale are consistent with this thesis since abusive families appear to experience more failure in this area than controls. Thus, unlike Justice and Duncan (1976), our hypothesis is not that change alone causes problems, but rather that particular sorts of change upset family equilibrium by disturbing the role expectations which parents have come to assume as just. Further, the increasing divorce rate, combined with the rapidly developing opportunities for women, suggests that traditional role expectations are increasingly more likely to fail to be realized. Thus, until or unless our expectations of family roles change, we are likely to see a great deal of emotion generated by these factors. The argument thus far is too simple since all that has been done is to restate the frustration-aggression hypothesis which itself has proven to be an unreliable predictor of violence. To say that people may get angry when deprived gives little information about what form their anger will take.

LIFE CHANGE AND SOCIAL LEARNING

Indeed, Bandura (1973) has pointed out that feelings of injustice alone will not produce aggression unless violent response has been learned as an appropriate behavior when one is frustrated. In order to test this notion with abuse parents, we dichotomized both them and the control group into those with either mild or no life crisis and those with moderate or severe life crisis. In addition, both groups are divided into two other categories: (1) those who agree that either they were or a sibling was severely punished as a child and (2) those who disagreed with the same question.

Table 2

LIFE CRISIS BY PUNISHMENT AS A CHILD FOR ABUSIVE AND CONTROL PARENTS (IN PERCENT)

		ABUSE			CONTROL		
		Life Crisis			Life Crisis		
		Mild or None	Moderate or Severe		Mild or None	Moderate or Severe	
Severe Childhood Punishment	Agree	6	41	47	6	0	6
	Disagree	24	29	53	39	55	94
		30	70	100	45	55	100
		n = 17			n = 18		

As Table 2 shows, not one control parent who was experiencing moderate or severe life crisis also reported severe punishment as a child. On the other hand, almost one-half of the abuse parents report they were exposed to severe punishment as children and are currently undergoing moderate or severe life crisis. It appears, then, that when severe punishment of children has been modeled for a parent, possibly under conditions of life stress, current life change will produce similar behavior in the parent. Thus, life stress apparently interacts with early learning to increase the chance of an abuse incident.

CONCLUSIONS

Certainly, this paper is speculative. But the chain of reasoning seems logical enough in light of current information. If a parent has learned to react violently under conditions of stress, that violence may be directed toward a child, especially if one's own parents were more likely to abuse during periods of rapid change. Moreover, such learning can occur not only if one is directly abused but also if stress-produced aggressivity is observed.

One source of stress is found in changing family relationships where the failure to meet role expectations of the parents may produce conditions viewed as unjust or inequitable with attendant emotional reactions. Finally, as marital stability decreases and women continue to challenge the traditional roles of males and females, whether through conscious effort or economic necessity, there should be increasing numbers of men and women who see their learned expectations for family role relationships seriously violated.

Fortunately, expectations can and will change. There seems little doubt that economic opportunities for women will increase, prompting major modifications in our beliefs about what family members should do. As Homans (1974) has said, what is done becomes what ought to be done, and as the interactions between men, women and children change so will our expectations for the roles they occupy. In the meantime, efforts to teach reactions to stress which are nonviolent in nature appear important not only for the prevention of child abuse but also as a means for decreasing the generally high rate of interpersonal aggression we experience in this country.

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Changing Family Roles and Structures: Where Can a Parent Find Support?

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We have been asked to draw together our various views about changing family roles and structures, and discuss whether or not this multiplicity of changes will have an impact on the current status of child abuse and neglect in our country. I address my comments to the following areas: the changing family roles; the changing family structure; and the problems inherent in a family where the parent or parents are isolated socially, have poor self-concepts, and have unrealistic expectations of the children in their households. Often, overlaid on this family is the uncertainty of adolescence, poverty, migration, prison, unemployment, and underemployment.

I believe that the role of the family has changed little during the generations within our memory. The role of the family, as I see it, is the provision of intimacy for adults and the time and space for that to occur, emotionally and sexually. For the children, the family serves as a place of learning about what it means to be an adult in our culture and in the child's particular subculture. Ideally this period of socialization should provide protection, be safe, and reinforce the accepted mores of the society. Not all families or children are lucky enough to have such a positive family setting in which to flourish. It is a basic human need to be admired, respected, loved and cared for, and to give the same in return. Our job is to address the issues that make it impossible for families to become the kind of families they would like to be—without violence, abuse, derision, and fear.

Roles within the family are changing radically. Fathers are expected to be more nurturant—to have a greater role in childrearing. Mothers constitute an ever greater proportion of the work force. In 1972, 12.7 million of the 33 million women in the labor force had children under 18 years old. Women are economic providers for their families, while in some families the parent roles of nurturance and financial support are merging. In single parent households, one parent must fulfill all the parental functions at home and at work.

The once common extended family, with grandparents, aunts, uncles, cousins, and siblings living in close proximity, has now been separated by distance, primarily geographical, but sometimes emotional as well. The ready-made supports or "life-lines," necessary during the natural crises of life, are often no longer available during "rites de passage" (puberty, marriage, birthing, divorce, death, disability). Financially, people may have more resources than ever. There are the insurance programs, employee benefits, social security, public assistance and other benefit programs, but these programs do not take the place of necessary emotional support. So other solutions, providing "life-lines" for families at these times of "natural crises," must be innovatively created. This is our challenge.

My major concern is that our social policies enhance the breakdown of the family, rather than strengthen it. In the past, Aid to Families with Dependent Children (AFDC) was called Aid to Dependent Children (ADC) and for families to be eligible the father could not live at home. Thus fathers left their homes so that their families would not starve. Currently, in two-parent households the average income is $12,000 yearly, whether or not both parents are employed. In a single parent household headed by a male, the average annual income is $9,000, while in a single parent household headed by a woman with one child, the average annual income is $3,021. Living in poverty is being a woman with one child. In a country that has the resources that we do, this issue must be addressed.

We have many answers on this panel and the audience has many also. However, the difficult part is implementing them. How do we get the resources redirected so a new orientation can be facilitated? We need to provide "automatic" life-lines at times of natural crises.

A young woman delivered a baby in a hospital in New York City and returned to her bleak apartment. Later, she left the apartment to go shopping and the baby was eaten by a dog. It became very apparent, upon investigation, that this woman had no life-lines and no supports, and no one anywhere along the process of birthing asked her if she needed anything or if there was someone to help her after the birth of the baby. That does not seem so difficult at the time of a natural crisis: to ask if the person needs help. But, it is something that we do not commonly do. So the time has come to recognize that birthing is definitely a crisis time for many women as well as most families. Thus, it is a time for intervention.

In San Antonio we are trying to do something about this problem of unaided new parents. In February of 1977 I had the pleasure of being a member of a small group that created the Teenage Parent Network. Usually teenage parents, particularly the girls, are reached in school if they remain in school, but once the baby is born most services cease.

The Teenage Parent Network is a support system. We are assisting adolescents in the transition to parenthood by connecting them to appropriate community agencies. By modeling interpersonal exchange via a three-way telephone hookup system, and with home visits and office interviews, the Network broker can show the parent how to ask for and receive assistance. Careful documentation of each client contact will locate these young families and identify their specific needs, whether they be in the area of housing, health care, vocational training, or counseling. Additionally, we envision promoting a network of professionals who work with adolescents and encouraging them to exchange information and share expertise. Why? Because just at the time when a teenager delivers a baby, most of the available programs are pulled out from under her. In San Antonio, we are attempting to help create an independent person who can obtain what is needed for her and her family (particularly when she does not have her parents or the father of the baby as supports). We believe this Network will enhance her ability to function as an adult. During the second year of our program, we will begin a competency-based curriculum (based on high school educational programs developed in Oregon) called "survival courses." They will teach adolescent parents how to use a checking account, complete a job application, select an apartment, understand loans, take out a mortgage, etc.

Prenatal screening is another important area. We know (from the work done by Kempe in Denver and Helfer in Michigan) of ways to identify parents who might have poor parenting skills and poor parent-child relationships. Automatic means for intervention—helping a family before a newborn is injured—is essential. Along with the two previous ideas is the need for preparation-for-parenthood courses. The Exploring Childhood program, sponsored by the Department of Education, is a fine example. But it is only a beginning for a small proportion of our youth who are learning the ways of child care, child growth, and development and parenting skills while on the job in day care centers affiliated with the high school. These parenting courses should be available not only for the young and first-time parent, but to the experienced parent who has not adequately handled rearing a "special" child and to parents who have not been able to accept that age-appropriate behavior differs from child to child.

Child care is crucial. As a nation, we have not resolved our ambivalent attitudes; yet families and children need good quality and safe child care (nonpunitive) during work time and after school. Use of flexible work hours, as well as use of the work place for day care centers and after-school programs are additional approaches to solving the problems of leaving children unattended for hours on end.

Some businesses are beginning to allow paternity leaves for a birth in the family, and it is becoming more acceptable to have fathers in the delivery room. The emerging role of fathers as child-caretakers needs more attention. This implies being allowed to leave the work place, without penalty, to attend to family responsibilities. Another approach is to make certain that young people have access to a job and vocational training as they graduate from high school. This is crucial in cases where young people intend to go to college and their financial support changes (due to death or disability of parents or family). Thus they have a difficult time in finishing their education and yet do not have the training to support themselves or a family.

There are ill-defined problems inherent in the relationship between child abuse and drug abuse. All too often we pretend not to recognize the problems of drug abuse, especially those of alcoholism—alcoholism on the job, the problems of the troubled employee, and the direct relationship of alcoholism and the potential for child abuse. However, when employers have been willing to address the problems of the troubled employee with Employee Assistance Programs, there has been a financial return to the business in increased efficiency, less absenteeism, less on-the-job injury and increased work performance.

Books developed to orient people to services in their cities are available. In Chicago, they have a *"Peoples Yellow Pages,"* while in Philadelphia they have *"A Philadelphia for Children."* These books, available to the public, allow people to learn about their community and the available services. They include social service programs, activities, free programs, craft centers, health programs, legal services, etc.

As a final suggestion, I propose a program that hopefully will have far-reaching effects by creating a more realistic and serviceable financial security for individuals in our country. If we gave $1,000 to every family at the time they had a newborn, placed in trust for the child and available to the family only at the time of disability or 50 years later (as what we call now social

security), that $1,000 at 9 percent would provide $75,000. If it was $2,500, at 9 percent, that individual would have $185,000 at the end of 50 years. The $199 a month for an elderly person that we often hear about would be replaced by substantial dollars. Not $86 a month for a woman and her one child on AFDC in Texas, but real dollars: to live on, to share with one's family, or to inherit. It is an exciting idea to know that a small amount of money could grow so large, that a family in times of crisis, disability, or need, could actually use the trust. Thus, money-poor families would not continue to be the exploited families and the high-risk families in our country.

"Just a Housewife," or The High Cost of Isolation and Devaluation: What's the Bottom Line for the Child in the Family?

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As a counselor to women ranging in age from 24-60, I repeatedly encounter the discouraged homemaker/mother who feels seriously devalued in her role. Obtaining a "paying job" often symbolizes the attainment of some self worth, despite the fact that fully 2/3 of all working women have pink collar jobs which yield little money, satisfaction, or status. Her feelings of inadequacy are reinforced by the mixed messages she receives from other women, men, the media, and her daily milieu.

As the key figure in the "nuclear family", she is frequently trying to be an effective parent while coping with her own frustration and confusion. In a highly mobile society, she is often new in town, new in the neighborhood, and far away from family and familiar friends. She has few resources to turn to when she is fed up with the constant demands of small children and can't afford or can't find babysitting relief. Not surprisingly, she also may feel intensely guilty about her desires to escape to "some other kind of life." The bottom line for the child in that family may well be neglect or abuse.

The runaway success of Marabel Morgan's book, *The Total Woman*, a manual for manipulative behavior, is a dramatic alarm bell. Its surface attempt to deal with complex human needs is widely embraced. Why? Because thoughtful, experienced, articulate women and men are not bothering to offer any usable guidance to the great numbers of women threatened by ERA, the putdown of home and family, escalating divorce rates and the deceptive choices they are supposed to have in choosing a life style. Thus, it is no surprise that the "Total Woman" philosophy rushes into the vacuum with pat tricks and saccharine solutions.

Amitai Etzioni employs three concepts useful to our discussion: societal bonds, or the glue that holds society together; societal structures such as family, school, government; and societal processes, which refers to the ways in which the bonds and the structures can be changed. Clearly, the responsiveness of the processes will determine the fate of the first two. Therefore, I would like to begin to identify the ways a social network can be developed to provide a nurturing base for each child, each coping mother and father.

There are three main categories of possible action:

1. Educated, concerned, and articulate women must make a large niche in the feminist movement for the homemaker/mother. The professional woman must become the advocate, not the patronizer, if homemaking and the nurture of the next generation are to be considered a legitimate career choice.
2. Fee for service is a well recognized feature of American life. The woman who works at home deserves her share of the economic pie. To have the same minimum economic security other workers demand and receive, coverage by social security, pension plans such as Individual Retirement Accounts already approved by IRS, and health and disability insurance through a group designation (homemakers are a large insurable group) are essential. Divorce or widowhood is difficult enough to bear without the burden of finding that the homemaker/mother has no benefits in her own name.
3. Let all interested social, professional, and civic workers serve as facilitators and organizers helping homemaker/mothers form cooperatives for child care, protection, companionship, and emotional support. Self help groups such as Alcoholics Anonymous have demonstrated their effectiveness. Saul Alinsky demonstrated the power in neighborhood organization many years ago. These can be the preventive actions: the development of helping networks, by building, by block, and by neighborhood, to include the lonely, frustrated, despairing parents who cannot give their children a decent chance unless they experience some security for themselves.

Home Free: A Look at the MOTHERS Organization

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MOTHERS Organization
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Needing help is legitimate. Motherhood is a profound crisis for which we are not adequately prepared. Although manuals and guides for "effective parenting" and baby-care fill the bookshelves, and many valuable how-to-parent groups have sprung up, they all place the emphasis on the child. There is very little information on the growth and development of mothers. Women themselves have only recently been aware that while the child is going through his stages of development (e.g., Terrible Two's, Naughty Nine's) his mother is developing and changing simultaneously. That at any given time one's life incorporates both internal and external aspects, in constant flux.

> The external system is composed of our membership in the culture: our job, social class, family, and social roles, how we present ourselves to and participate in the world. The interior realm concerns the meaning this participation has for us (Sheehy, 1976).

The Women's Movement, long neglectful of the homemaker, is now realizing that a civil rights program for the professional woman alone is not sufficient for liberation. The homemaker must be included as a vital part of the Movement, as it is at this 'grass roots' level that attitudes are molded and/or changed. Increasingly, feminists are writing of their experiences as mothers. They are joining the ranks of mothers in reaffirming the sublime nature of motherhood, but not at the expense of themselves as whole persons.

THE MOTHERS ORGANIZATION

MOTHERS was formed in August, 1976, in Austin, Texas. It now involves 300 mothers in the Austin area. MOTHERS was formed as a support group for the self-aware, thinking mother. MOTHERS also has a political thrust in that we believe that the future of women can be regarded in a hopeful light only if a new definition of the homemaker is adopted. Until women stop being suspicious of each other and learn to talk honestly about themselves—first in groups such as MOTHERS, then in unity—we will not make any headway in the task of reconceptualizing motherhood.

What is it about motherhood that needs rethinking?

1. The role of what Jessie Bernard calls "Motherwork" in the larger economy.
2. Society's conflicting attitudes towards the institution, i.e., the hope that "the earth will turn into paradise if mothers will only produce a generation of satisfied individuals—orally-anally-genitally" (McBride), which contradicts the equally prevalent attitude that mothering is an unskilled profession, unproductive, with no tangible evidence of achievement.

A SUPPORT NETWORK

In forming MOTHERS we felt we were dealing with a Catch-22 situation. We had heard phrases like "isolated housewife" and "housebound" and that familiar phrase, "I'll ask my husband". And here we are attempting to lure the mother out of her home to spend an evening dedicated to her own independent intellectual and psychological growth. Could we possibly succeed?

We decided that the woman who needed a service like this was middle-class, educated and had probably left a high-esteem job or career in favor of child-rearing—at least for five or six years. She would not be prepared for the incredible adjustment from her previous role as earner to one as dependent, from concern with pursuing self-interests to concentrating solely on the welfare of another human being. Yet she would be a woman who would understand intellectually that these adjustments and changes in her lifestyle were inevitable. Mothers who were not willing to settle down and repeat the feared pattern of boredom and frustration would need a group that expressed their own values and goals and provided an appropriate setting for them to verbalize their concerns.

One attitude that women grow up with is that financial stability goes along with being a perfectly coping mother. But many experts indicate that abuse and neglect of children in middle and upper class homes occurs at least as frequently as in lower income families. It is widely assumed, however, that because these acts are not reported or are dealt with privately, nothing can be done about them. MOTHERS cannot claim to prevent child abuse, but we do offer a preventive support system to the middle-class housewife.

OBJECTIVES OF THE ORGANIZATION

1. MOTHERS provides a forum for discussion of common concerns related to the psychological and creative growth of the woman with children.
2. MOTHERS provides a support group particularly for women who have made a conscious decision to be at home and who have definite goals towards achieving success as a mother and as a person.
3. MOTHERS places a high priority on home life and is dedicated to raising the status of motherhood in a realistic way, by challenging the myths of that institution.
4. MOTHERS believes in maintaining contact with current issues. This will be reflected by the variety of topics and invited speakers.
5. MOTHERS, as a group with special interests and special representation, will monitor and react to public affairs affecting its interests or those of its children, and take initiatives by proposal and majority vote of members.
6. MOTHERS supports the idea that motherhood is not necessarily appropriate for all women and that being a mother is a matter of choice—not destiny.

LONG-RANGE PLANS

a) MOTHERS Centers.

For many mothers, the physical environment consists of their lonely and isolated homes, their cars and impersonal shopping malls. Opportunities for meaningful social interaction at an adult level are sorely missing. Superlative day-care nurseries in combination with parks, meeting rooms and shopping facilities could re-create the "village well" in modern suburbia. The concept of a facility which is geared to the needs of the mother and her children is unique, and we feel, long overdue.

b) Studying the well-functioning mother.

What are the critical differences between a coping and non-coping mother? The MOTHERS organization took this question and the idea of a questionnaire whose content would be based on the thoughts and experiences expressed by the members of the group to Dr. Mary Teague of the University of Colorado. Under her professional guidance we developed the initial stages of a questionnaire designed to study the attitudes of the coping mother.

The questionnaire is experiential in nature. We realize that attempting to systematize something as variable as the human personality is no easy task. However, it is our belief that this questionnaire, when fully developed, will at least provide a starting point for the study of the well-functioning mother.

Taking a cue from Maslow, through observation, interaction, and questionnaires like this, MOTHERS hopes to develop instruments that define and characterize the coping mother. This body of women and such knowledge as is developed could well serve as a role-model and a normative model for professional action with regard to non-coping mothers.

APPENDIX: THE COPING MOTHERS QUESTIONNAIRE

Your Age: _____

How many children: _____ Birthdate: _____, _____,

_____, _____, _____, _____,

Your Education level: _____(Highest grade or Degree)

Income of family: (Check one)

1 - 10,000
10 - 20,000
20 - 30,000
30 - 40,000
above - 50,000

Are you employed outside the home at present _____

full-time _____
part-time _____

Married Divorced Single Widowed

If married, how long _____

Have you ever sought help from a social agency for you or your family _____

Have you ever had counseling from a professional in private practice _____

1. I have felt generally happy and content with my life as a whole since I became a mother.
2. When my child(ren) make(s) too many demands on me I feel helpless and unable to deal with the situation.
3. My mother was comfortable and content with being a mother.
4. Since I became a mother I feel guilty about taking much time to do things for myself.
5. I feel isolated from the outside world most of the time.
6. I feel "in control" most of the time with the child(ren).
7. I have close friends I can talk to when I am feeling low or upset.
8. Much of the time I feel that situations in my life control me rather than that I control them.
9. My husband is very understanding and supportive when I am unable to cope (do not answer if you do not have a husband).
10. I feel that I (rather than my husband) have most of the responsibility for caring for and spending time with my child(ren).
11. I was very fearful of becoming a mother because I thought I would not be a good mother.
12. I have given up most of my interests and aspirations and feel that I will not ever be able to get back to them.
13. I had a larger part than my husband in the decision to have children.
14. There are people I trust (relatives or friends) who are available to take care of my child(ren) when I want to go out or to get away.
15. I wish that I had never had children.
16. I feel that I am as good a mother as I am anything else (such as career women, wife, musician, friend, etc.).
17. When I was growing up my mother and I were very close.
18. I tend to feel trapped since becoming a mother.
19. When I am feeling very frustrated with taking care of my child(ren), I cannot believe that things will get better or that the bad times will never end.
20. I believe that being a mother is the most important thing a woman can do.
21. I feel that I am not really handling my child(ren) the way I should.
22. I am involved in and get satisfaction from activities other than mothering.
23. I feel that I (rather than my husband) have most of the responsibility of disciplining my child(ren).
24. I generally base my mothering attitudes on someone I have known (including your own mother).

(Each question is scored on a five-point scale from "Extremely true" to "Extremely untrue").

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One Mother's Thoughts

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I am a mother. I feel very isolated; isolated from my husband sometimes; isolated from my friends who aren't married; isolated from friends who don't have children; from people who work outside the home; from all people outside my home.

I need to be around people from diversified backgrounds, backgrounds other than those of the plumber, the TV repairman, the mailman. I need people to talk to, like other mothers. I want to learn how other mothers think. I want positive, constructive conversation with other mothers. I want more than just an outlet to complain, but I need that, too.

I need to talk to other mothers about how motherhood has affected them as people. I need this so I won't feel so alone. I need new and stimulating relationships with women and with men, too.

I want to know what other people are doing with their lives. I have a low self-concept. I don't feel that my job is seen as important. I need help in mothering. Often I don't know the answers. No one ever taught me how to be an effective parent.

I need to learn how to be selfish, to take time for myself, to do things that I want to do. This will help me to become a better partner for my husband. I want to explore what other husbands think about the responsibility of mothering. I know what my husband thinks about it—or I think I know what he thinks.

My relatives are so scattered throughout the country. They are so far away. I need their support, but how do I get it? Letters and long distance calls don't seem to bring them close enough to me.

I feel guilty about so many things: when I take time for myself, when I leave my children with my husband to go to a meeting at night, when I ask my husband for so much help with the children.

Sometimes I think I'm hurrying through these most precious years when my children are so young, so sweet, so innocent, so adorable. I want to appreciate this valuable time so very much, but I often find myself wishing it away.

I need support, I need understanding, I need respect from my husband, my children, my relatives, my friends, my neighbors, my "business associates", and others. I hope that some day when I have this support, understanding, and respect that I'll recognize it and finally feel with deep fulfillment and personal satisfaction that I am indeed a truly worthwhile person because I am a mother!

Cultural and Cross-Cultural Perspectives

The Significance of the Child's Cultural Milieu and Family Environment for his Mental Health and Development

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The critical importance of a family for the developing child is universally recognized. An infant could not survive without a nurturing parent. Family interactions of mother, father, and young child leave a deep indelible impression upon the child's personality. Down through the ages and across the many cultures of man, the family in some form or other is the most durable of our social institutions. Too often we take the family for granted because of its pervasive influence upon us. One only has to experience a disruption of the family or the loss of a loved one to realize its fundamental importance. Families differ markedly in life style, social interaction, cohesiveness, size, and the degree to which grandparents, aunts, uncles and others are thought of as part of the extended family.

Many families are in trouble today. Family patterns are changing in ways that spell trouble for the children of our society. The National Academy of Sciences has just published a major report aimed at establishing a new national policy for children and families. Among the disturbing statistical trends noted in this report are the following:

1. One out of every six children under the age of 18 now lives in a family with only one parent—double the percentage of single-parent families in 1950. In single-parent families, it is usually the father who is absent. The effect of father's absence depends largely upon why he is absent and the attitudes that remain after his departure. Children can develop normally in a single-parent home but it is often more difficult: there must be adequate alternative supervision of the child while the parent works, there must be adequate contact with the child when the parent is at home, and the absent parent should not be denigrated in the eyes of the child.
2. Adult family members are less available to children today than a generation ago. The number of working mothers with preschool children has tripled, while the proportion of working mothers with school-age children has doubled since 1950. More children than ever are left to fend for themselves. After school hours, the passive viewing of television has substituted for parent-child interaction in all too many homes.
3. The number of illegitimate births, mostly to teenage mothers, has increased sharply in the past 15 years. Today one out of every eight births is illegitimate. About 10 percent of American teenagers get pregnant and six percent give birth each year. The Alan Guttmacher Institute (1976) reports that more than half of the twenty-one million teenagers in the United States are sexually active. Of the 600,000 teenagers who gave birth in 1974, only 28 percent had conceived following marriage. Although fertility in general has declined since 1960, birth rates among young girls have actually risen. This epidemic of adolescent pregnancies contributes significantly to the number of infants and young children who receive inadequate care. U.S. teenage child-bearing rates are among the world's highest. The frequent lack of prenatal care and the fact that most of these mothers are very young produces an unusually high percentage of babies who are underweight and frail.
4. Child abuse, infanticide, teenage suicide, school dropouts, drug use and juvenile delinquency have increased concurrently with these other major social changes in the family. Youngsters growing up in low income families are at especially high risk of damage physically, intellectually, emotionally, and socially.

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5. The middle-income family of today in America increasingly resembles the low-income family of the early 1960's on most of these indices of social disorder. Quite clearly, the children of so-called traditional families are also in serious trouble to a higher degree than our society can tolerate.

What can be done about these alarming trends? The medical model of diagnosis and treatment by a professional specialist may be an appropriate way to cope with these problems which have clearly negative implications for the health of our nation, as well as the mental health of our children and families. A different approach that might be more appropriate is the public health model with its emphasis upon epidemiology, innoculation, and preventative measures. A third point of view is that of the educator, social planner, or policy maker who believes that social intervention aimed at eradicating the root causes of social disorder is the only long-term solution. Before examining these three points of view in more detail, let's look at what we mean by mental health and illness.

Severe mental illnesses, such as schizophrenia or depressive psychoses are only one aspect of mental health problems. Chronic alcoholism, drug addiction, social alienation, child abuse, crime and delinquency, some forms of interpersonal aggression, dehumanizing and degrading social practices, family disintegration, neurotic behavior, and a host of other common psychological and social problems are of even greater importance in a society that is searching for better ways to promote mental and emotional health for all of its people. Absence of mental illness is not synonymous with the presence of mental health. All of us are faced at some time in life with identity crises, severe emotional stress, frustration, and failure. At one time or another each of us desperately needs help. A mentally healthy person is one who not only has learned to cope with most life stresses but who also understands when help is needed.

While every culture has some way of coping with psychological and social problems, complex industrialized societies create for their members unusual stresses that require professionally trained people to provide a wide range of services to people in need of help. For each highly trained professional in the mental health field, a number of paraprofessionals, technicians, and volunteer workers are needed for services to be effective. Most professionals come from middle-class or upper-class backgrounds, creating particularly acute problems in services for the large number of relatively uneducated, lower-class families who desperately need help.

A child's cultural milieu and family environment have a more profound impact on mental health and illness than upon any other aspect of individual health and illness because of the interpersonal and behavioral nature of mental health. The medical model emphasizes the professional expert engaging in diagnosis and treatment of a mental illness. Here the clinical skills of the professional and his assistants are of paramount importance in providing effective services for an individual in need of help. In most cases, close attention must be paid to environment-behavior interactions within the family as well as in the cultural milieu in order for intervention to be effective. A second approach grows out of the preventative model championed by public health. Here the strategy is one of locating the focal points in society where high risk of emotional breakdown can be determined and developing social practices that are aimed at minimizing the degree of mental illness that occurs. Again, the primary focus is upon illness and the prevention of it. The third point of view, which has sometimes been called the positive mental health approach, emphasizes educational and social intervention on a large scale to overcome the cultural and environmental factors which prevent the full development of an individual's growth potential.

The community mental health movement, which has grown rapidly in the past fifteen years, places strong emphasis upon a combination of preventative public health measures and social intervention aimed at promoting greater mental health. Clinical services tend to be short-term, to provide crisis intervention. The professional devotes more of his time to preparing others such as parents and teachers to deal with problems themselves rather than offering to deal with the problems directly. Both the medical model and the community mental health model are valid approaches in dealing with the mental health of families and their children. Both also have serious limitations that are overlooked all too often. Let's examine the significance of the child's cultural milieu and family environment from each point of view.

Mental and emotional disorders of childhood have been a primary focus of research programs supported by the National Institute of Mental Health since its beginning nearly thirty years ago. Research support of child mental health by NIMH can be roughly divided into three nearly equal areas: (1) child mental illness, (2) learning disorders, and (3) social disturbances

reflected in juvenile delinquency and child behavior disorders. Studies of childhood mental illness have concentrated primarily upon infantile autism, regressive psychosis in young children, and childhood schizophrenia which generally appears between the ages of ten and fifteen. All three of these illnesses are serious and exceedingly difficult to treat. A generation ago, it was widely believed that pathological behavior on the part of parents was primarily responsible for the development of severe mental illness in children. Research in the past twenty-five years has uncovered little if any scientific evidence to support this hypothesis. Nor is there any strong evidence that the child's cultural milieu plays an important role in the development of severe mental illness. While the mental health of the family may be seriously impaired by the presence of a psychotic child, it is unlikely that the child's illness is directly caused by the parent's behavior or social forces in the environment, except in extreme instances. Some of the most promising treatment methods are those in which parents are trained as therapists to cope with the child's inability to communicate normally or to develop normal social relationships. While the family may not be primarily at fault in most cases of childhood psychosis, recent research has demonstrated that even the severely psychotic child responds more normally when placed experimentally in a family with "normal" parents. Communication styles in some families appear to exacerbate psychopathological symptoms while communication styles in other families tend to normalize schizophrenic language and behavior. Clearly, some as yet unknown interaction between biological and genetic factors on the one hand and psychological and environmental factors on the other is responsible for the development of severe mental illnesses in children.

For child mental illness and some specific neurotic symptoms and related behavior problems, the medical model with its clinical emphasis upon diagnosis and treatment is still the preferred approach. At the same time, it should be recognized that the kind of treatment to be prescribed for such disorders inevitably involves family members or substitute caretakers in a much more profound way than they are characteristically involved when physical illnesses are present.

Learning disorders, the second major concern in child mental health, can lead to serious emotional and behavioral disturbances if they persist into late childhood and adolescence. Modern society places a heavy premium upon learning basic skills in school. Children with learning disorders represent the major single cause of school dropouts. Only occasionally is the medical model appropriate in coping with such disorders. Labelling a child as having a reading disability or minimal brain damage where no direct evidence of such a diagnosis is present can adversely affect the child's later psychological development. Most of the experiments involving special educational programs to deal with learning disabilities have demonstrated that the great majority of such disorders arise from failures within the cultural milieu and the family rather than genetic or neurological defects. As many as eighty percent of children with reading disabilities can be brought up to normal classroom levels if given special education during the first two grades of school. Early intervention with infants and preschool children has proven equally promising, provided certain general principles are carefully followed. In a recent review of large-scale experiments in the United States, Bronfenbrenner (1974) has formulated some principles of early intervention that are worth noting.

First and foremost among these principles is the development of family-centered intervention. The evidence to date indicates that the family is the most effective and economical means for fostering the development of the child. Active participation of family members is critical to the success of any intervention program. Ideally, intervention begins in preparation for parenthood and in providing an adequate cultural milieu for nourishment of the newborn infant. Large-scale parent-child development centers established as national experiments have clearly demonstrated the value of parental training in the first years of life, followed by preschool group experiences in which parent and child continue to work closely together. Highly significant results have been obtained not only for disadvantaged black minorities but also for middle-class white families, Spanish-speaking Mexican-Americans, and other ethnic groups. A closer look at the Parent-Child Development Center, a program for Spanish-speaking Mexican-American children in Houston, illustrates the way in which this type of educational-social intervention improves the mental health of children and their families.

In the Houston model program, social intervention consists of working closely with both the mother and father of very young children. Beginning when the child is 12 months old, frequent home visits by a bilingual worker introduce the mother to a number of techniques for intellectual stimulation of the child. The mother is coached in her communication with the child in order to promote cognitive and personality growth while maintaining strong affectional bonds between mother and child. Mothers and fathers meet regularly several times a month in the

evening to discuss their family problems, to share their ideas and to seek advice. The family is dealt with as a whole and the techniques are carefully adapted to the cultural milieu in which the family lives. Consequently, the parents are uniformly enthusiastic.

When the child is two years old, mother and child attend a special nursery school four mornings a week where parent-child relations continue to be stressed at the same time that the child is introduced to social interactions with other children in a controlled, stimulating, but playful environment. Videotape recordings of mother-child interactions are played back for the mother so that she can see how she is facilitating or inhibiting desired behavior in the child. Periodic contacts with the family are maintained after the child is three years old in preparation for entering school.

A model program of this type incorporating all of the best techniques for earlier experiments is expensive, particularly when carried out as an experiment with a great deal of research and evaluation accompanying the program. Most of the essentials of such a preschool program, however, can be applied without a great financial investment by use of volunteers and the heavy involvement of parents. Still, one can rightly ask whether or not the benefits from such a model program are worth the costs. The final answers to this important question are not yet available. Nevertheless, early returns from evaluative research indicate the following important findings when the experimental families receiving the program are compared to similar families who do not participate:

1. As compared to controls, the program mothers grew significantly more affectionate, encouraged more child verbalization, showed more praise, and had children who were more verbally responsive.
2. Home observation scales revealed greater maternal involvement with the child, greater emotional and verbal responsivity of the mother, avoidance of restriction and punishment, and more provision of appropriate play materials on the part of the program mothers.
3. The experimental children maintained a nearly constant level of mental ability over time, as measured by the Bayley Scales and the Stanford-Binet, while the control children fell steadily behind the norm.

Reports on the effectiveness of similar programs elsewhere indicate that children of trained mothers have gained in both IQ and school achievement, compared to children growing up in comparable homes where the mothers do not receive training. The gains resulting from such "home intervention" programs are largest and most likely to endure when substantial changes occur in the environment of the child as well as in the quality of the mother-child interaction. When adequate health care, nutrition, housing, and general support of the family as a child-rearing system are not provided, the gains tend to fade once the intervention program is discontinued.

While there is certainly room for the medical model of diagnosis and treatment to be useful in dealing with learning disorders, large-scale preventative programs are far more effective for improving the mental health of the population as a whole.

Juvenile delinquency and antisocial behavior disorders constitute the third broad category of concern in the field of child mental health. Antisocial behavior disturbance is the most common childhood psychiatric disorder. Indeed, its prevalence is sufficiently widespread and its causes so complex that many experts would challenge the idea that such disturbances are psychiatric disorders at all. Such antisocial behavior can range from repeated resistance to authority to violent criminal acts. Other signs of emotional disturbance may also be present. The medical model of diagnosis and treatment has generally proven ineffective except in special cases where an underlying specific disorder can be treated.

As one might expect from social learning theory, antisocial parents tend to produce antisocial children. Erratic discipline, negligent child-rearing practices and abuse are important factors, although some antisocial children have conforming, nurturant parents. Antisocial behavior in childhood is frequently continued into adult life where it is transmitted to a new generation of children.

What are some of the important findings that have repeatedly emerged from research on parent-child interactions?

1. The most effective parent is the one who combines affection with strict control and joint discussion of family related issues. Neither the parent who is

affectionate and permissive nor the parent who is cold and authoritarian is as effective, when effectiveness is measured by the child's later competence in dealing with his environment away from home.

2. An infant's intellectual and social development during the first two years of life is facilitated if his mother provides varied stimulation, shows affection, and responds fairly quickly and consistently to his signals.
3. A "vicious cycle" develops in certain families—the child misbehaves, the parent punishes, and the punishment only stimulates the child to further misbehavior. Families which have been caught up in these cycles can, if they wish, be trained to interrupt the cycles themselves and to substitute a pattern of family functioning that is increasingly tolerable to both parents and children.

Parent-child relations are often adversely influenced by psychopathology in a parent. Social policies in the United States for the past fifteen years have called for the phasing out of mental hospitals and the maintenance of mental patients in the community. While there are many desirable benefits from such policies, one negative outcome has been the fact that many families that are unable to cope with the mentally ill patient in the home seriously endanger the mental health of their children. Children who were born to mental patients twenty years ago, when either the husband or wife was initially hospitalized, have been studied recently to see what difficulties were encountered by the child with a mentally ill parent at home. In one-third of these families with mentally disturbed parents, at least one child has had severe psychological difficulties. In less than one-tenth of these families has any guidance been provided to help the children cope with the problems posed by the parent's mental illness. In many families, the well parent has turned to alcohol or has developed emotional problems requiring treatment. Even where treatment was provided to both father and mother, the children were largely ignored. A very early return to the home of heavily tranquilized mothers who are then responsible for the care of their children, usually without additional help, may be producing deleterious effects upon the children. The rehabilitation of a mentally ill mother may take six to twelve months, a critical period for the family when additional support services are badly needed and too often missing.

Family relations and child-rearing practices are topics of continuous concern in most societies. What does it take to be a good parent? How can I make my child behave? Am I doing the right thing when I praise or punish my child? Such questions naturally arise in the minds of every parent. The steady flood of books, magazine articles, lectures, movies, and television soap operas concerned with family life and child rearing testify to the central importance of such continuous reexamination in our society. Acceptable family patterns and child-rearing practices undergo continuous refinement as society changes. Transmitting the primary values, skills and other personality characteristics from one generation to the next is the key to survival as a society. Granted that biological as well as social factors enter into the development of an individual personality, certain shared attitudes, beliefs, and values within the culture provide a common basis for socialization of the child. These implicit attitudes, beliefs and values constitute sociocultural premises that are fundamental determinants of shared personality characteristics within a given culture. For these reasons, studies of families and their children within different cultures can shed considerable light upon the significance of both psychological and cultural factors as they influence the mental health and development of the individual.

Rogelio Diaz-Guerrero, Jon Swartz, and I (1975) recently completed a six-year longitudinal study of over 800 children and their families in Mexico and the United States which illustrates the importance of cultural factors in child development. A large staff of research associates in Mexico City and Austin, Texas, gave an extensive battery of psychological tests to each child once a year for six years. The children were originally drawn from the first, fourth, and seventh grades so that a complete developmental continuum from age six to seventeen could be covered in the six years of repeated testing. Pairs of cases were closely matched across the two cultures in order to control for socioeconomic status, age, and sex of the child. Midway through the study, intensive interviews were conducted with the mothers in their homes in order to obtain information about family life style, home environment, parental aspirations for the child, child-rearing practices, and other factors believed to be important influences upon the child's development. Illustrative of the many findings are the following:

1. The Mexican family is less likely than the American to have intellectually stimulating reading material or study aids for the child in the home. Only rarely

does the Mexican parent read regularly to the child before the child enters school, while the majority of Anglo-American parents read to their children on a regular basis. Most middle-class Mexican children are unable to read, count, or write before they enter school, while most middle-class American parents take pride in the fact that their child has made significant progress in these skills prior to school entrance. A greater value is placed by American mothers on the development of independence and a high degree of intellectual curiosity than is typical of Mexican mothers.

2. The Mexican child's behavior typically involves a coping style based more upon passive obedience and desire to please. By contrast, the American child tends to show a more active coping style, a struggle for mastery. Specific anxieties and defensiveness about test-taking are more acture for the Mexican child than for the Anglo-American. Tests are a necessary hurdle repeatedly demanded of children by modern society. An active coping style provides a self-directed means of reducing such anxieties. A passive-obedient coping style leads only to conforming behavior in the face of threatening tests, a form of inactivity that seems only to heighten specific anxieties. When faced with a testing situation, the Mexican child is willing to cooperate although he will seldom take the initiative. By contrast, the Anglo-American child will see the testing situation as a challenge to be mastered, an opportunity to show how much he can do.
3. American children tend to show more hostility and anxiety in their fantasies, as well as more vivid imaginations. Differences between boys and girls were greater for Mexican children than for American. The Mexican adolescent shows a lesser need to be spontaneously impulsive and a greater need for independence, a need growing out of his increasing awareness that he is indeed highly dependent upon others within his extended family and affiliative network.
4. On psychological and educational tests of cognitive development and social achievement, only minor differences of no consequence exist between Mexican and American first graders when social class and education of the parents are controlled. As children grow older, however, the performance of American children gradually pulls ahead of that for the Mexicans. The more rapid development of the American child through the school years is probably due to a combination of greater intellectual stimulation in the home and different instructional methods in school. It is interesting to note that Mexican girls from working-class families are placed at an increasingly noticeable disadvantage with increasing age.
5. A much wider gap exists between children of working-class families and upper middle-class families in Mexico than in the United States. The values of the working-class parent in Mexico tend to be the most traditional in reflecting the earlier beliefs of traditional Mexican society, while the educated classes are more similar to both working and middle-class families in the United States.
6. Family life style and socialization practices differ appreciably in the traditional Mexican and American families. Fewer Mexican fathers share activities with their sons; Mexican children are given less responsibility in the home and are more likely to have their friends chosen by their parents; Mexican mothers are more controlling of their children, give their children less freedom to express themselves and are more likely to admit to problems in child rearing.

Most of the differences in personality discovered between Mexican and Anglo-American children can be attributed to the differing sociocultural premises underlying the two cultures. As Diaz-Guerrero (1973, 1975) has pointed out before, the majority of adolescent Americans subscribe to active self-assertion as a sociocultural premise while their Mexican counterparts prefer affiliative obedience. Mexicans tend to be more family-centered and cooperative in interpersonal activities while Americans are more individual-centered and competitive.

These examples serve to illustrate the general point that cultures differ in ways that are important for personality development of the child. Variations within any modern urbanized society such as the United States or Mexico are much greater than the general differences between societies. Some shared beliefs, values, customs, life-styles, and child-rearing practices differ considerably from one family to the next within the same society. Normative standards and sociocultural premises only represent the ideals of the society against which the individual

and his family are compared. Marked deviation from such ideals can produce new levels of self-actualization and maturity or desperate feelings of alienation and conflict, depending upon the kind of dissonance and how it is resolved by the individual. In either case, too much deviation from societal norms can lead to anxiety and despair. The recent movement in America toward a pluralistic society has gone a long way toward overcoming the excesses of strong social conformity pressures, making it possible for many more individuals to resolve their deviance in a mentally healthy way.

In spite of these differences nearly all families share a common purpose. Nearly all parents want a better life for their children even though they may not always know how to achieve it. They want their children to succeed in school, to be popular among classmates, to take pride in their heritage, to be respectful toward their elders, and to live happy, healthy lives. As often as not they may set unrealistically high standards for their children, which leads to rejection and disappointment when failure is recognized.

A deeper understanding of human development, families, and their children throughout the life span has been a major goal of philosophers, educators, behavioral scientists, and, for that matter, parents and children themselves. We have begun to discover ways to strengthen the forces for constructive growth and mental health. We have begun to understand the conditions leading to mental illness and malfunctioning of individuals and groups. Enough is already known to see more clearly what must be done to help families in trouble if we are to survive as a society. A new national policy is needed, aimed at reestablishing the family as the primary caring, nurturing and socializing agency of our society. Most families want to be responsible for their own development. Most families also need help to accomplish their goals. Services for families and children should be made available on a universal basis. Where choices must be made with limited resources, the balance of choice should favor children over adults. It must be remembered, however, that you cannot pay anyone enough to do what a mother and father will do for nothing if given a decent chance. Many have called for new national policies placing families and children first among our priorities. Few, if any, have expressed this plea as well as Nicholas Hobbs (1976) who stated the following in a major address on mental health, families, and children:

> "We need to rekindle the caring spirit in America. To nurture altruistic impulse. To restore civility. To rediscover self in the service of others. To encourage fidelity to family. To honor those who fulfill the difficult role of parent, of father and mother. We need a revived national ethos that cherishes communities, families, and children, out of respect for our heritage and in the service of a noble national tomorrow."

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Changing Family Roles and Structures: Impact on Child Abuse and Neglect?: A Cross-Cultural Perspective

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We are now faced with the difficult task of determining what there is about American society and American families that contributes to the incidence of child abuse. I would like to discuss the usefulness of a cross-cultural perspective in understanding what conditions may contribute to positive or negative childrearing. An understanding of the cross-cultural record permits us to view human behavior in a much broader context than is possible in studies of the United States or of Western societies alone. This in turn will enable us to understand which features of our society (and which changes) are most likely related to the incidence of child abuse and neglect.

American families have changed considerably in the last several decades. These changes include a decline in extended families, an increase in divorces and single parent families, and an increase in the percentage of working mothers (Bronfenbrenner 1976, 1976; Chase, 1975; Glick, 1975). There are problems, however, in making causal inferences about the relationship of such changes to the incidence of child abuse. Our awareness of child abuse and neglect has increased markedly since our recognition of the problem 15 years ago (Kempe et al, 1962). However, we still have differing estimates of the actual incidence of child abuse in the United States (Gelles, 1977). While the number of child abuse and neglect cases that are reported has increased, we cannot reliably say that child abuse itself has increased. Thus it would be premature to associate changes in family roles and structures with child abuse until we have more information.

Our knowledge of child abuse and neglect stems almost entirely from studies of Western cultures, the United States in particular. It is an open question, however, whether this is because abuse occurs predominantly in Western societies, or whether this is due to an increased awareness of the problem and consequent improvements in reporting of incidents. Nevertheless, Western cultures are rarely indicative of universal human traits and are often on the extreme end of the continuum for childrearing practices (Minturn and Lambert, 1964; Whiting and Child, 1953). For example, American parents begin to toilet train their children earlier and are more severe in their training methods than are parents in most other cultures (Whiting and Child).

Child abuse, per se, is a topic covered by no more than a handful of anthropologists. Consequently, we need more information; we do not yet know the incidence of what might come to be defined cross-culturally as child abuse. The anthropological literature, however, presents a picture of broad cultural variation in almost every aspect of childrearing. Cultures and individuals form a continuum of behaviors in their treatment of children that range from harsh physical sanctions and early deprivations to total indulgence and nurturance. For example, in one Papua New Guinea culture, a child is apt to lose a portion of a finger or a part of an ear for intruding upon the mother's garden (Meggitt, 1965). In another nearby culture, children are virtually never punished, even for accidentally killing valuable pigs while playing (Langness, personal communication).

For the purposes of this discussion, I will focus on four of the issues that have been linked to the incidence of child abuse in the United States: social isolation, understanding of normal child development, self-esteem, and role reversal. Some factors that bear on these issues will be discussed in terms of our knowledge of childrearing in various cultures around the world. These factors include household composition, alternate caretakers, child caretaking, economic roles and tasks of family members, support systems for parents, beliefs and values about children, and urbanization. Each factor is complex and worthy of extended treatment. The following discussion will be an overview of these factors in order to suggest some of the areas in which a cross-cultural perspective could contribute to interdisciplinary efforts to find solutions for child abuse.

Differences in household composition have been related cross-culturally to differential treatment of children. The sheer number of individuals residing in the same household and the adult-to-child ratio have been associated with the treatment of children. Children tend to receive more warmth and acceptance in households where there are more adults who can fill a caretaker role and fewer children to make demands (Minturn and Lambert). Cross-culturally, extended households tend to be the least severe in their child training practices, providing children with the most warmth and acceptance. One cannot predict the treatment of children in

nuclear households cross-culturally since the caretaker (usually the mother) is able to more freely express both warmth and anger towards her children. Mother-child households tend to be the most severe in their child training practices, with physical punishment most frequent, cross-culturally. (Minturn and Lambert; Murdock and Whiting, 1951; Rohner, 1975; Whiting and Child).

However, the effects of household composition are not free from complicating factors. For example, while extended households tend to be the least severe with children, positive affect is sometimes muted to avoid jealousy between the numerous cousins living in the same household (Minturn and Lambert, Rohner). Similarly, the specific personnel in the extended household is important. In sororal polygynous households (in which the husband has several wives who are all sisters) children are treated more nurturantly than in polygynous households in which the wives are unrelated (Rohner, Whiting and Child). Spatial living arrangements also have an effect. Unrelated co-wives in poloygynous societies who live with their children in separate dwellings have more positive interactions with their children than do co-wives who share the same dwelling (Rohner).

Intracultural studies further support the contention that household composition is related to child treatment. In a study of Kenyan infants, those who resided in extended households were held more while being responded to more quickly when they cried, than were infants in nuclear households (Munroe and Munroe, 1971). In a study comparing nuclear and extended households in India, children were subjected to the same frequency of rejecting behaviors (e.g., "go away") in both kinds of households. However, the rejecting behaviors were performed almost exclusively by the parents (Ames, 1974). Thus, in the extended households, children resided with additional adults who did not display the rejecting behaviors of the parents.

Associated with differences in household composition, the roles that various people in the household fill are significant in terms of the affect directed at the child (Levine, 1967). For example, the presence of grandparents, particularly grandmothers, has been linked cross-culturally with increased warmth and nurturance of children (Minturn and Lambert, Rohner). When the grandmother is the head of the household she tends to act as a disciplinarian; when she has a lesser status, she tends to fill a more nurturant role (Apple, 1956). In the study of households in India cited previously, grandmothers, while not providing essential physical care for the child, were a source of "extras" (Ames).

The presence and availability of alternate caretakers is closely related to household composition. Cross-culturally, mothers who are unable to break continuous contact with their children are most likely to react negatively towards their children (Rohner, 1975; B. Whiting, 1969, 1972). In the Six Cultures Study, the mothers in India, who were confined to their courtyards by strict cultural sanctions, were the most irritable with their children. Mothers with heavy responsibility for child care and little opportunity for relief are the most likely cross-culturally to "blow hot and cold" towards their children (Minturn and Lambert). In this light, it is interesting that the United States component of the Six Cultures Study was the only group in which the mothers spent the majority of their time in infant care without others in the household, or nearby, to regularly relieve them of the task (B. Whiting, 1963, 1972). Children in households with a grandmother present who participants in child care are more likely to be treated warmly and positively (Minturn and Lambert, Rohner). When fathers regularly participate in child care and when they are important socializing agents, there is a cross-cultural tendency for children to be treated with more warmth and nurturance (Rohner).

The household, however, is not only the source of alternate caretakers. The mothers of the Philippines component of the Six Cultures Study, while not living in extended households, had close contact with other women in their neighborhoods who were readily available and willing to assist one another with child care (B. Whiting, 1963). These mothers ranked high on a cross-cultural scale of nurturance and warmth towards their children (Minturn and Lambert). Societies with state organized child care, such as China and Russia, fulfill many of the functions of the extended family in assisting the parents with child care responsibilities (Bronfenbrenner, 1970; Sidel, 1972).

We can only speculate about the relationship between the importance of extended families and alternate caretakers cross-culturally, and the social isolation and lack of others to call upon for help in childrearing that appears to play an important role in child abuse in this country (Elmer, 1967; Evans et al, 1974; Helfer, 1973; Johnson and Morse, 1968; Spinetta and Riggler, 1972; Young, 1964). Even if we could return to the days of extended families, this would not, in itself, insure a decline in the incidence of child abuse. But by considering cross-cultural information we might learn which features and functions of the extended family situation are

important and attempt to apply this information to the solution of child care problems (including child abuse) in this country.

We must also examine the variations in household composition in this country in a total cultural context, not simply as forms of households that can automatically be connected with specific child treatment practices and/or child abuse. In recent years, in the United States, there has been active experimentation on the part of some parents with alternatives to the nuclear family (Glick, 1975; Kornfein et al, 1977). A project at UCLA is examining childrearing in four types of families: single parent families (with the single parent being the mother); communal groups; two-parent, social-contract families; and legally-married, two-parent families (Eiduson, 1974; Weisner, n.d.). This longitudinal study now has information for the first year of life for infants in these different types of households. Interestingly, children are as likely to thrive, or to be developmentally at risk, in all of the groups; presumably, while the composition of the household will show a relationship to later social behaviors of the children, it is not related to deprivation of the child up to one year of age (Weisner, 1976).

This study also provides information about social isolation and support systems for parents of various kinds of households as they undertake the task of childrearing. Parents in the four types of families showed no differences in their recollections of relationships with their own parents. However, it was the legally-married couples who had the most contact with grandparents. Generally, this contact seemed to be supportive and similar to extended family supports, yet from separate dwellings. Individuals in communal groups had less satisfactory current relationships with their own parents and were striving, through participation in a communal living situation, to provide themselves with a support system for childrearing. Other communal group members were available for child care, sharing other household tasks, and to provide the mother (and the father) with adult contact.

The single mothers in this study were particularly interesting because of the increase in single parent households (particularly mother-child households) as well as the stereotype of single mothers in this culture. This study indicates that in our culture, single mothers do not constitute one classification and are not indicative of single pattern of childrearing. Thus, it may be premature to draw a causal inference between the rise in single parent households and the incidence of child abuse.

The study divided single mothers into three groups. The first group was called "Nestbuilders" and included those women who made a decision, prior to attempting to conceive, to be single mothers. These women had prepared themselves emotionally and financially to assume childrearing responsibilities by themselves. The second group, "Post Hoc Adaptors," consisted of those women who resigned themselves to the idea of being single parents after conception but who did not consider this the optimal situation. They did not plan to rear the child alone, but something went wrong with their marriage plans. The third group, called the "Unwed Mothers," corresponds most closely to the stereotype of a young unwed mother, unprepared for the task ahead of her. All three groups of single mothers, like the mothers in the communes, had less satisfactory current relationships and less frequent contact with their own parents than did the legally married mothers. The single mothers, however, particularly the "Nestbuilders" and the "Post Hoc Adaptors", showed evidence of building support systems for the task of childrearing outside of the kin-based group. Natural childbirth classes, La Leche meetings, informal groups of mothers who exchanged information and babysitting help, and so on were utilized to avoid social isolation and to provide information and support in childrearing (Kornefein et al, 1977). Perhaps what we are seeing is parents themselves pointing out the support systems needed for childrearing in the absence of extended family supports.

Using children to care for younger children is significant in cross-cultural childrearing. It may also have important implications for child abuse in this country. Children of seven or eight do much of the infant and small child care in many cultures (Rogoff et al, 1975; Weisner and Gallimore, 1977; Whiting and Whiting, 1973). While older children can be an important source of alternate caretaking, removing the total burden from mothers and other adults, much of the importance of this practice lies in the experience with infants and small children that is provided before parenthood. In the United States, such sibling caretaking is often impossible because of the predominant sibling constellation in which families have two children, separated by only a few years (B. Whiting, 1972). Additionally, in this country, the notion of young children caring for even younger ones has been considered abusive (L.A. Times, 8/19/76). Perhaps this is because of the work-related abuses of children during and after the Industrial Revolution (Spargo, 1913).

The lack of child participation in the case of younger children raises the important issue of the economic roles and tasks of family members. In our society, children have little or no

opportunity to perform tasks that are important to the welfare of the family and that give them practice in the nurturance, responsibility, and altruism that they will require as adults and parents (Benedict, 1938; B. Whiting, 1972). Cross-cultural studies indicate that children who have tasks that are important to the welfare of their household (particularly caring for younger children) develop more positive social behaviors as well as a sense of self-esteem (Whiting and Whiting, 1971, 1973). The task of caring for younger children is an explanation of why female children frequently tend to be more altruistic and nurturant cross-culturally than male children (Whiting and Edwards, 1974). In societies where male children perform more domestic tasks, and in this country where girls have little responsibility for child care, such sex differences are less pronounced. In the Kenyan study group, some of the boys (due to a lack of female children) were assigned the care of young children as well as other domestic tasks usually assigned to girls. These boys exhibited the traits of nurturance and altruism that are usually associated with girls (Ember, 1973). Communal societies, such as China, Russia, and Israeli kibbutzim, have incorporated tasks for the well-being of the group into their child care systems. These activities are considered important to the development of the child (Bronfenbrenner, 1970; Sidel, 1972; Spiro, 1965).

It is curious that we deny children access to adult activities and tasks at the very age that children seem most anxious to imitate adult life (B. Whiting, 1972). This has much to do with the extreme stance our culture takes in contrasting childhood and adulthood (Benedict, 1938), and with the age segregation so prevalent in our society (Bronfenbrenner, 1970, 1975, 1976; Greenfield, 1974). Our children "play" house, "pretend" to go to work, and so on. At the same ages in many other cultures, children learn how to perform adult activities and tasks through actual participation, or, at the least, through observation of adults at work. In addition to being denied important tasks, our children are denied access to adult work activities and have little opportunity to observe what adults do with their work day (Bronfenbrenner, 1970, 1975, 1976). The ethnographic evidence overwhelmingly indicates that children look forward to assuming adult responsibilities and tasks deemed important by the adults in their household. Since children in our society are not often given the chance to be important to the well-being of their household, they have decreased opportunity to develop a strong sense of worth and self-esteem (B. Whiting, 1972). The lack of self-esteem in parents has also been associated with child abuse (Blumberg, 1974; Fontana, 1964; Johnson and Morse, 1968; Silver, 1968; Steele and Pollock, 1968).

In addition to providing a source of alternate caretaking and a medium for the development of self-esteem, child participation in the care of younger children has another important relationship to the prevention of child abuse. The absence in our society of child involvement in caring for other children is coupled with the lack of a passing down of folk wisdom about childrearing. Folk wisdom, including that concerning childrearing, is no longer automatically passed from one generation to the next (Chase, 1975; Mead, 1970; Whiting, 1971). In most other cultures, women are surrounded by other women who have had experience in childrearing. These more experienced women, usually the mother's kinswomen, help the new mother and instruct her in the care of her new and developing child. In our society grandparents and other kinswomen do not usually reside in the same households as new parents, and are often not even in the same city. However, the problem is deeper than proximity. With all of the changes and conflicting advice that is available concerning childrearing, folk wisdom is often not applicable or trusted. Whiting cites an example of a woman who bottle-fed her child on a schedule as was recommended in her generation, who is of little help to her daughter who wants to breast feed her child on demand (B. Whiting, 1971). Mead has noted that a regularity in American childrearing is parents trying to rear their children differently from how they were reared by their parents (Mead, 1955). Thus parents in the United States, particularly new parents, are at a double disadvantage. The experience of their own parents is not put to use and they themselves have little or no experience in caring for infants and young children (B. Whiting, 1971). This is of considerable importance because one factor contributing to child abuse is a lack of knowledge about normal child development (Galdston, 1966; Johnson and Morse, 1968; Spinetta and Riggler, 1972; Steele and Pollock, 1968).

The beliefs that Americans have about children and childrearing are another possible source of difficulties. Most cultures have definite beliefs about the nature of children and whether characteristics are inborn or malleable (Minturn and Lambert). One cultural group believes that the child's characteristics are passed to him from the ancestors through his mother's milk (Ammar, 1954). Rajput mothers believe that the child's characteristics are written on his forehead at birth and are predetermined (B. Whiting, 1963). In the Six Cultures study, United States mothers saw their children as a "bundle of potentialities" with inborn

characteristics, but with the ability to be shaped by their environment (Minturn and Lambert). With the American ideal that all people are equal, it is understandable that parents believe that they have some control over and responsibility for their child's successes and failures. Additionally, most cultures have beliefs about the age at which a child should be expected to behave in given ways. For example, just as adolescence is not universally a time of stress and trauma (Mead, 1928), the "terrible two's" of our culture are not an inevitable part of human experience. Among the Maori of New Zealand, children are expected to be independent at a much earlier age than are children in our culture. Thus Maori children have their sense of autonomy and independence before there is a need to have a conflict with parents (Ritchie and Ritchie, 1970). In many groups, children are not expected to follow certain rules until they are old enough to "understand" and participate as full members of their culture (Rogoff et al, 1975). Among the Ngoni of Malawi, for example, when children acquire their second set of teeth they are expected to follow the rules of their culture and be responsible for their own actions (Read, 1968). Thus, it would be unreasonable to punish children for things they are incapable of understanding, much less doing. The sanctioning and general acceptance of physical force in childrearing in our culture (Gil, 1970; Gelles, 1977), coupled with the belief that parents can shape or direct their child, and with the fact that most parents have little previous experience with children, can present a very difficult situation and a cultural milieu ripe for child abuse.

The value that societies place on children and childrearing should also be considered. Cross-culturally, wanted children are more likely to be accepted and treated warmly than unwanted children (Rohner, 1975). A study in Czechoslovakia recently concluded that children of mothers who had been denied abortions had significantly more emotional problems than children whose mothers had not sought abortions (Los Angeles Times, 10/5/75). Children in many societies are valued for their participation in economic activities (Johnson, 1977). In many groups, the birth of a child validates the marriage of the parents and raises their status in the community (Gallimore et al, 1974; Raum, 1970). In Japan, children are highly valued and the ideal of most women is to be a "mother of promising children" (Wagatsuma, 1977). The conditions in which many children in the United States live brings into serious question how much value we, as a society, place on the next generation (Bronfenbrenner, 1975; Chase, 1975; Gil, 1970; James, 1975; Wooden, 1976). In our society, children are no longer an inevitable part of life; due to effective methods of contraception, they can be a matter of choice. Additionally, children, in most cases, are no longer a particular economic or social asset. Children do not help tend the livestock, harvest the crops, or necessarily support their parents financially or emotionally in their old age. Raising children is costly (Benning, 1976), and even makes such necessities as renting an apartment difficult (Los Angeles Times, 2/6/77). Children are often desired for purely psychological reasons. In this light, some of the psychological dynamics leading to child abuse, such as role reversal, become more understandable (Blumberg, 1974; Galdston, 1966; Sinetta and Riggler, 1972; Steele and Pollock, 1968).

Urbanization, with its structural and psychological concomitants, also appears to have an effect on the nature and quality of childrearing. Changes in household composition, availability of alternate caretakers, and economic requirements of household members are, in most cases, associated with urbanization and industrialization. Cases like Japan, however, where industrialization and urbanization have not brought the demise of the extended family, must be further studied (Wagatsuma, 1977).

Psychological factors associated with urbanization are also of interest to the problem of child abuse. Studies in Uganda, Venezuela, Kenya, and among Chicanos, indicate that mothers in urban areas are less self-confident, less self-sufficient, and less sure about their abilities to rear their children (Greenfield, 1974; Graves, 1968; Watson, 1970; B. Whiting, 1969). In general, there is a lower self-esteem among these mothers which arises from their diminishing economic importance to the household and from the pressures of urban life (B. Whiting, 1969, 1972). As previously noted, the level of self-esteem in parent-child relations is important and is linked to child abuse.

A discussion of changing American family roles and structures is incomplete without some mention of women's role. Our culture is undergoing change with more mothers working outside of the home (Bronfenbrenner, 1975, 1976; Chase, 1975; Glick, 1975). The topic is a large and complex one, but I would like to raise a few crucial points. First, in most cultures, women have economic responsibilities other than, or in addition to, child care and housekeeping (Greenfield, 1974; B. Whiting, 1972). As previously noted, the cross-cultural evidence indicates that a woman isolated in child care responsibilities without relief is more likely to treat her child in a negative fashion (Rohner, 1975; B. Whiting, 1972). Second, for a woman to develop self-esteem, she must

have a role that is valued by her as well as by her society (B. Whiting, 1972). When women are restricted to the homemaker role, they are restricted to an ascribed status; that is, one based on characteristics at birth, in this case being female. This denies women access to the achiever status that is valued in our culture (Greenfield, 1974). Since child abuse seems to be associated with unemployment of fathers (Gil, 1970; Light, 1973), we might postulate that a similar frustration of not being a productive member of society (functioning in an achiever role) also acts on mothers restricted to, and dissatisfied with, the role of homemaker. A study of fathers in this country who are assuming child care and household responsibilities while their wives work indicates that some of these fathers, like some mothers with total child care responsibilities, feel socially isolated with only small children to talk to all day (Levine, 1976). This can be compared with some of the Scandinavian countries where fathers and mothers receive more social support in childrearing. I am not suggesting that all men or all women should work at given tasks, whether they are inside or outside the home. Rather, the cross-cultural record indicates the importance for all household members—mothers, fathers, and children—to have tasks and responsibilities that enhance their self-esteem and provide them with a means for developing and maintaining positive social behaviors. Child care, considering the nature of our society, should be a chosen role rather than an ascribed status (Greenfield, 1974). Men and women who choose to play a large part in the rearing of their children, as well as men and women who choose to work outside of the home, should have the support of their society in filling a valued role.

The American family cannot always provide itself with the support systems that a cross-cultural perspective indicates are necessary for positive childrearing. Such supports are provided in some societies by the extended family and small, close-knit communities. In other industrialized nations, the state actively provides supports to parents and families (Bronfenbrenner, 1970). In our society, individual families are left largely to their own devices to find and build support systems. It appears inescapable that societal measures must be taken in this country to improve the conditions of children and adults which, in turn, will act to prevent child abuse. This is not to diminish the importance of psychological factors associated with child abuse. Child abuse is a complex interaction of psychological and situational/environmental factors (Helfer, 1973; Johnson and Morse, 1968; Kempe, 1973; Kempe and Helfer, 1972). Neither psychological nor situational/environmental characteristics are sufficient in themselves to cause child abuse or to differentiate between abusive and nonabusive families. Thus, environmental or societal changes will not be sufficient to totally eradicate child abuse. However, in the effort to promote a social milieu that fosters positive parenting, improvements could be made in environmental situations that mix unfavorably with psychological factors, causing child abuse.

Improvement in day care is among the suggestions for improving the conditions of parents and children in this country and for reducing child abuse. I would like to make an additional suggestion for the structure of day care as an example of how a cross-cultural perspective can be utilized in forming solutions to problems such as child abuse in this country. Since young children do much of the infant and child care in other societies, they should be allowed to participate in child care in our society (Whiting and Whiting, 1973). This should consist of active participation (with adult supervision), rather than being a book-learning experience. Attaching day care centers to existing elementary schools and then involving elementary school children in the care of younger children has several potential advantages for the prevention of child abuse, while also serving the need of our society for improvements in child care facilities. Presumably, such a practice would enhance the development of self-esteem, and of nurturant, responsible, and altruistic behaviors among the children doing the caretaking. As was discussed earlier, children in our society have little opportunity to perform tasks that give them practice in behaviors necessary for their future roles as adults and parents. Second, the practice would educate the members of our society, from their earliest years, about normal child development, with all of its individual variability. This might reduce the problems of new parents in our society who have had little experience with children and who do not have access to individuals experienced in childrearing. Third, the practice would provide parents with a source of alternate caretakers, although, optimally, parents would be involved. This would relieve parents of the constant interaction with and responsibility for their children associated, cross-culturally, with rejecting behaviors toward children.

A cross-cultural perspective on childrearing can be a useful complement to what we already know about child abuse in this country. In this discussion I have presented an overview of some of the factors that are important in parent-child relations, cross-culturally, that we might apply to generally improve conditions for parents and children and prevent child abuse. In the examination of the cross-cultural record, certain facts emerge about human behavior in

childrearing. Interactions between parents and children are more likely to be warm and accepting when: the adult-child ratio in the household does not include too many children making too many demands on too few adults; others are available to help the mother with childrearing responsibilities (this can involve personnel from the household, or personnel from outside the household); significant others, particularly grandmothers and fathers, are willingly involved in child care; the primary caretaker is not restricted to the household and is in continuous interaction with the child without the opportunity for periodic relief; the mother has the option to participate in economic roles other than child care and housekeeping if she wishes; there is a familiarity with normal child development and with individual variability (this can arise from childhood experience in child care, or from contact with others who have had experience in childrearing and can pass folk wisdom concerning childrearing on to the new parents); children are given the opportunity through important tasks, particularly through participation in child care, to develop the nurturance, responsibility, and self-esteem that they will require as adults and as parents; there are support systems for parents (this can be through the extended family, through the state, through informal networks of parents, and so on); and children are desired and valued by their parents and by society at large.

The task remains for us to apply this cross-cultural information in light of our own cultural context.

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Towards a New Perspective

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> For no other group in American life is the matter of family life more important than to the Negro. Our very survival is bound up in it...No one in all history had to fight against so many physical and psychological horrors to have family life. Dr. Martin Luther King, Jr.

In 1975, the National Urban League received a federal grant to establish a child abuse/neglect resource project: Project THRIVE. As local project director, I have spent a good deal of time responding to comments like these: "Why a Black project? Is it because Blacks are more violent and tend to abuse? I don't know why you're making a difference; we treat all children the same. There's just something wrong with an all-Black focus. It's reverse discrimination."

I answer these questions in much the same manner that I will address you as readers. If we are to develop the child abuse/neglect discipline, we must take a pluralistic approach to the problem and its management. Every aspect from policy making to service delivery must be explored. We must continually work to dispel the myths and stereotypes about Black families that pervade our child welfare system. In their book, *Children of the Storm*, Andrew Billingsley and Jeanne Giovannoni (1972, p. 12) state:

> Of the twin evils of our time, racism and poverty, racism ranks first and poverty second as causes of the difficulties Black children face. Neither of these maladies is caused within the Black community. Both are generated, operated, and perpetuated by the white community and the institutions it dominates. We must examine and speak to societal abuse.

Let us examine the dynamics of the abuse/neglect issue as it affects Black families. How do we define abuse and neglect? In 1974, Congress passed Public Law 93-247 which defined abuse and neglect. Neglect, as constituted, refers to acts of omission, such as failure to provide adequate food, shelter, and medical and emotional care. Until we have a national commitment to a full employment economy and guaranteed minimum income for those unable to work, the poor will continue to "provide inadequately." The failure of society to address itself to the problems of poor children is a special failure in relation to Black children because disproportionate numbers of them are born into poverty.

In defining child abuse, the law specifies acts that are physically or mentally injurious to the child. General characteristics for identifying the abused child have been developed. They require, at best, some subjective judgment on the part of the observer. This may prove problematic when racial elements are a factor. A White person unaccustomed to dealing with Black children may observe welts or redness on a fair-skinned child and determine that he/she has been abused. What the worker failed to consider was the sensitivity of the child's skin, equating skin tones of Blacks with that of Whites and determining the severity of the bruise by that frame of reference with which he/she was familiar. There is a distinct possibility such welts could be the results of a mild switching or scratches which manifest themselves in redness and immediate swelling but fade in a matter of hours.

Language can pose still another barrier to accurate assessment of situations. People investigating abuse and neglect must often rely on statements from witnesses and neighbors who can confirm that abusive behavior took place.

A Black neighbor reports to a White police officer that the family in question "beat" the children all the time. It is necessary to understand that in many Black communities "beating" is synonomous with "spanking" and does not connote the severity assumed in the larger white context. At the other end of the spectrum, attitudinal racism often prevents Black children from

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receiving the protection they need (Billingsley and Giovannoni, p. 8). Attitudinal racism exists when one racial group thinks or believes another is inferior.

In the last few years we have witnessed a move by most states toward more comprehensive reporting laws. The benefits of strong reporting laws are twofold: they help us keep track of those children who have been abused and neglected and provide a better data base for ascertaining the scope of the problem. What was well intentioned in design has proved hazardous in practice. The statistics gained through mandatory reporting are skewed. Overwhelmingly it is the poor who are being reported. Individuals working in public agencies have greater access to these families and report far more frequently on them than those in private or upper-income settings.

At present Blacks are overrepresented in child abuse/neglect statistics. While the racial breakdown is unavailable for most states, the American Humane Association estimates that in 1968 the nationwide reporting rate was 6.7 cases per 100,000 for White children compared to 21.0 cases per 100,000 for nonwhites.

We can speculate as to why this overrepresentation exists:

1. There are biases in who generally reports child abuse and who gets reported. There is a differential reporting by both states and individuals. Some states, for example, combine reporting for abuse and neglect and make no distinction between the two. Other states carry statistics that contain only confirmed cases of abuse, and some carry both confirmed and suspected cases. Many states and municipalities exclude coroner's reports of suspected child abuse and maltreatment, often the cause of death.
2. There are state variations in terms of definition of child abuse. The definitions range from, "when a parent habitually uses profane language in front of a child," to "a condition in which a child is suffering from serious physical injury inflicted upon him by other than accidental means."
3. Individuals of like social classes and race tend not to report each other. There is underreporting by private physicians and underreporting in suburban communities; middle class and upper income families rarely get reported. It is simply made easier for them to maintain anonymity (Dowdell, 1976).

How do we treat the abused/neglected child and family? Unfortunately, we are just now moving away from the posture that removing the child alleviates the problem. Services to enhance the welfare of children living with their own families have been only minimally developed and do not constitute the majority of the child welfare efforts. We have operated from the posture that if the family is inadequate there is little value in maintaining it.

> A major misconception in child welfare has been that Black children have no parents, or at best only one. A second assumption has been that the major problem within the Black community is parental inadequacy whatever the number of parents. It is for this reason that child welfare services for Black children consist in large part of "rescuing" them from these inadequate parents and herding them into large impersonal institutions or shelters until they can be placed in more adequate homes. These homes are, according to child welfare ideology, hard to find within the Black community because of the "pervasive internal pathology" (Billingsley and Giovannoni, p. 17).

We must begin to recognize the Black family as viable and examine and incorporate its inherent strengths in our treatment modalities. Robert Hill, director of National Urban League's Research Department, has identified five of these strengths: strong achievement orientation, strong kinship bonds, adaptability of family roles, strong work orientation and strong religious orientation. We must begin to examine the societal norms by which such terms as "appropriate, adequate, and proper" derive meaning and recognize that such norms were never intended to accommodate racial and cultural differences.

Another approach to the child abuse neglect problem has been the evolution of parenting programs. I endorse such efforts and agree that despite all our educational expertise, this area has been neglected. I would caution against, however, the assumption that the new parenting materials are universal in their appeal. Clara J. McLaughlin, coauthor of *The Black Parents' Handbook* (1976), says, "Shortly after I became a mother, I realized that I was not able to use the

developmental scales outlined in any of the books on infant care, without reading far in advance of my baby's age. I discovered that other black mothers had the same experience." In researching for her book she discovered that the average Black infant develops mentally and physically at a faster rate than that indicated by the standard infant development scales. Investigation also showed that environmental, genetic, and medical problems common among Blacks were not addressed in books on infant care and sometimes not in medical journals! Black parents need help dealing with the political and economic influences that affect child rearing. Black children must be taught at an early age to cope with racism. Dr. Spock is not much help here. White educators need to be aware of those resources written by and for use with Black families. Black researchers, practitioners, and educators must continue to document and publish relevant materials.

There are several other programs designed to aid in our efforts to combat the child abuse/neglect problem, many of which pose some particular problems for Blacks. I can think of two immediate situations. A local Parents Anonymous sponsor came to me concerned that they could not involve Black parents in their group. When I spoke with these parents regarding their feelings about PA, one replied, "What Black person that you know is going to sit with a bunch of White folks and tell all their business?" Our community also started a program for volunteers to become lay therapists or parent aides to work with parents involved in abusive/neglectful situations. They designed an elaborate seven-week training program meeting one day a week. In a country where Black family income is a little more than half of White family income, "volunteerism" is practically nonexistent! In most families adults worked and could not attend day-time training programs; those that were at home but interested in the programs had child care responsibilities and could not afford babysitters and/or transportation.

The problems cited here are not new nor are they unique to the child abuse discipline. The probable solutions have been posited before. In 1968 the Urban League in its Statement on the Black Family said,

> The misconceptions about Black families require changes in the basic institutions. These institutions need to serve and reflect the pluralistic needs of all the people—black and white. These larger institutions must begin to be specific about the needs of Blacks, be deliberate about ethnicity and become truly interracial in conception, structure, staff, boards, and services.

At the same time, parallel institutions must be created at the community level, owned and controlled by Black people. These parallel institutions are needed because Black people for the most part live in Black communities. Although the community may opt for quality, integrated institutions and/or parallel institutions, the guiding principle is the right of the community to have a substantial stake in the decision making process of the institutions which exercise control over their lives. The business of opening services to Blacks and helping to establish parallel institutions is not an either/or proposition. Institutions must engage in both efforts.

In 1977, the concerns are still the same. Where will we be in 1980? The challenge is yours.

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Community Development: Possibilities for Effective Indian Reservation Child Abuse and Neglect Efforts

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INTRODUCTION

In the State of Arizona there are 14 Indian tribes living on 20 reservations representing over 19,000 square miles and 115,000 people. Two of these reservations are located in two states—Arizona and California, and one is located in three states—Arizona, Utah, and New Mexico. The tribal members of two tribes reside in two countries, the United States and Mexico. There are similarities and variations in the cultures and lifestyles of these 14 tribes. Tribes living in Arizona are: Apache, Chemehuevi, Cocopah, Havasupai, Hopi, Hualapai, Maricopa, Mohave, Navajo, Paiute, Papago, Pima, Yavapai, and Yuma (Quechan).

HISTORICAL BACKGROUND

Indian tribes have a special relationship to the federal government on the basis of treaties made with them as sovereign nations. The recognition of tribal sovereignty entitles each tribe to operate within its own tribal courts with its own set of codes. Tribal law and order codes were written shortly after the Indian Reorganization Act of 1934, which allowed Indian tribes the right to self-government. These laws and courts are as varied as the tribes themselves. Where the states have mandatory laws for reporting child abuse and neglect, the tribes differ in their codes. Some tribes have laws for the reporting of child abuse and neglect. Others have no provisions for these, and still others have no codes at all. Tribal courts were not set up to allow the child or parents to be represented by counsel or otherwise be advised of their rights. Today, efforts are being made by tribes to revise their codes. Through the Office of Economic Opportunity and passage of the Civil Rights Act, legal services are made available to Indian people on and off reservations. Efforts are made to train indigenous people to serve as lay advocates in tribal courts.

The special relationship of the federal government with Indian tribes allows tribes the opportunity for direct federal funding for the establishment and continuation of programs on the reservations. The tribes, through their Councils, have the option to employ or not to employ the services available through the state of Arizona. Tribes are not always receptive to state intrusion and will effect special agreements to protect tribal sovereignty. One tribe which uses Title XX funds for a nutrition program did so only after a special agreement was reached between its Tribal Council and the Arizona Department of Economic Security to protect the rights of the tribe to use tribal norms in establishing eligibility and to use foods that are a part of the daily diet of that tribe. Another tribe established a special agreement directly with the United States Department of Agriculture to continue the surplus commodity food program on the reservation in lieu of the Food Stamp Program because of inaccessibility to service offices and food stores.

Some of the federal and state programs used on Indian reservations are the food stamp program, AFDC, employment and training, and nutrition for the elderly through Title XX. Protective services are available to Indian tribes and are utilized by some of the smaller tribes which have limited reservation programs. Most tribes choose not to use state protective services and employ their own people to work with child abuse and neglect problems.

In the age of technology and high mobility the Indian family has been affected by the disruption of the family system. Young people are moving into the cities for education and employment, weakening the opportunities for children to learn their tribal ways. Families are living in a different economic system than their parents may have lived in the past. Families are exposed to different life styles and are incorporating these into their own lives. In spite of the changing life styles, the extended family system is still very much alive in the Indian community. It may not be as strong as it was in the past, but it does exist. Children live comfortably with grandparents, aunts, uncles, and other relatives. To the Indian family this is a sharing of children and a means of strengthening family relationships. By living with relatives, the child learns who his family is and learns the values of sharing his life and material wealth with others. Under a functioning extended family system child neglect is rare, because care of children is the responsibility of the entire family unit.

Indian life, for the most part, goes on at a slow pace. Children are fully accepted and are allowed to grow through the normal developmental stages. They are not forced to perform skills that they are not yet physically ready to perform. Young children are not forced to learn to drink from a cup or to use a spoon to feed themselves, nor are they forced into toilet training before they are physically ready. The non-competitiveness in Indian society allows children to grow at their own pace.

CURRENT TRIBAL/STATE RELATIONS

The attitudes of workers on Indian reservations play a major role in how the Indian people respond to services provided, whether they be health, education, or social services. Some workers on Indian reservations show their disdain for the life style of the Indian. Through ignorance they alienate the consumers of their services. Many workers, ignorant of Indian cultural values and norms, make decisions that are detrimental to the Indian family. Too often they see neglect where none exists. The person who is working in the Indian community must be aware of and sensitive to the cultural diversity among the many tribes of Indians with whom he is working.

To the uninformed worker an Indian child may be labled as shy, withdrawn, uncooperative, or a slow learner when the child may be doing what he has been taught as part of his early childhood training. A child is taught to listen and to learn by observation. He is taught to respect other people. He must not interfere in a conversation. Direct eye contact is discouraged, for this is a sign of disrespect.

Other aspects of child rearing unfamiliar to the worker may be interpreted as neglect. The use of herbs and teas and the employment of the medicine man to cure illnesses may be seen as negligence in health care. Although many Indian people are using the health facilities available to them, there are families who still adhere to tribal health practices.

Child abuse and neglect on Indian reservations is dealt with by various agencies such as the Bureau of Indian Affairs, Indian Health Service, Tribal Courts, and tribal service-delivery programs, with the Social Services Branch of the Bureau of Indian Affairs assuming the major responsibility for child welfare on reservations. Like the Indian tribes, each agency has its own set of rules and regulations. In one tribe, the tribal law and order code has a reporting law that provides immunity to the person making the report. However, Indian Health Service has its own operating procedure and may not feel obligated to follow tribal reporting law. Difficulties arise when a child abuse case is not reported by the hospital.

With regard to state jurisdiction on reservations, conflicts could be avoided if workers recognized tribal sovereignty over tribal members, cultural variations and lifestyles, and worked with the various agencies within the jurisdiction of the tribal courts.

ACDAN PROJECT DESCRIPTION

Arizona lives in cultural and demographic diversity. Needs must be revealed by the local eye. Solutions have to be designed in a local fashion. Human growth in perspective must be accepted as developmental, evolutionary, slow.

Arizona's project is based on the philosophy that the state's most valuable resource is its people. Given the opportunity and encouragement, we believe people can reestablish their sense of community and personal concept of belonging (wherever they are located) through "local-focus" efforts and will commit themselves to a "good of all" approach to child abuse and neglect. Thus the name: Arizona Community Development for Abuse and Neglect.

The project itself functions in close alliance with Arizona's Department of Economic Security, the grantee. Placed within the Social Service Bureau of the Department, the project maintains close communications with statewide service personnel, while reserving independence of operation through administrative structure.

Staff consist of a project director, project psychologist, reservation liaison, seven district coordinators (five full-time, two 3/4 time), and two clerical workers. All staff are fiscal agent employees except for the psychologist and one coordinator, who are state employees responsible to the project director.

There are six planning districts in the state of Arizona. Coordinators are housed in DES district installations with the availability of ATS lines and some clerical support to facilitate activities. The state office is housed in the DES state office building, Social Services Bureau.

The project, funded in January, 1975, operates on a $250,000 annual base budget. All coordinators function under the advice of county as well as district committees. District committee representatives comprise a project committee to aid the project director.

Objectives for all program years have included public and professional awareness, resource identification and needs assessment, and training and technical assistance as well as advocacy. All coordinators have been trained intensively as trainers in child abuse and neglect as well as community assessment and organizational techniques. While coordinator approach varies by district necessity, public/professional awareness occupies a fair percentage of all staff time. More than 800 speaking engagements are recorded per year throughout the state as well as close to 600 training sessions representing 8400 person days of training. In addition, staff records show over 800 technical assistance events per year (estimated to be ¼ of actual) and 150 instances statewide of expanded resources.

While ACDAN takes no direct credit for communities' efforts to alleviate CA/N problems statewide, having staff available and accessible to facilitate work on CA/N related issues has unquestionably proven to be the cementing link between problems and attempts at community solutions.

COMMUNITY DEVELOPMENT STRATEGY

Arizona's resource project accepted the challenge in 1975 to demonstrate community development as an effective method for establishing statewide resource capability for child abuse and neglect identification, prevention, and treatment. Operating within a global framework of four basic objectives (public/professional awareness, need/resource assessment, resource capacity expansion, and coordination of services) ACDAN has done exactly that. Much has been learned over the past 18 months, but mostly that community development works in facilitating locally designed and sponsored community problem-solving efforts.

Before examining the specifics of ACDAN/Reservation CA/N efforts, it seems important to remind the reader of some of the "givens" of community development. Without an understanding of the philosophy and corresponding approach techniques of community development, the project cannot really be assessed at all.

Defined as it is practiced in the Arizona Project, community development represents:

> 'a process of social action in which people organize for planning and action; define common and individual needs and problems; ... execute those plans with maximum reliance upon community resources; and supplement those resources when necessary with services and materials from governmental and non-governmental agencies outside the community' (International Cooperation Administration, 1956).

Operating "givens" of community development include:

1. There exists, in a community development effort, a basic belief and trust in people and their capabilities for self-direction.
2. There exists, on the part of those encouraging the effort, a basic commitment of "beginning where the people are" and a willingness to commence efforts with whatever "sparks" are available—in spite of numbers or group mix customarily valued.
3. There exists, to the extent humanly controllable, no preconceived plan for the imposition of projects, expertise, and/or progress on effort-participant function in advance of needs evolving out of the group at its own pace.
4. There exists the recognition of a need for a facilitator or encourager of local initiative, hired or voluntary, free of professional and institutional constraints, to function in accord with and to support group-paced activities.
5. Process facilitators must be generalists, in spite of professional training, must be perceived as open, caring individuals, and must be considered acceptable and believable by the community served.
6. Facilitators must accept and encourage low publicity and group-dependency profiles of themselves in order to build strength within the group and the process.
7. There exists in community development a de-emphasis on tangible products of effort while accountability of process is required as a measure of group development.
8. In multi-group efforts, there is an underlying acceptance of and protection for non-uniformity in group approach or levels of concern.

9. There is a recognition of several process needs: (a) to work with a core group—a nucleus—expecting to train and retrain committee members as they flow in and out of the process; (b) to accept the formation of many spin-off, satellite interest groups as part of the whole; and (c) to recognize developmental change as slow, with the process taking approximately three years to institute fully.
10. And last, there is a consistent focus throughout the effort on people development related to the issue, as opposed to program development for specific achievement.

ACDAN RESERVATION EFFORTS

From the beginning of the project, services have been made available to the reservations upon request, but because of a Head Start training mandate requiring grantee coverage prior to June 30, 1976, ACDAN staff stepped up its outreach to Indian reservations in Arizona beginning March, 1976. Before June, 1976, ACDAN had facilitated orientation sessions on child abuse and neglect for approximately 500 reservation residents: parents, social service staff, health and education officials, as well as tribal representatives. All sessions (totaling eight major reservation entities to that date) were held on-site and were custom designed for the awareness level and resource capacity of the given community.

In addition, because of ACDAN's community development "model of approach," each session required two to three pre-planning sessions with the reservation residents involved to:

1. Establish initial trust and develop "team rapport";
2. Assess basic level of awareness and concern with CA/N in the respective community as well as previous exposure to CA/N training;
3. Assess basic community resources operating on the reservation;
4. Encourage consideration for "global" participation as opposed to "restricted" involvement in the planning and execution of the workshop;
5. Acquaint the team with written and audiovisual materials available for their selection for distribution with suggestions for corrections, additions, deletions;
6. Encourage selection of local panel and moderator;
7. Assist in the formalization and in some cases informalization of the workshop agenda.

To do this required time and the luxury of being accessible to the reservation communities when the spark required kindling. All ACDAN staff members have teamed up and exchanged districts of primary responsibility because of our commitment to being available when there is a need (what facilitation is all about), but also because of the incredible time and mileage demands experienced in servicing Reservation communities.

Beginning in September, 1976, ACDAN was able to add a reservation liaison to its staff to assume prime responsibility for the expansion of reservation-ACDAN CA/N efforts. With the added staff and outreach capability, program efforts have extended to a total of 17 reservations and approximately twelve hundred reservation residents.

With regard to the feasibility of interface between reservation communities and state agency services we have learned that:

1. Working with reservations is not only possible, but welcomed, given the proper perspective, approach, and the capacity to be accessible.
2. The "non-verbal Indian" has simply not been our experience. When allowed their own setting, their own concerns, their own verbal expressions, their own timing for involvement, and their own responsibility for contribution, and where ACDAN has remained low key in direction and has partieipated as a background supportive team member, reservation residents have proved time and time again to be every bit as articulate and expressive as off-reservation residents.
3. Money available from the project has not proven to be a concern to the reservation communities with whom we have worked. Reservation communities have appeared appreciative of the time spent and the willingness to appear on-site that ACDAN staff members have demonstrated as well as for audiovisual materials and training resources available through the resource project.
4. Non-Indian staff members have been able to relate successfuly to Reservation residents when their approach reflected the following:
   a) Low key/non-directive behavior;
   b) Minimal demand for attention;

c) Willingness to be part of the team with its conditions, setting and time;
d) Commitment to community development approach model;
e) Capacity to be accessible and accountable.

5. Being affiliated with the state has not hindered our rapport with reservation communities as some might have predicted. Again, ACDAN feels it is because of perspective, approach, and accessibility factors.

CONCLUDING SUMMARY

Perhaps the most significant thing to be said for community development as it relates to reservation efforts is that it seems to be philosophically consistent with many Native American values. For example, Community development: Native

1. Stresses cooperation in participation as opposed to competition between people.
2. Stresses maximum utilization of local resources, which strengthens the extended family system as well as tribal culture and lifestyle.
3. Stresses a non-directive approach to decision making, which eliminates program imposition and promotes self-determination of tribes.
4. Encourages citizen participation for decision making, thus reinforcing the old tradition of community collaboration for community problem solving.
5. Promotes respect for all, which reinforces the values of human equality and individual capabilities.

The staff of the Arizona CA/N Resource Project (ACDAN) has found community development to be an effective method for promoting reservation utilization of state resources. While it is not suggested as the only approach, it is felt to be viable enough to merit consideration by state agencies considering similar outreach efforts to Indian reservation communities.

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The Relationship Between Child Abuse and Neglect and Substance Abuse in a Predominantly Mexican-American Population

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The basic objective of this research was to gather data on families known to have a parent who was an alcohol abuser, drug abuser, child abuser, or child neglector. Data on both Anglo and Mexican-American families was gathered. The major hypothesis was that a positive relationship existed between the abuse of alcohol or other drugs and the abuse or neglect of children. Other hypotheses under investigation were that Mexican-American families were different from Anglo families; that abusing families (child abuse/neglect, drug abuse, alcohol abuse) were different from control families; and that families where child abuse/neglect occurs were different from families with a parent who abuses a substance (alcohol or other drugs).

PROCEDURE

An interview was used for data collection. It was designed and developed by psychologists, social workers, and other experts in the fields of child abuse/neglect, alcohol abuse, and drug abuse, including parents who had abused their children in the past, and underwent the cycle of pilot testing, revision, and further testing until everyone involved was satisfied with its content and form. The final version of the interview contained over 300 questions divided into 10 major sections: demographic data, stress factors, children's medical history, responsibility of child care, reality perceptions, the respondent's home environment as a child, family relations and role expectations, alcohol abuse, marijuana abuse, and other drug abuse.

The San Antonio Child Abuse/Neglect Research Project (SACA/N) staff utilized several local agencies that deal with child abusers/neglectors and substance abusers to obtain subjects. All respondents used in the sample were parents or guardians of children under eighteen years of age, living in the home. The cooperating agencies delivered an explanatory letter to prospective clients. Clients were told that they would receive $10.00 for their participation, and those wishing to do so signed a release of information form. SACA/N then contacted the interested person to set up an interview date.

The Control group was drawn from the San Antonio Street Directory and a sample of addresses in Bexar County (excluding San Antonio). For research purposes, it was assumed that people selected for the control group were not child abusers or neglectors, alcohol abusers, or drug abusers. The people selected for the control group were contacted in person or by telephone, and if they wished to participate in the study, an interview date was arranged.

SACA/N used the signed release of information form to compile a master list of names, addresses, and classifications of respondents. Each name on the list was assigned a unique identification number, and only that number appeared on the interview instrument. The master list was maintained in a safe location to insure confidentiality.

The interviewers represented the three prominent ethnic groups in Bexar County (Anglo, Mexican-American, and Black). The Mexican-American interviewers were fluent in both Spanish and English. Interviewers interviewed people of their own ethnicity to avoid biased responses due to interviewer prejudices, and subjects were assigned randomly to interviewers within their ethnic group. To avoid further interviewer bias, interviewers were not told the particular classification (i.e., child abuse/neglect, substance abuse, control) of the respondents.

Interviews were held in various locales, including the subjects' homes, out-patient agencies, and residential agencies. After the interview, the respondent was paid $10.00. The interview usually took between one and two hours to administer.

The SACA/N field coordinator reviewed the questionnaires for major errors, and handed them to the SACA/N coding staff for keypunching. The extracted information was keypunched and placed on magnetic tape for analysis. Names and addresses of respondents were irrelevant to the analysis process and were not stored.

Table 1 contains information on the demography of the sample. This study was designed with two ethnic groups involved, Mexican-Americans and Anglos. Complete data was obtained on

43 Black subjects, but this small number did not permit any kind of reasonable analysis. Within each of the two ethnic groups, there were four groups: the control parent group (Control), the child abuse/neglect parent group (Child Abuse), the alcohol abuser parent group (Alcohol), and the drug abuser parent group (Drug). The number of subjects in each of the groups is contained in Table 1.

TABLE 1

DEMOGRAPHIC DATA

		Mexican-American				Anglo-American			
Item		Control Parents	Child Abuse Parents	Alcohol Abuse Parents	Drug Abuse Parents	Control Parents	Child Abuse Parents	Alcohol Abuse Parents	Drug Abuse Parents
Number of Males		23	8	65	35	10	2	6	5
Number of Females		36	47	19	27	23	19	1	15
Total Number of Subjects		59	55	84	62	33	21	7	20
Age	Mean	35.1	31.5	30.6	32.5	29.8	31.2	37.6	23.8
Educational Level	Mean	9.7	7.1	9.5	8.9	12.2	9.7	12.7	11.0
Monthly Income	Mean	$ 528	235	333	431	641	279	479	275
Subjects Currently Employed	%	46	11	21	40	61	19	43	15
Number Living on Income	Mean	4.1	5.1	3.3	4.5	3.5	4.0	2.7	3.1
Subjects Married	%	68	36	64	74	70	19	57	75
Subjects Owning Own Home	%	34	11	15	15	27	10	43	10
Number of Rooms in Home	Mean	5.3	4.3	4.7	4.2	5.5	4.4	5.3	4.8
Interior of Home in Good Repair	%	58	18	80	26	82	48	43	10
Number of Children in Home	Mean	2.3	3.7	1.9	2.8	1.8	2.6	1.9	1.4
Age of Mother at Birth of 1st Child	Mean	23.7	20.5	21.2	20.3	21.6	19.7	21.3	19.1

As Table 1 shows there was very little difference in the mean ages of the subjects in these groups. The one notable difference was that the Anglo Drug group was younger than any of the other groups. The mean education level for the Anglo and Mexican-American subjects was consistent with that which was obtained in the 1970 census. The Anglos had a higher educational level than the Mexican-Americans. The mean educational level of the Mexican-American Child Abuse group was lower than the other three Mexican-American groups. Similarly, the Anglo Child Abuse group had a lower mean educational level than the other Anglo groups.

The mean monthly income of the Mexican-American and Anglo subjects is also consistent with the income information obtained from the 1970 census. The Anglos had higher average incomes than the Mexican-American subjects. The Child Abuse subjects in both the Anglo and Mexican-American groups had a much lower average monthly income than the subjects in the other groups. Note also that the Child Abuse groups had a much larger number of people living on that income and a much lower proportion of people currently employed. In addition, the Child Abuse groups had the lowest proportions of married people (legal or common law).

Within the Mexican-American subjects, all three Abuser groups showed a small proportion of subjects owning their homes. Among the Anglo groups only the Child Abuse subjects and the Drug subjects showed an inability to buy their own homes. The size of the subject's home followed this same pattern. The Mexican-American Control group had more rooms in their homes than any of the Mexican-American Abuser groups, while the Anglo Control group and Alcohol group had larger homes than the Anglo Child Abuse group or Drug group. In terms of the proportion of subjects whose home's interior was in good condition, the Mexican-American Child Abuse and Drug groups and all three Anglo Abuser groups were low.

The Child Abusers tended to have larger families; that is, the number of children in the homes of the Child Abuse groups was greater than the number of children in the homes of the other three experimental groups. This finding was consistent across all four groups for both ethnic groups. An initial suspicion was that women in the Child Abuse groups might have become mothers at a very young age. This does not seem to be true; no real pattern emerged to indicate that mothers in the Child Abuse groups were younger at the birth of their first child than mothers in the other groups.

RESULTS

In the spring of 1976 the following analysis was performed with 80 "pilot" cases (20 Control, 20 Drug, 20 Alcohol, and 20 Child Abuse). Questions within each of the ten parts of the questionnaire were selected for further analysis. Questions were eliminated if there were more than 10 percent missing responses or if more than 70 percent of the subjects responded with the same answer in the case of dichotomous response questions.

The remaining questions in each section (excluding the demographic section) were subjected to a principal components factor analysis. The factor analytic approach was used with a varimax rotation employing Kaiser's rule, and a criteria cut-off for the factor loadings of 0.35. The varimax rotated factor structure was interpreted and named. The names and brief descriptions of the resulting 22 variables are contained in Table 2.

TABLE 2

Factor Analysis Variables Used in Discriminant Analysis

STRESS1	-	Additions to family
STRESS2	-	Health
STRESS3	-	Employment
STRESS4	-	Income
STRESS5	-	Peer separation
REALITY1	-	Personal impact and influence
REALITY2	-	Personal contentment
REALITY3	-	Change in self-perception
PARENTS	-	Happiness and freedom from responsibility during respondent's childhood
CHILDREN1	-	Time spent with children at home
CHILDREN2	-	Time spent away from home without children
FAMILY1	-	Respondent's expectation of child's self-reliance
FAMILY2	-	Reaction to time with children
FAMILY3	-	Children and family stress
FAMILY4	-	Expectations of mate
FAMILY5	-	Respondent/Mate communication
FAMILY6	-	Compatability with mate
ALCOHOL1	-	Use and effect of alcohol
ALCOHOL2	-	Anxiety and depression relating to alcohol use
HEROIN1	-	Knowledge of heroin use
HEROIN2	-	Effect of heroin on self and family
MARIJUANA	-	Marijuana use and knowledge

The factor coefficients which resulted from the factor analysis on the 80 subject sample group were applied to the data of the 341 subjects now being examined. Thus, 22 new variables, which consist of the linear composites of individual questions within the interview, were produced for each subject.

The 22 factor analyzed variables were compared within and between the ethnic groups and experimental groups using a discriminant analysis. Table 3 represents a summary of those comparisons, and the Chi-Square tests associated with each analysis. In addition, univariate F tests were performed on each factor within the various comparisons listed in Table 3.

TABLE 3

OVERALL DISCRIMINANT ANALYSES SUMMARY TABLE

MEXICAN-AMERICANS

Group	X^2	df	Sig.
CHILD ABUSE vs. SUB ABUSE	88.102	22	.0001*
CONTROL vs. ABUSE	105.588	22	.0001*
CONTROL vs. CHILD ABUSE	71.502	22	.0001*

ANGLO-AMERICANS

CHILD ABUSE vs. SUB ABUSE	40.667	22	.009*
CONTROL vs. ABUSE	63.882	22	.0001*
CONTROL vs. CHILD ABUSE	43.201	22	.004*
MEXICAN-AMERICAN ABUSE vs. ANGLO ABUSE	43.960	22	.004*

*Significant at .05 probability level or less.

Overall, the major working hypotheses of the project were confirmed. Highly significant differences were obtained for all the overall comparisons in Table 3 with the greatest difference between the Mexican-American Child Abuse (CHILD ABUSE) group and the Mexican-American Substance Abuse (SUB ABUSE group is a combination of Alcohol and Drug groups). Ethnicity proved to be an important variable. Mexican-American Abusers (ABUSE group is a combination of Child Abuse, Drug, and Alcohol groups) and Anglo Abusers differ in their questionnaire responses at the .004 significance level.

From the 22 factor analyzed variables, the discriminant analyses attempted to classify subjects into experimental and control groupings. The accuracy of those categorizations range from 71.1% to 100%. For one of the classifications of much practical interest, 100% of Anglo Child Abusers and 93.9% of their Controls were correctly assigned. Among Mexican-American subjects, 81.8% of Child Abusers and 81.4% of their Controls were correctly classified. Mexican-American Controls were classified correctly in comparisons with all Abusers 81.4% of the time whereas the Abusers were identified as such 78.1% of the time. Anglo Controls were correctly predicted for 87.9% of the cases when compared with Anglo Abusers, who were classified properly 93.7% of the time.

STRESS

The five stress factors found using the factor analyses may be described by the sources of stress loading high as follows: STRESS1 was Additions to Family, STRESS2 was Health, STRESS3 was Employment, STRESS4 was Income, and STRESS5 was Peer Separation.

Questions loading highly on STRESS1 dealt with the occurrence of pregnancy or addition of a new family member in the past two years. Only for the comparison of Mexican-American Child Abusers with Controls ($p<.01$) and with Substance Abusers ($p<.001$) did STRESS1 differentiate.

Questions loading high on STRESS2 related to illness or injury of the respondent or mate within the past two years. Ethnicity proved to be important on this factor. Anglo Abusers were more likely ($p<.05$) than Mexican-American Abusers to experience poor health. The difference was more pronounced ($p<.01$) when Anglo Abusers were compared with their Controls.

Employment was the theme of STRESS3. Items contributing substantially to the factor were "Work or business changed in last two years?" and "Trouble meeting payments?". Mexican-American Child Abuse subjects demonstrated more employment interruption than did Mexican-American Substance Abusers ($p<.05$). All types of Mexican-American Abusers had more employment problems than Controls ($p<.05$).

Income-related items provided the basis for the STRESS4 factor. Mexican-American Abusers had significantly ($p<.01$) more income problems than their Controls. Much of this difference can be attributed to the Mexican-American Child Abusers since that group was highly significant ($p<.001$) in exhibiting more income disruption than Controls. STRESS4 was not an important differentiating factor for the Anglo groups.

Separation from peers was the central theme of the STRESS5 factor. Loading high were items asking about relocation and death of a close friend. For Mexican-American subjects, both the Abusers and Child Abusers showed highly significant differences when compared with Controls ($p<.001$). The same held true for the Anglo subjects. In fact, Anglo Abuse subjects experienced more peer separation than Mexican-American Abusers ($p<.01$).

REALITY

A set of three factors emerged which reflected the subjects' perceptions of reality, past and present. REALITY1 was termed Personal Impact and Influence, REALITY2 was Personal Contentment, and REALITY3 was named Change in Self-Perception.

REALITY1 included items which explored the locus of responsibility for events occurring in the respondent's life. Subjects were offered the choice of "Your own or other efforts" or "Fate or luck" to explain good and bad occurrences in their lives. Although Mexican-American Abusers scored significantly higher ($p<.001$) on the factor than Anglo Abusers, no differences emerged in the other comparisons. While the factor has a definite ability to detect ethnic variances, it does not contribute to the explanation of child or substance abuse.

Subjects reporting less personal happiness presently and in the past scored high on REALITY2. Results revealed a greater personal dissatisfaction on the part of Abusers from both the major ethnic groups. The strongest difference was noted between Anglo Abusers and their Controls ($p<.01$). Other significant differences arose in comparisons between Anglo Child Abusers and Controls ($p<.05$), Mexican-American Child Abusers and Controls ($p<.05$), and Mexican-American Child Abusers and Substance Abusers ($p<.05$).

REALITY3 was comprised of items dealing with perception of change in personal happiness from childhood to adulthood. No difference emerged in the comparisons between and among the groups.

PARENTS AND CHILDREN

A single factor, PARENTS, gathered information on the parent's perceptions of his/her own childhood. PARENTS proved important in differentiating between Mexican-American Abusers and Controls. Mexican-American Abusers were very likely ($p<.01$) to report a relatively unhappy childhood as compared to Controls. Curiously, this factor did not differentiate between the Anglo subject groupings.

CHILDREN1 was composed of items dealing with the amount of time the respondent and his/her mate spent at home and with the children. This factor produced interesting ethnic differences. Mexican-American Abusers generally felt that the amount of time parents spent at home with children was enough as compared to Anglo Abusers ($p<.01$). Yet, Mexican-American Child Abusers were significantly less satisfied than Substance Abusers in this respect ($p<.05$). In addition, Anglo Child Abusers were less satisfied with parental time investment at home than their Controls ($p<.05$). No differences were found on the CHILDREN2 factor, which investigated the time spent away from both home and the children.

FAMILY

Questions asked of respondents explored children's roles in the family, mate compatability, and expectations of parents concerning themselves and their children. The six factors which resulted from these questions were FAMILY1, Respondent's Expectations of Child's Self-Reliance; FAMILY2, Reactions to Time with Children; FAMILY3, Children and Family Stress; FAMILY4, Expectations of Mate; FAMILY5, Respondent/Mate Communication, and FAMILY6, Compatability with Mate.

FAMILY1 dealt with the respondent's expectations of his/her children's ability to care for themselves, i.e., self-reliance. This factor had a different response from the major ethnic groups. Mexican-American Abuser parents had higher expectations of self-reliance from their children than Anglo Abuser parents ($p<.05$). Mexican-American Abusers and Child Abusers had higher expectations for self-reliance than their Controls ($p<.01$). The findings of no difference between Mexican-American Child Abusers and Substance Abusers suggests that abuse and high

expectations for self-reliance are associated for Mexican-Americans. In Anglos, no differences emerged on FAMILY1.

Reactions by respondents to time spent with their children formed the basis for FAMILY2. This factor was crucial for Anglo comparisons only. Anglo Abusers were more dissatisfied with both the quality and quantity of time spent with their children than were Controls ($p<.05$). This difference also held for the comparison between Anglo Child Abusers and Controls ($p<.05$). The lack of a significant difference between Anglo Child Abuser and Substance Abuser groups suggests the important contribution of negative reactions to time spent with children to all types of abuse by Anglo parents.

FAMILY3 tapped various stresses on the family resulting from children's actions. Family size, school problems, and reliance on children were areas explored by questions weighing heavily on this factor. In both ethnic groups, Child Abuse subjects were significantly more stressed by their children than were Substance Abusers ($p<.01$). Additionally Anglo Child Abusers reported more stress created by children than Controls ($p<.01$).

Items dealing with expectations of the respondent's mate formed the FAMILY4 factor. Subjects of both ethnic groups were well differentiated between experimental groupings on FAMILY4. Anglo Abusers had significantly more ($p<.01$) difficulties with expectations of their mate than did Mexican-American Abusers. Within their own ethnic group comparisons, Anglo child Abusers reported more difficulties ($p<.05$) than Substance Abusers, and considerably more difficulties than their Controls ($p<.001$). Anglo Abusers reported significantly more difficulties in mate expectations than did Controls ($p<.001$). Mexican-American Child Abuse subjects reported more difficulties in expectations than Controls ($p<.01$), and considerably more ($p<.001$) than Substance Abusers.

FAMILY5 was based on items examining respondent-mate communication. Only the comparison of Anglo Child Abusers with Substance Abusers revealed a significant difference ($p<.05$). The Anglo Child Abuser reported less effective efforts to communicate with his/her mate than did the Substance Abuser.

Compatability with one's mate was the essence of the FAMILY6 factor. Although Anglo Abusers reported more arguments and negative affect in the mate relationship than did Mexican-American Abusers ($p<.05$), FAMILY6 was a crucial factor of the Mexican-American groups. Mexican-American Child Abusers viewed compatability as much poorer ($p<.001$) than either their Controls, or Substance Abusers ($p<.01$). The fact that Controls viewed the mate relationship as more compatible was underscored by their difference in this direction when compared with Abusers of all types for both ethnic groups ($p<.02$ for Mexican-Americans and $p<.05$ for Anglos).

ALCOHOL

Although the design of the sample provided for alcohol abusers being selected for that characteristic, the questionnaire included two items to gauge the nature of alcohol use by respondents. ALCOHOL1 represented the accumulation of several questions on the use of alcohol by respondents including where they drink and whether in the presence of their children. The results were much as expected. Mexican-American Abusers and Anglo Abusers reported more visible drinking behavior than their respective Controls ($p<.01$). Mexican-American Substance Abusers reported more drinking than did Child Abusers ($p<.001$). Although the tendency was in that direction, a significant difference was not reached in the analogous comparison between Anglo groups. On the whole, Mexican-American Abusers reported significantly more drinking than did the Anglo Abusers.

The ALCOHOL2 factor explored anxiety and depression associated with drinking plus possible hereditary influences. This factor strongly differentiated both Mexican-American and Anglo Abusers from their respective Controls ($p<.001$), with the Abusers showing more mental symptoms and family history of drinking. Both Mexican-American and Anglo Child Abusers reported significantly ($p<.001$) more of these problems than their respective Controls. It was interesting to learn that there was no difference in either ethnic group for the drinking problems associated with ALCOHOL2 between the Child Abuse and Substance Abuse subjects.

DRUG USE/KNOWLEDGE

Several items on the questionnaire explored the respondent's knowledge and use of drugs, including heroin and marijuana. Because use of these drugs is illicit, respondents were reluctant to be very open on this section of the questionnaire. Regardless, three factors emerged: MARIJUANA, Marijuana Use and Knowledge; HEROIN1, Knowledge of Heroin Use, and HEROIN2, Effect of Heroin on Self and Family.

Items comprising the MARIJUANA factor covered knowledge of marijuana's form, people who use the drug, and personal use by the respondent. As would be expected, Substance Abusers of both ethnic groups reported significantly more knowledge and use of marijuana than did Child Abusers of the same ethnicity ($p<.001$ for Mexican-Americans and $p<.05$ for Anglos). Abusers from both ethnic groups evidenced more knowledge and use of marijuana than did their respective Controls ($p<.001$), indicating the high weighting of the Substance Abuse subjects on MARIJUANA.

HEROIN1 items explored knowledge of the substance heroin and people who use it. As expected, Substance Abusers from both ethnic groups showed more familiarity with heroin than did Child Abusers of their ethnicity ($p<.001$). The strength of this difference was further demonstrated by the significant ($p<.001$) differences between Abusers of each ethnic group and their respective Controls. Apparently, Child Abusers are not unfamiliar with heroin, at least among Anglos. A difference at the .05 level was found for HEROIN1 between Anglo Child Abusers and their Controls. HEROIN2 examined effects of heroin use on interaction with children at home. No differences were found on any of the comparisons.

DISCUSSION

Inferences from the data presented in this report must be tentative for several reasons. Although the findings presented in the Results section are based on 341 subjects, the factor structure was derived from data on only 80 subjects. Some items were not entered into the factor analysis due to incomplete data and insufficient distribution of responses. Preliminary comparisons of differences on factors and items loading high on them suggest that the factor analysis based on the final sample of approximately 1,000 interviews will show somewhat different results.

The final sample itself will bear some important improved features. This study contained no Blacks despite the presence of this group as a third main ethnic group in San Antonio, and few Anglo Alcohol Abuse clients were located for the study. Both these differences are being remedied for the final sample. The subjects in this report were biased toward higher income Control subjects, or, conversely, to lower income Experimental subjects. The latter is more likely since cooperation from referral sources has been achieved with public or nonprofit agencies and their caseloads are skewed to the lower end of the income scale. A correction of this problem is not likely for the final sample.

Definitional issues offer further cautions to conclusions based on this report. After considerable difficulty arriving at specific criteria for classifying subjects as child, alcohol, or drug abusers, the pragmatic decision was made to accept the referring agency's criteria even though these differed among referral sources. Since many drug and alcohol abuse clients were referred from Victory Outreach, a religious program, the criteria for substance abusers may have biased the sample toward inclusion of persons willing to participate in a highly religious program, especially among alcohol abusers.

The overall discriminant analysis revealed a clear separation of the various Experimental and Control groups. With all of the differences likely to occur less often than one time per hundred, the power of the questionnaire to reflect differences between Abuse groups and their Controls was demonstrated. So were the ethnic differences between Mexican-American Abusers and Anglo Abusers. Future studies of child or substance abuse will need to treat ethnicity as a variable, at least in mixed populations including Mexican-Americans and Anglos.

ALCOHOL AND DRUG USE

Results of the chief factors of interest, i.e., drug and alcohol use, were mildly promising. The ALCOHOL1 factor did not support our major hypothesis (i.e., a positive relationship between the abuse of substances and the abuse or neglect of children). However, ALCOHOL2 which coupled the anxiety or depression associated with drinking and a family history of drinking led to interesting findings. In both Mexican-Americans and Anglos, Child Abusers reported more of these problems than Controls. In fact, they did not differ from the identified Substance Abusers of their respective ethnicities. It might be that Child Abusers manifest a certain type of alcohol abuse, perhaps learned from their parents, where they drink to relieve troubling mental symptoms. Responses to the drug use factors added little, probably because respondents were reluctant to state the commission of illicit acts. The significant difference between Anglo Child Abusers and their Controls in HEROIN1 which deals with knowledge of heroin and heroin users bears close scrutiny to see if it holds up in the final sample analysis.

STRESS

For Mexican-American subjects, STRESS1 revealed that Child Abusers had experienced more additions to family within the past two years than either Controls or Substance Abusers. This could be a situational stressor that, added to other causal forces, might precipitate an incident of child abuse. STRESS2 was a more sensitive factor among Anglos. Abusers of that ethnic group experienced poorer health recently as compared to Mexican-American Abusers and Anglo Controls. This illness or injury may be a precipitant to a form of self or child abuse among Anglos. It will be interesting to see if the differences persist in the final analysis.

Interruption of employment was the theme of STRESS3 and bore heavily on differences among Mexican-American groups. Child Abusers had the most severe employment instability, followed by Substance Abusers and then Controls. Stress induced by the insecurities of unemployment may contribute substantially to instances of Mexican-American child abuse or self abuse through chemical means. A related factor, STRESS4, dealt with income and again was a crucial factor among Mexican-American Substance Abusers. Perhaps source of income is a key factor among Mexicans in determining whether abuse is inflicted upon oneself or upon one's child, with disrupted employment related to child abuse incidents.

Separation from peers was the central focus of STRESS5. Abusers from both ethnic groups had experienced more interruption of peer relationships than Controls, and this was especially true for Child Abusers. This factor was stronger for Anglo Abusers than for Mexican-American Abusers. Perhaps the loss of people with whom to share frustrations and enjoy activities and companionship leaves the potential child abuser tense and more vulnerable to impulsive striking out.

REALITY

While REALITY1 indicated that Mexican-American subjects attributed more responsibility for events to forces external to themselves than did Anglos, this factor did not loom important in explaining child abuse and its relationship to substance abuse. REALITY2, which dealt with personal contentment, distinguished far better. Abusers of both ethnicities reported less past and present personal happiness. For Anglos, this finding was approximately of the same strength for both Child and Substance Abusers. Yet, for Mexican-Americans, Child Abusers reported more dissatisfaction than Substance Abusers. A lack of personal contentment, then, is a personality feature that contributes to or results from chemical or child abuse. Whether this feature precedes situational stresses or other forces or results from them bears further investigation. The finding of no differences among groups in change of personal happiness from childhood to adulthood on REALITY3 is suggestive of personal contentment as an abuse-predisposing conditions triggered by acute events.

TIME SPENT WITH CHILDREN

Satisfaction with the amount of time that parents spent with their children at home had a bearing on the groups of interest, especially among Anglo subjects. Anglo Child Abusers were more dissatisfied with time spent at home with children (CHILDREN1) than were Controls and Substance Abusers. In Mexican-Americans, the Child Abusers were more dissatisfied than the Substance Abusers, but not different than Controls.

FAMILY

Quality of time with children is influenced considerably by the Respondent's Expectations of Child's Self-Reliance, FAMILY1. This variable differentiated among Mexican-American groups except between Child Abusers and Substance Abusers. Unrealistically high expectations of children can lead to frustration with children's "dependencies" and to either child abuse or substance abuse among Mexican-Americans.

Anglos had negative Reactions to Time with Children, FAMILY2, while no differences were found among Mexican-Americans. All types of Anglo Abusers felt more negative than Controls about the quantity and quality of time spent with children. Apparently, a lack of enjoying one's time with children is frustrating enough among Anglos to lead to self or child abuse. Child Abusers of both ethnic groups reported more family stress on FAMILY3 than did Substance Abusers. Apparently, the choice of target for abusive behavior is related to the locus of perceived stress.

The remainder of the FAMILY factors dealt with the relationship between mates. Expectations of mates (FAMILY4) clearly differentiated the subject groups. Anglo Abusers reported more difficulty in mate expectations than did Mexican-American Abusers. Child

Abusers of both ethnic groups reported incompatability of expectations, with this factor separating Anglo Child Abusers more from Controls and Mexican-American Child Abusers more from Substance Abusers. These strong findings lead one to believe that an atmosphere of disharmony is present in many Abusers' homes, especially those of the Child Abusers. FAMILY5 supported this notion with respect to mate communication among Anglo Child Abusers as compared with Substance Abusers. For Mexican-Americans, mate incompatability (FAMILY6) revealed large differences among the study groups, with Child Abusers reporting the most incongruency. There is little doubt that mate differences are related to child abuse and substance abuse with patterns varying according to ethnicity. Most of the ethnic variation is explicable as semantic. Anglo subjects seem to label and evaluate difficulties in communication more readily than Mexican-American subjects whereas Mexican-American subjects reveal their differences by answering specific, behavioral questions about spouse interaction. Factor analysis on the final sample may separate some different items into factors that will more clearly partition mate relationships and their impact on the family.

For this report, practical applications of findings will not be addressed, due to methodological improvements being made for the final data analysis. However, the data obtained thus far emphasizes the importance of exploring the budding of child abuse among substance abusers. Further, the relationship between mates in child abuse families is not good, and child abuse potential could be explored in families evidencing marital incompatability and the other factors identified in this study as differentiating child abusers from other abusers.

Finally, many differences found in this study applied only to Mexican-American or Anglo subjects. Service agencies working with chemical or child abusing clients need to become responsive to these differences.

The SACA/N Project is ongoing and will be completed in June, 1978. For further information, write to: The San Antonio Child Abuse/Neglect Research Project, 2811 Guadalupe St., San Antonio, Texas, 78207.

Paradoxical Aspects of the Housewife/Mother's Role in Society

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"A jolly place," said he, "in times of old!" "But something ails it now..." Wordsworth—Hart-leap Well, Pt. II.

These lines of Wordsworth's are not unlike the statements and sentiments used by sociological experts to describe the changes on the home front. Something has gone awry.

Housewife/mothers have suspected for some time that something was going wrong, but only recently have they begun to announce their own"findings". Changes are in the wind! The invitation for members of this panel to participate in this National Conference on Child Abuse confirms that at least some experts are convinced that the housewife/mother, who is personally involved in family life (to say the least) has worthwhile ideas about what the problems are.

This conference was called to explore ways that the community and family can join efforts to meet the challenging responsibility of rearing children so that they can grow without the scarred personalities that result from abuse and neglect, and so that parents can enjoy and take pride in nurturing their children. Families need help in solving specific problems. But beyond that, there is the need for the creation of a social and economic atmosphere that fosters healthy parent-child relationships, healthy parent-parent relationships as well.

However, to talk about the family as "the family" is an evasive generality. If we are serious about helping families rear their children more skillfully, we must look at the people who head the family. In this workshop, this means talking about one of the parents—the housewife/mother. We must confront reality. She does not perform her role in a vacuum or in a controlled, research-type setting. She must handle her responsibilities as mother and homemaker in the real world—a world in which her role depends to some extent on factors beyond her control. The possibility that her husband may lose his job hovers in the background for many wives. Amidst updated announcements of the high divorce rate, she may wonder if she is to become one of those statistics. Though educators themselves are unsure, the housewife/mother needs to try to understand the school system so that her children stand a chance in it. Meanwhile, her children are coping—for better or worse—with influences that originate outside the home, and she must try to help them make wise choices. Finally, as her children's shoes become too small and their jeans or dresses too short, she must worry not only about replacing clothes, but also be reminded that the children are growing and will be gone some day. Then, what will she do with her time, with her love, with her mind?

The past 25 years have brought significant changes in attitudes about the woman who is a full-time housewife and mother. The adjective "successful" is seldom applied to her. The once normal expectation that she would stay home is—so we hear—being replaced by the opinion that she is abnormal, inadequate or without ambition if she is not occupied outside the home or at least preparing for a career. Attempts to offset such opinions and to upgrade the housewife/mother's role by semantic sleight-of-tongue through the use of titles like "domestic engineer" have failed. The use of the title "homemaker" has not brought dramatic transformation of attitude, but the use of both titles has given notice that housewife/mothers think they are being put down. I use the title "just a housewife" because I believe that more needs to be changed than the title, and that one has to begin where it's at.

It seems strange that mothers were given more credit by society for parenting when—if not easier—it was certainly less complicated. Twenty-five years ago Dr. Benjamin Spock was the single important voice of guidance for the rearing of children. Now there are hosts of voices competing for the parent's ear, each claiming to have a sure technique for rearing children. Traditional concerns such as the effect of thumb-sucking on teeth and the effect of toilet training on the personality have been augmented with concerns over sex-role identity, occupational goals, and similar questions. For the secure parent, all this expert advice is just that—advice. For the less secure parent, the overload of conflicting advice may add to the confusion and may further erode an already fragile self-confidence. The process of obtaining assistance may be more confusing than the situation for which assistance is needed.

Twenty-five years ago the vast majority of married women with school-age children were on the job at home full time. Not so today. According to Professor Urie Bronfenbrenner of Cornell University, 54% of mothers of school-age children were working outside the home in 1975, as opposed to the 28% in 1950. In 1975, 39% of mothers with children under six were working; 33% of mothers with children under three were working (Washington Post, 1977). Occupation has become a major basis for personal identity, the proof of accomplishment and self-worth. Being productively employed is more than a source of income; it is a source of status in our society where the question, "What do you do?" inevitably follows the question, "How do you do?".

Value clarification is the "in" topic when educators meet, but there exists no standardized formula by which the role of the housewife/mother can be measured and evaluated. Understandably, if a so-called value cannot be measured and computed in our computerized age, it is presumed not to exist.

Although the housewife/mother does have a career ladder, it has no scale for promotion, only a scale for demotion. A woman on this career ladder starts at the top when young. As she perfects her skills on the job as wife, mother, and homemaker, she works her way down the career ladder. Upon nearing the bottom rung, her children will leave home, and increasingly, through death or divorce, her husband, too. In fact, the housewife/mother may, upon reaching the bottom rung of her ladder, abruptly discover that she not only has less to do, but that she has no home in which to do it. Pending legislation to provide job training and placement assistance for "displaced" homemakers recognizes that the housewife/mother needs help. After some twenty years of work, when one might be expected to be at the peak of a chosen career with a lengthy vita, the full-time housewife/mother's portfolio is empty.

Paradoxically, in an occupation-conscious society, the housewife/mother—even when she is at the peak of her career ladder—is not considered to be officially occupied. John Kenneth Galbraith in *Economics and the Public Purpose* (1973), with a combination of knowledge and foresight, devoted a chapter to the housewife's contribution to the economic system. His appraisal of these contributions includes: selection, purchase, and delivery of merchandise (shopping), and in the case of food, preparation for consumption; care of the home and the direct care of children; procurement of health care for the family; involvement in the provision of education and recreation for the children; and volunteer aid to the community's social, health, and educational institutions. According to Galbraith:

> "Were the workers so employed subject to pecuniary compensations, they would be by far the largest single category in the labor force. The value of the services of the housewife has been calculated, somewhat impressionistically, at roughly one-fourth of Gross National Product."

But, as Galbraith points out, this work of the housewife is not counted in the GNP. Even though GNP is a term that the housewife/mother understands—it is a household word—she is not considered to be "occupied" and the tasks listed above are not counted in the GNP when performed by the housewife.

The Women's Lib movement, coupled with equal rights legislation, has struck down many of the barriers against women in education and the labor market. The fact of obvious ability, and the newness of the opportunities to use this ability, have given women in the working world group recognition and singular attention. This makes the ongoing lack of recognition of what women do at home all the more obvious. The lack of comparable action to increase the status of women who are primarily involved in family and household responsibilities has broadened the breach between them and employed women. It has made the latter's work appear more important, the former's work less so. Opposition to the Equal Rights Amendment has been lodged by some women who are not in the labor force or preparing for employment; they have apparently not envisioned the ERA as expanding rights or opportunities for <u>them</u>. The result is that women have become divided on yet another issue, and are expending energy on polarization. Groups of women who might be mutually helpful are arguing about who has it easier, who has it better.

Federal Aid to Families with Dependent Children was established in the mid-1930's with the original intention of enabling mothers with no income to stay home and care for young children. This program was intended in part to help prevent neglect and abuse in a single-parent family in which the mother would otherwise have to leave her children anywhere, or with anybody or nobody, in order to work and survive.

Since 1967 the official federal stance has been to strongly encourage the mother receiving such aid to seek training and employment. One consequence of this position was the beginning of a federally-financed multi-million dollar day care program for mothers in job training. This program opened employment opportunities for women. Women who had no previous occupational status while caring for their own children found jobs in day care centers. As a result, they became social security card-carrying members of the work force and were counted in the GNP. In a sense the government helped both groups of women, but there was an odd message in this act of assistance. Mothers were told that the federal government would pay some women more to care for other women's children than it would give in assistance to mothers to stay home. The government was saying, in effect, "You are working when you care for someone else's children, but you are not working when you care for your own."

Gradually, another result of the day care program has become evident. Mothers who work, whether because of economic need, desire for more family income, or for self-actualization, need day care facilities. The growing demand for this service, and the high cost of providing it, has led to direct federal subsidy of day care centers. Beyond that, the recent Internal Revenue reforms include tax credits ($800 limit per family) for the paid care of children and dependent handicapped adults inside or outside the home. This form of subsidy for paid child care has had a side effect of creating a still greater demand for adequate day care facilities.

The federal government subsidizes day care centers directly and indirectly. It subsidizes institutions caring for dependent and handicapped persons. It subsidizes institutional and foster care programs for children from broken homes. It requires that the husband and father be out of the home before assistance is granted to dependent children. The government subsidizes the fragmented family to a far greater extent than it provides supplemental support that might enable a family to remain intact.

These changes and trends have taken place to the accompaniment of constant, calculated and frequently infantile radio and television commercials that frequently portray the housewife/mother as vain, stupid, and gullible enough to buy anything. There appears to be no consideration of the damaging effect of these commercials on the family's self-image. What about the woman who has trouble buying enough food to put in her dishes—sparkling clean or otherwise—who is told that if she uses the right detergent she won't need a maid? And, how does she feel about the television star extolling the virtue of a substitute orange juice when she can't buy the real thing praised by another famous person? It seems odd to think about how much these people are paid to demonstrate products that the housewife/mother uses in her "non-job."

As a result of the cited trends and developments, the full-time housewife/mother at all income levels—and increasingly in all cultural groups—has found herself in a devastatingly devalued position. She is performing in an occupation that is not recognized as an occupation. As she goes about her tasks, she is reminded that each of them would have more importance and more value if done by another person for pay. All this has left the impression that it is she who does not count. Continuing to work in this atmosphere puts the housewife/mother in the untenable position of collaboration with society in a process of self-veto.

A paradox exists. The housewife/mother in a devalued role is expected to perform responsibly, competently, even good-humoredly in the many roles for which even John Kenneth Galbraith has given her credit. In a society which places great store by personal achievement, the housewife/mother is involved primarily as an enabler, helping other family members reach their goals, achieve their potential, and develop strong self-images. This is at best an uphill job, and even the most appreciative and helpful family cannot fully offset the impact of society's messages that tell her she does not really count. What's the bottom line for the child—girl or boy—growing up in a society that is permeated with these paradoxical messages?

What does the housewife/mother do when she finds herself in this untenable position? She can leave it—and many have. She can deny its existence. She can defend the position in "my country, right or wrong" style. She can overplay the submissive dedication to family. Either extreme—denial or glorification—is an attempt to cope, but this approach removes any rationale for negative feelings she may have about the situation. She can see no reason for her lack of incentive to create a caring and stimulating atmosphere in the home. No reason for temper flare-ups that may result in specific incidents of child abuse, no reason for those incapacitating periods of depression that descend like a cloud. She is finally left with the impression—or worse, the diagnosis—that there is no option but to blame herself for being the apathetic victim, without ambition, drowning in self-pity. But underneath there is anger, and because of this anger—for which there is no apparent reason—there is guilt. This sets the stage for a cycle of anger, striking out, guilt, over-compensation, anger again for overwork, striking out and around it goes. All this with no discernible rationale.

What is the bottom line for the child in such a family? What is the bottom line for the husband? Children and husbands are the people most likely to bear the brunt of angry feelings that are the result of societal pressures. It's hard to tell off society!

Major policy changes will be required to create a support system for the family unit in which the role of the person taking the major responsibility for the care of children and the home is recognized as having value. As an initial step in this direction, I have proposed a Department of Households on the cabinet level. Such a department could begin to make some sense out of conflicting messages that society is currently sending us. Another proposal which I have made is a White House Conference for Homemakers. Such a conference would highlight the importance of the responsibilities of the homemakers. I have sent both of these proposals to President Carter.

Housewife/mothers need all the assistance they can get from governmental leaders, legislators, and social scientists. But the time has come for homemakers themselves to participate in all planning that concerns the family.

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Child Abuse: The United Kingdom—Another Country, Another Perspective

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> The child shall enjoy special protection and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually, and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration (United Nations Charter, Principle 2, Declaration of the Rights of the Child).

INTRODUCTION

The United Nations Declaration of Human Rights sets out a clear mandate for children. Unfortunately, resolutions, however well intentioned, do not take into account the perversities of human nature, and child abuse continues to present a major problem, both nationally and internationally.

In the past few years an increasing number of countries have become particularly concerned at the numbers of children who receive nonaccidental injuries at the hands of their parents or guardians. Many of these children suffer trauma that will affect them for the rest of their lives, while others die as the result of their injuries. The tragedy is that a large number of these families could have been helped and the suffering of these children prevented had those responsible for providing service been attuned to the real needs of the families concerned and understood what they have to tell us.

More and more we have recognized that this is a phenomenon that crosses all national frontiers and is one in which we can all learn from each other's experiences to the ultimate benefit of those we serve. On the international scene, events have transpired quite rapidly. The first International Congress on Child Abuse took place in Geneva in September 1976. The second is to be held in London at the Imperial College from the 12th to the 15th September. 1978.

The following is a discussion of some of the developments that have taken place within the United Kingdom that have relevance to any consideration of present service delivery systems and their effectiveness.

HISTORICAL TRENDS

If one studies the historic beginnings of services to protect children, it becomes immediately apparent that there have always been strong links of cooperation between the United Kingdom and the United States. For example, the story of Mary Ellen, whose suffering in 1874 affected American legislation and brought about the founding of the New York Society for the Prevention of Cruelty to Children, had an indirect but significant bearing on what followed in England. As the movement in America gained momentum, numerous people were becoming growingly concerned about the number of children who appeared to be suffering needlessly in Great Britain, and many letters were written to the press, urging that some action be taken.

In 1881, following these events, a Liverpool businessman, Mr. Agnew, visiting New York, saw the title Society for the Prevention of Cruelty to Children. He got an introduction to its president, Mr. Elbridge T. Gerry, who, together with a Mr. F. T. Jenkins, the superintendent of the Society's Children's Shelter, did all they could to help him in his quest for information (Morton, n.d.). This resulted in the promotion of a similar organization in Liverpool which was swiftly followed by the setting up of the National Society for the Prevention of Cruelty to Children (NSPCC) with branches all over the country and a headquarters in London. That organization is now the oldest and most experienced independent child protection agency in the United Kingdom, undoubtedly owing its existence to the courtesy, patience, and cooperation shown by our American colleagues back in those early days.

PROBLEMS OF STATUTORY PROVISION

Although statutory welfare services are provided as a right in the United Kingdom, it is a misconception to think that the state alone can provide all services necessary to adequately meet the needs of deprived children.

Too often social services departments find themselves short staffed with the added problem of very high generic caseloads to deal with a situation which frequently precludes them from being able to provide the on-demand availability so necessary for many of the families we see.

One has only to examine the statistics of the NSPCC to see that this agency alone was called upon to provide service to 52,200 children during last year and of these, 34,850 were potentially at risk of abuse (NSPCC, 1976).

THE NSPCC RESEARCH-TREATMENT PROGRAM

By 1967, the National Society for the Prevention of Cruelty to Children, together with a number of eminent members of the medical and legal profession, was becoming increasingly concerned at the number of very young children coming to notice with serious physical injuries for which there appeared to be no adequate explanation. NSPCC undertook a study seeking to find ways of effectively intervening in family situations where children under the age of four had suffered, or were in danger of suffering, nonaccidental injury and to create an informed body of knowledge about the syndrome (NSPCC, 1976). By contrast with some other studies, the NSPCC project was primarily social work orientated and community based; a consultant psychiatrist and psychologist were available to the team for consultation and assessment purposes.

The department was established in October, 1968 and in 1974 was expanded to become the NSPCC's National Advisory Center on the Battered Child. As part of its clinical treatment program, a 24-hour on-call service is provided to the hospitals and communities of four London boroughs. Families are referred for help at any time of the day or night, and self-referrals are encouraged. Facilities include a therapeutic day nursery, play therapy for the children, and group therapy for parents. Appropriate psychological and psychiatric services are also available. Current research, assisted by a grant from the Department of Health and Social Security, involves two projects. The first is concerned with the analysis of video recordings of mother-infant interaction. Its purpose is to discover and demonstrate to workers in the field essential behavioral differences between parents who physically injure their infants and those who do not. A second project is aimed at devising a method of investigating subsequent health and educational development in children who have suffered nonaccidental injury.

Over the years, the department has published a number of articles and research reports, the latest of which are *At Risk*, an account of the work of the Battered Child Research Department (NSPCC, 1976), and "Case Conferences—a Cause for Concern" (1976).

Proposals put forward by the department have led to the setting up of seven special treatment units by the NSPCC. These units are linked to the National Advisory Center for research purposes and have responsibility for administering and monitoring registers of suspected nonaccidental injury in their regions.

The informed body of knowledge accumulated from its work over the last eight years has enabled the center to provide educational and consultative facilities to many agencies and bodies, both nationally and internationally. There are also strong links between the National Advisory Center in the United Kingdom and that headed by Professor Henry Kempe in the United States.

RESEARCH FACTORS HIGHLIGHTED IN THE BRITISH STUDIES

Family Psychopathology: The Children

Two earlier studies showed that the greatest number of children coming to attention were in the five month or under category and that the younger the child, the more likely it is to be injured and the more serious the injury is likely to be (Skinner and Castle, 1969; Castle and Kerr, 1972). This has subsequently been supported in other reports (Rose et al, 1976; Oliver et al, 1974).

Trauma to the soft tissues of the face and mouth appeared in 43.5 percent of all cases notified, and it became clear that bruises and injuries that might appear to be of a minor nature could signify the beginnings of increasingly violent forms of injury. It has been pointed out that the high incidence of trauma to the face may, like bruising, be an aid to early diagnosis of a nurturing problem that, if modified, may avert serious injury to a child.

In families where a firstborn child has been injured, records showed that there was a 13 to 1 chance that a subsequent child would be injured. The high risk in these families is a finding of particular importance to all those who take responsibility of weighing up the risks of supervised home care for the nonaccidentally injured child against an alternative protective course of action.

Low birth weight is a consistent factor, and in both the studies mentioned there was a significantly high rate, 13 percent and 14.5 percent respectively, more than twice the average nationally for that period. Of the most important factors, feeding difficulties and continual crying present as those causing parents most distress as illustrated by the following statement from a mother.

> I felt no love for the child when it arrived, and on getting home from the hospital, felt very distressed by a feeling of fear and inadequacy. This was accentuated when the baby cried to the point of almost uncontrollable rage and revulsion. The need to stop the noise was as overwhelming as that of a drowning person to clutch at something solid.

Family Psychopathology: The Parents

A number of suppositions are prevalent concerning the parents involved. Some suggest that the majority are of psychopathic personality and cannot be helped; others say they are individuals of low intelligence. Psychological and social work studies carried out at the National Advisory Center with the cooperation of parents do not support these propositions. Tests (Wechsler Adult Intelligence Scale and Cattell Sixteen Personality Factor Test) of a group of battering parents matched with a control group for parental and child age, ordinal position of the child, social class, educational level, type of living accommodation, and nationality, showed that the mean IQ's of both groups fell within the normal range. The majority are neither mentally subnormal nor frankly psychotic, although personality problems of long standing are more common among battering parents than the general population.

The tests did show that parents who injured their children were relatively less able in their command of verbal concepts than in their practical abilities, which suggests a rather concrete style of thinking, consistent with relative difficulty in seeing the consequences of actions and in controlling impulses to act. The integration of these findings with those of the social work research confirm an implication of immaturity, impracticality, and a tendency to flee into fantasy in the face of real problems.

Our report points out that "there is no support in this investigation for the idea that battering (as it is more widely known), is undertaken by the mother while the father passively looks on, nor for the reverse situation". Test results concur in showing abnormalities in both parents. The main contributions of the fathers are their own specifically introverted schizoid personalities. They present an abnormally introverted group.

Close contact with these families reveals that in many cases the parents themselves have from early childhood been consistently subjected to experiences of disapproval and rejection. Dr. Steele (1970), the eminent American psychiatrist, in his studies of families in which children have been abused, writes that "throughout life they (the parents) have pathetically yearned for good mothering, returning again and again to their mother, seeking for it but not finding it and ending up with disappointment, lowered self-esteem, and anger." Our own experience very much supports this view and, indeed, we have been struck by the similarity of patterns between those families being worked with here in the United States and those that we are working with in the United Kingdom. In many instances, if the names and details of residence were excluded you would be unable to tell which of our countries they actually came from.

Depression and anxiety are common, although hostility may mask the symptoms. While we know that nonaccidental injury occurs in all strata of society, we are seeing the greatest number of cases from the lower socioeconomic groups. This is not surprising when one considers that families in these groups are generally under much greater social stress and have fewer avenues of relief.

A question raised of late concerns the possible correlation between abused children and battered wives. The initial country-wide NSPCC study identified a group characterized by their essentially antisocial behavior of the predominantly aggressive type (Skinner and Castle). There were indications that these adults were habitually aggressive and that their behavior tended to be released against any source of irritation. In our latest study, nine mothers describe their husbands as having been physically violent towards them at some time.

In these families, the main lines of tension, aggression, and violence flowed between the parents rather than between parent and child. Children were more likely to be injured by accident rather than design. In three cases, the violence was serious, frequent, and associated with drink. The three men involved often resorted to violence in other situations. Although there was occasional violence towards the children, the disorder in the family was based primarily in the psychopathology of the father and, thus, in the marital relationship rather than

in the parent-child relationship. The majority of nonaccidentally injured children do not appear to come from families in which the wife is also injured. There is, however, some overlap, and we will always see a number of parents who are habitually aggressive. These particular cases make special demands on those who, while attempting to protect a defenseless child, are confronted with the possibility of increasing hostility and tension that might further endanger life.

PROBLEMS OF PROVIDING SERVICE

At present, it is estimated that approximately 3,500 to 4,000 children under the age of four suffer nonaccidental injury at the hands of their parents or guardians annually in Great Britain (Rose et al). Over the last few years, there has been a growing recognition of the problem and, understandably, medical diagnosis, particularly in the field of pediatrics, is now much better than it was at the time we started our research. If, however, we accept that this is essentially a sociomedical problem that, in a large number of instances, could be prevented, we must also recognize that growing awareness and better medical diagnosis alone cannot resolve the problem. It will greatly assist in our understanding if those concerned with diagnosis, treatment, and, ultimately, prevention, are able to accept that in the majority of cases coming to our notice, the parents, due to those factors already discussed, are to a great degree captives of their own childhood experiences and have no conscious desire to harm their children.

Henry Kempe (1976) makes the point successfully when he says "with the exception of a relatively few sadistic parents, who are child torturers in the Dickens sense of the word, child abusers are, themselves, in very deep pain." In our attempts to offer effective support, it may also be helpful to remind ourselves that angry, aggressive feelings towards those we love are perfectly normal emotions. There are probably very few people with children who have not, at one time or another, been pushed to the limit of their endurance and have felt like doing the child an injury, using such expressions as "If that child doesn't stop, I'll kill him," or "Take that baby out of my sight before I strangle her." Many will recall instances when this kind of situation has arisen. How much worse must it be for young parents often living with children in social isolation, facing numerous pressures and stresses, and unable to cope because of their own limited experience of nurturing. These are adults who have very low points of tolerance and who do need a considerable amount of reaching out to, in a supportive, nonauthoritarian manner. If prevention of injury or reinjury is the aim, the main objectives must be this difficult task of demonstrating, within the context of the professional relationship, to parents who are often hostile and highly suspicious, a genuine concern and desire to help.

This must not blind us to the fact that we are going to see some adults who have been so badly damaged in their own childhood that they are never likely to be able to provide the relationship that is so important in a child's development, and where we will have to act using what legislation is necessary to secure the ongoing welfare and healthy emotional development of the child concerned.

Following the tragic Maria Colwell case, in which a child under the supervision of the local authorities died, the Department of Health and Social Security issued a memorandum, in which it said: "Recent events have left us in no doubt of the need to repeat the professional guidance about the diagnosis, care, prevention, and local organization necessary for the management of cases involving non-accidental injury to children" (DHSS, 1974), and went on to recommend the setting up of area review committees in all regions. While these committees are doing much to ensure better management of cases involving nonaccidental injury to children, tragedies continue to occur.

The following is a headline and extract from one of our national newspapers dated 26 November, 1976.

> Boy 2, Died After False Assumption by Authorities
>
> In Birmingham, a social worker erroneously assumed a health visitor was checking on a two year old boy who later died after a violent attack by his mother.

The enquiry, formally conducted by the district council and the area health authority, found that "the full picture of events was not known to any one agency involved in the case." The child concerned died from abdominal injuries three months after his older brother was taken into care as the result of nonaccidental injury. It was assumed that the older child was scapegoated and therefore the younger child was not at risk. Two months after intensive visiting commenced, the case was transferred from the Parent and Child Center to the local health visitor, who then became the primary worker.

"It is doubtful whether she realized the real risks that were inherent and she had not the time to give adequate support," says the enquiry. "Perhaps the most crucial aspect of decision-making in relation to the younger child was the lack of consideration and assessment, both at the case conference and the following month at the Juvenile Court."

A number of problems that could arise anywhere are highlighted by this case: lack of communication, changes of worker during the early stages of treatment, a primary worker overburdened and not sure of her role, inadequacy of the case conference, and inadequacy of the juvenile court. These are situations that all of us will come across from time to time, and it may be helpful to look at some of the lessons we can learn from them.

First, it must be recognized that our prime responsibility in cases of nonaccidental injury to children must be the protection and ongoing welfare of those children.

In many of the cases coming to the notice of the center, it has been found necessary to implement juvenile court proceedings at a very early stage; in a large number of instances, after assessment, a period of separation between parent and child has been seen as in the best interest of the family as a whole, while initial relationships are being established between worker and client. The initiation of juvenile court action as a coordinated part of a casework plan can often not only protect the child but also has the effect of protecting the parents from their own actions.

One cannot overemphasize the importance of coordination and cooperation, the free-flowing interchange of information between all concerned and a recognition of each other's professionalism. Often in practice it is quite difficult to get people from different backgrounds and professions to truly coordinate and cooperate in a way that would be of the greatest benefit. It lays a responsibility on all to do much more in the way of reaching out to other colleagues, both professional and voluntary.

Case conferences should and can be the most effective way of sharing information. They need not take a lot of time, providing the conference is structured with an experienced chairperson and participants take the time to prepare reports on their involvement rather than trying to extract information from bulky files at the meeting. In the initial stages of contact with these families, there is a need for a high degree of skill and sensitivity on the part of the worker involved. As was pointed out earlier, a multiplicity of workers can increase family stress, and a type of supervision that is limited to an anxious watchfulness without specific treatment goals is not in the child's best interest (Skinner and Castle).

In some instances, shortage of qualified and experienced personnel has led to trainees being given these cases to handle; in others, because of frequent staff changes, families have had as many as three different social workers in six months. Quite often the parents involved see this as a reenactment of their earlier life experiences and feel completely rejected and bitter. This can have very serious repercussions for any future therapy, particularly if a change takes place when, for the first time in their lives, they are just beginning to respond in a positive manner.

Our work with these families leads us to believe that the first few months of contact and how they are handled are crucial to any positive movement that might be achieved. It is also a period when the parents will test out the relationship in a variety of ways and be at their most demanding. A considerable amount of reaching out on the part of the worker and a great amount of time are required. It is, however, the period when the parents, if they are at all amenable to help, will begin to respond.

In circumstances where work is progressing with a family and a change of worker must take place, it is of great help to all concerned if the parents can be forewarned and prepared for the change by the outgoing worker, allowing them time to ventilate their feelings and, when possible, to be introduced to the new worker prior to departure. Frequently, the only notice families have received is a short letter saying that their social worker is leaving, or has left, and another will visit in due course, occasionally followed by a long delay before anyone is actually able to visit. The buildup of tension created for the family by this situation can be a potentially dangerous one for the child. Those of us having administrative responsibilities should also recognize that adequate support and consultation must be readily available for the social workers involved.

One other aspect that requires our consideration is the effect these families can have on those of us who are providing a service. Families of this nature have an uncanny knack of highlighting our own inadequacies, and continually confront us with situations geared to raising our anxiety levels. For the inexperienced, this can produce a state of immobility at a time when clear objective thinking is imperative.

Richard Galson (1970) succinctly grasps the problem when he says "the anxiety produced by anger which is unassimiliated is highly contagious. It lies about like a time bomb waiting to go off and it intimidates others to flee, to put distance between themselves and source either directly or through the use of one of the many administrative devices available to any clinic or agency." One of the most important resources called upon by any therapist involved in this kind of situation is a capacity to bear the anxiety. Just as we accept that there are going to be a small number of families unable to respond to treatment, we must also accept and recognize those few instances when the social worker is unable to respond.

ALTERNATIVE DELIVERY SYSTEMS

Most research programs into the treatment of abused children and their families stress the need to provide a number of services that would not be available under normal delivery systems. In the United Kingdom there is particular concern at the lack of specialized treatment facilities for very young children who may have suffered severe emotional damage (Attention was drawn to this in a recent report (NSPCC, 1976). There are, however, a number of models now in use that have been of benefit to the family as a whole and are generally adaptable to most countries' settings. Some of those being used in the United Kingdom are described below.

CRISIS NURSERIES AND DROP-IN FOSTER MOTHERS

In setting up a serivce for families in which child abuse had occurred, we were concerned that we should learn from the experience of those parents who felt that available services did not meet their particular needs. One of the most pressing of the requirements voiced was for some form of nursery facilities where a parent under stress and frightened of injuring his or her child might leave him for a while without fear or remonstration. It became apparent that many parents had suffered quite traumatic experiences when seeking this kind of help and had consistently met with rebuffs of one kind or another. Some even felt they had been forced into a tragic situation where they had actually injured their child because they could not get the various authorities to recognize or understand the urgency of the matter or danger involved. The following is a graphic example of this situation.

> I got to the point where I seemed to have been to (sic) everyone! Things were getting worse and worse, but no-one (sic) would listen! In the end, I nearly killed my baby and then they said it was my fault.

Taking these points into consideration, there are two alternatives available. First, a nursery where the staff are geared to cope with children being brought in for varying periods and at any time. Our own experience has shown that a nursery of this kind has a particular therapeutic value if it is seen to incorporate facilities for the parents. At all times it is essential that they are made to feel welcome and have a room in which they can relax without the children. We have found that one of the results tends to be the development, quite spontaneously, of a self-help group, and many of the newly referred parents respond much earlier to treatment because of the help given them in this manner.

A vital feature of this service is the provision of a transport that goes out in the morning to all the homes of the families, brings the children and any parent who wants to come back to the nursery and returns them again at night. A member of the nursery staff accompanies the driver who, if necessary, can dress the child and ensure that he or she attends if the parent is ill.

Another extension of this can be in the form of a preschool playgroup. In both circumstances play therapy is of great assistance to the children in preparing them for later life and providing some of the outlets they have not perhaps enjoyed at home.

The nursery nurses are very much part of the therapeutic team and attention has to be given in these circumstances to ensuring that they receive adequate orientation toward their widened role, since they will find themselves as involved with the parents as they are with the children.

The second alternative, which is of particular value in areas where nursery provisions are poor, is to set up a system of drop-in foster mothers. These volunteers are paid a small retainer and provide short-stay emergency placements for children at times of crisis. For example, quite often mothers will telephone when they are going through a particularly difficult period saying that they cannot cope and asking if the baby or child can be taken out of the home and looked after for a short time. In most instances, an overnight stay is all that is needed, but it is possible to extend this for any period up to a week. As with most provisions in this field, the key factor is

flexibility, and drop-in foster mothers have to be prepared to accept children at any time of the day or night. Again, when selecting suitable people, emphasis is placed on personality rather than any professional skill.

We have also tried to recruit from as wide a variety of social backgrounds as possible, since we have that found many abusing parents find it much easier to respond to someone whom they feel has had the same kind of problems to contend with. Some of our earlier referred parents who responded to treatment are helping as part of this network.

FAMILY DEVELOPMENTAL CENTERS

In a few enlightened areas, attempts have been made to set up treatment programs that will provide residential facilities for the whole of a family where significant child abuse has occurred. There is, for instance, a unit operating at the Park Hospital for Children, Oxford, England, where over the last 10 years 230 families have been successfully treated. In essence, these families are received into a small family unit within the hospital grounds for a period of 28 days and then followed up with supportive services. During this period all the family members experience the rare combination of practical help, medical treatment, and applied psychology.

CONCLUSION

While we can never hope to completely prevent child abuse, there are a number of ways in which we can reduce it drastically. Research in the United Kingdom has shown similar patterns to those reported in the United States, in particular, the very young age of many of the children involved and the low points of tolerance shown by their parents.

For any program of preventive treatment to succeed, parents should be able to seek help without being made to feel guilty and afraid. The provision of such a service requires a team approach involving both availability and flexibility on the part of those operating it. Cooperation and coordination between all concerned, (both professional and lay personnel), are vital, and they can only be achieved if we are prepared to remove some of the artificial barriers that sometimes prevent them from occurring.

Finally, we cannot consider any program of service to abused and neglected children adequate unless we are able to meet some of the very specialized treatment needs of the children, many of whom survive physically but are severely damaged emotionally and some of whom may have to be removed from their natural parents to a more conducive and nurturing environment before this can be effected.

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Corporal Punishment in the Schools: America's Officially Sanctioned Brand of Child Abuse

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The United States Supreme Court is currently preparing a decision on a case of child beating in Florida (Ingraham v. Wright, 1974). In this case, a young teenage child was extensively beaten on the buttocks with a wooden paddle. The resulting damage required medical treatment for wounds that prevented the child from sitting for an extended period of time. Any parent who exerted similar force on a child would be liable for reporting under the child abuse legislation. However, the incident occurred in a school and therefore this cruel and sadistic use of force on a young person was protected by law. In fact, hitting, paddling, pinching, punching, strapping, shoving, throwing, kicking, and verbal abuse are treatments received everyday in schools throughout the "land of the free and the home of the brave." Unfortunately, the concepts of freedom and bravery have been distorted in support of physical assault upon children. The Constitution and Bill of Rights have only relatively recently begun to be interpreted as applying to children. And the concept of bravery as it applies to the upbringing of children within both the Judeo-christian morality and the Anglo-Saxon tradition reveals a history of officially sanctioned beatings of children. This societal background lends support and encouragement to the use of physical force within the American family. The purpose of this paper is to examine the extent to which corporal punishment within the schools lends credence to the use of physical force against children in the home. Without doubt, this is a "chicken or egg" problem.

In western culture, children historically have been considered to have few if any rights (Williams, 1976). In societies where violence and lack of due process are common, it is clear that the family mirrors the cultural milieu in relation to the use of force. A recent theoretical paper by Babcock (1977), a member of the staff of the National Center for the Study of Corporal Punishment and Alternatives in the Schools, suggests that there is some basis for predicting family use of physical force for discipline as a function of various facets of the culture. Babcock, in reviewing cross cultural studies, found a possible correlation of characteristics of cultures where corporal punishment could easily exist and those where corporal punishment would be incongruent with other characteristics. The major potential predictors for family use of corporal punishment and consequent child abuse were (1) belief in aggressive gods, (2) the infliction of pain on infants by the primary caretaker, (3) the generation of high anxiety in socializing children, (4) low indulgence of children, and (5) increasing complexity of cultural traits.

It is important to recognize that we are not the child-loving nation which we would like to believe. It wasn't until 1900 that American law even recognized that anyone within the family other than the father and husband had any rights at all (Drinan, 1973). American attitudes towards children are reflected in the fact that ten years after the founding of the Society For the Prevention of Cruelty to Animals a group in New York organized the first Society for Prevention of Cruelty to Children. One is led to the almost indisputable conclusion that the majority of Americans really do not like children. This conclusion isn't new (Keniston, 1975), but it is almost always rejected when presented to the average citizen.

The evidence adds up to one of two conclusions: at the least, we are a society which does not understand the difference between what we believe we do for our children and what we actually do for them. At worst, we really know that large numbers of children, some in the shadow of our nation's capital, are deprived of basic human rights, but we do not care as long as we can assure the health and safety of our own. This is not to condemn our society, for it is really a matter of cognitive dissonance that has never been resolved. After all, we are surely a nation of optimists, who believe in our own good will. And in truth, we periodically evidence that good will through generosity toward an unequaled system of private charities, international relief, and the acceptance of a continuing stream of immigrants and political refugees from the dictatorships and highly controlled countries which now make up much of the world. Despite the

continued corruption of our politicians, the avarice of big business and the seemingly never-ending growth of bureaucracy, American democracy still muddles on and cleanses itself periodically. Yet there is a paradox in our view of ourselves and others' view of us. As a society, we are often criticized from within and without as being overly child-oriented and permissive, yet in this same society child abuse accounts for more childhood deaths than any other single factor (Hyman and Schreiber, 1975), and we permit educators to use often barbaric methods of discipline. Infant mortality is quite high when compared with other western democracies; when we consider mortality among minority groups alone, it is shockingly high (Coles, 1975). Perhaps one of the best historical anecdotes illustrating our treatment of children as viewed by others was related in the Wall Street Journal (Chase, 1975). It seems that a great Nez Perce Indian chief was on a peace mission to a white general. He rode through a white man's encampment and happened to observe a soldier hitting a child. The chief reined in his horse and said to his companion, "There is no point in talking peace with barbarians. What could you say to a man that would strike a child?" The chief's diagnosis of our society in the 1800's, based only on his peripheral observations of an accepted practice towards children, was unfortunately and amazingly accurate if one considers the eventual fate of his tribe and that of others. But then our 20th century society has a long series of "broken treaties" with our children.

It is surprising that the public school is the last remaining institution where a citizen may be assaulted by authorities. The police, the military, and prison officials are not allowed to use physical force as a method of punishment. How this reinforces and perhaps encourages the use of force in the home is difficult to assess. However, the assessment certainly should begin with an understanding of the nature and extent of the use of corporal punishment in the schools. Until just recently, this area has been of little interest to professionals involved in child abuse.

The background of the attitudes and practices which have resulted in a codified pattern of institutional violence in our society is enmeshed in a confusion of causes. It is important, therefore, to approach the problem by separating the main etiological and conceptual frameworks within which the practice of corporal punishment is intertwined. The following discussion considers corporal punishment from the three approaches of legal, moral, and scientific issues.

LEGAL ISSUES

The general definition of corporal punishment stems from a legal framework and indicates it to be the inflicting of pain, loss, or confinement of the human body as a penalty for some offense (Barnhart, 1963). Black's Law Dictionary (1968) defines corporal punishment as "physical punishment, as distinguished from pecuniary punishment or a fine; any kind of punishment of or inflicted on the body, such as whipping or the pillory. The term may or may not include imprisonment according to the individual case." Educationally, corporal punishment has been generally defined as "the infliction of pain by a teacher or other educational official upon the body of a student as a penalty for doing something which has been disapproved of by the punisher" (Wineman and James, 1967).

Corporal punishment in the schools is not implied when the teacher uses force (1) to protect himself or herself, the pupil, or others from physical injury; (2) to obtain possession or a weapon or other dangerous objects; or (3) to protect property from damage (National Education Association, 1972).

There are two main areas in which the constitutionality of corporal punishment are argued (Reitman, Follman and Ladd, 1972). One focus, that corporal punishment is cruel and unusual, is based on the eighth amendment to the Constitution. This rests on a number of grounds, most importantly the concept that the application of physical punishment to children violates democratic freedom and the dignity of the individual. The other argument, based on the fifth and fourteenth amendments to the Constitution, is that corporal punishment violates due process of law. This is divided between substantive due process and procedural due process. Under the substantive issue, it is argued that corporal punishment is often conducted in an arbitrary and capricious manner and does not bear a reasonable relationship to a societal purpose. Under the procedural issue, it is argued that before being punished, one is entitled to certain procedural safeguards, such as notice of charge, right to a fair hearing, etc. (Friedman and Hyman, 1977).

Currently, 47 states allow or specifically endorse through state legislation the use of corporal punishment as a means of disciplining children in public schools (Friedman and Hyman). Some, states such as Hawaii, are currently reviewing their statutes and have imposed temporary bans on the use of physical punishment. Maine has a new statute, but its meaning is unclear.

Among those countries which have abolished corporal punishment are Poland, Luxembourg, Holland, Austria, France, Finland, Sweden, Denmark, Belgium, Cyprus, Japan, Ecuador, Iceland, Italy, Jordan, Qatar, Mauritius, Norway, Israel, The Phillipines, Portugal, and all Communist Bloc countries (Reitman, Follmann, and Ladd, 1972; Bacon and Hyman, 1976).

MORAL ISSUES

Puritan and Calvinistic traditions of American society and the early medical realities of infant and childhood mortality resulted in attitudes which are abhorrent to modern thinking concerning children. Estimates of mortality suggest that occurrences of measles, typhoid, small pox, diphtheria, dysentery and respiratory ailments resulted in a third of all infants dying each year (Coles). For most of those who did survive, childhood certainly had its pleasures, but pleasure was generally considered by religious society as evil. Even if one did not subscribe to the Calvinistic belief that children were "imps of darkness" the historical precedent for maltreatment of children goes back even to the schools of Sumer 5,000 years ago (Radbill, 1974). The most severe practice of corporal punishment leads to murder, and the concept of state-supported infanticide or child murder is not new. As late as the 16th century, the belief of inherent evil in children was so strong that Martin Luther, assuming that they must be inhabited by the devil, indicated that retarded children should be drowned (Radbill).

In America, the practice of corporal punishment has been overt and publicly sanctioned from colonial days. The "spare the rod and spoil the child" philosophy of that colonial era was reflected in the schooling of the times. Manning (1959) reports that a schoolhouse, constructed in 1793 in Sunderland, Massachusetts, had an ominous whipping post built into the schoolhouse floor. Erring young students were securely tied to the post and whipped by the schoolmaster in the presence of their classmates. Manning also reports, in a similar vein, about "paddling" devices being prominent implements of the classroom in the 1800's. Paddling rods, canes, and sticks were placed conspicuously in the classroom, easily accessible to the teacher.

The issue of moral lessons taught by paddling in schools is currently illustrated in the state of Maine. The Maine legislature recently enacted a law forbidding the use of corporal punishment in all schools. Shortly after passage, a number of groups of citizens and educators began lobbying for the return of corporal punishment. Especially vociferous were teachers, parents, and students from Maine Christian Schools (Connolly, 1977). Ralph I. Yarnell, executive director of the Northeastern Regional American Association of Christian Schools, claimed that spankings, paddlings and whippings teach students "obedience, thrift, and other virtues."

An elementary school principal from Bangor Christian School stated that paddling does "wonders for helping a student mature." These kinds of statements reflect a belief that punishment has a cleansing effect in removing sinful thoughts and preventing sinful acts. Even if one accepts various religious views of sin and immorality there is scientific evidence to indicate that the preventive aspect of punishment is greatly limited and overrated (Bongiovanni, 1977). Despite this, many Americans have a religious conviction that schooling cannot occur without paddling (Hyman, McDowell, and Raines, 1977).

RESEARCH

A staff member of the National Center for the Study of Corporal Punishment and Alternatives in the Schools completed an extensive and exhaustive review of the research on punishment during the last ten years. His findings are indicated below (Bongiovanni):

> The use of corporal punishment by school personnel provides the child with a real-life model of aggressive behavior which has been demonstrated to be imitated by young children (Bandura, 1962; Bandura, Ross, and Ross, 1961, 1963). Not only do children imitate such aggressive behavior, they also tend to employ these aggressive behaviors when faced with frustration in their own lives. In a study in which children observed a model being punished, a learned fear reaction was demonstrated to have occurred, although they were not recipients of any punishment (Berger, 1962). The implication for school personnel is that the use of corporal punishment may provide a living model of aggression which may be imitated by the classroom children. Such a model may provide a problem-solving method which can be utilized by the child in various settings. In addition, by visibly punishing a child in the presence of others, the other children may become fearful and anxious. Such conditions are not conducive to socialization or learning.
>
> The available research on punishment, when applied to schools, suggests that it is ineffective in producing durable behavior change, is potentially harmful to students and

personnel, and is highly impractical in the light of the controls necessary for maximal effectiveness. The maximal effectiveness of corporal punishment can only be achieved by close adherence to the basic principles and factors which have been shown to influence its ultimate effectiveness as a behavior-reducing method. In light of the role of school personnel in education, and the welfare of the student, corporal punishment appears to be impractical, time-consuming, and contrary to the goals of education.

The potential for social disruption constitutes the primary disadvantage of punishment. In light of these negative side-effects, the possible reduction of undesirable behavior should clearly be secondary in importance. The need for discipline and adherence to rules is a necessary part of education. However, there are many alternatives to corporal punishment which may be utilized by school personnel.

Those who defend the use of corporal punishment as a practical method tend to view the practicality issue from the perspective of school personnel only. As a method, it can be applied to anyone, there is no need for any type of specialized training, it can be applied to all settings, and no special equipment except a paddle is necessary. The fact that most school personnel are physically stronger than the children makes corporal punishment especially attractive. In defense of corporal punishment, Killory (1973) cites four criteria of punishment to be considered: first, it should result in the greatest behavior change; second, it should demand the least effort on the part of the user; third, it should result in behavior that is relatively permanent; and fourth, it should produce minimal side-effects. This writer contends that, by the research evidence available, corporal punishment meets none of these criteria.

Not only is punishment an ineffective and inefficient method of teaching, in more severe forms it decreases learning. An extensive review by Rosenshine and Furst (1971) considered seventeen studies which were based on counts of teacher use of criticism. Criticism in all studies was generally defined as negative statements, demeaning students or their actions, and/or the use of threats. Almost all of the studies reviewed indicated a negative relationship between teacher criticism and student achievements. In ten of the seventeen studies, stronger forms of criticism were clearly more negatively correlated with achievement than milder forms. Rosenshine and Furst conclude that "teachers who use extreme amounts and forms of criticism usually have classes that achieve less in most subject areas" (p. 51). Although all of the studies cited are correlational, there is certainly considerable evidence against the use of severe criticism and threats.

Research indicates that the use of corporal punishment is much more extensive than many believe. During the 1971-1972 school year, the Dallas public schools reported an average of two thousand incidents of physical punishment per month (National Education Association, 1972). In the Houston public schools, it was reported by Dr. J. Boney, an administrator, that during a two-month period in 1972, 8,279 paddlings were administered (Elardo, 1977). With a student population of about 200,000 children, this averages out to about four "licks" per child per year.

Finally, there is some evidence that increasing use of corporal punishment tends to increase the rate of school vandalism. Lee Hardy and Virginia Miller (Hyman, et al, 1977) made a study of twelve schools on the outskirts of Portland, Oregon, and found that rates of the use of corporal punishment appeared to be correlated with increases in the cost per pupil of vandalism against school property. Although the study is limited, it certainly suggests a fruitful area for further investigation.

IS CORPORAL PUNISHMENT A FORM OF CHILD ABUSE?

This paper has attempted to summarize some of the literature and writings collected by the staff at the National Center for the Study of Corporal Punishment and Alternatives in the Schools. For one year we and our organizers have attempted to offer evidence that reveals the practice as a particularly insidious form of child abuse. Funding has been extremely difficult to obtain and therefore our impact has been limited. However, this paper represents an opportunity to impress upon child abuse workers the importance of this issue.

With the information available it is difficult to measure to what extent family attitudes support or cause the use of corporal punishment in the schools and to what extent the official practice encourages the use of force in the home. The two practices certainly are closely woven into the fabric of our society.

There is some evidence that home-school practices of child rearing go hand in hand. An intercultural study of aggression by Bellack and Antell (1974) considered the playground behavior

of children in Germany, Italy and Denmark. Observers recorded aggressive behavior by adults and children. The results indicated a correlation between adult and child aggression which also reflected cultural beliefs about child rearing. The greater aggressiveness in German institutions and child rearing results in greater peer aggressiveness. The belief in force as a method of discipline in Germany was reflected in a poll which showed that 60% of parent respondents believed not only in spanking but in actually beating their children (Bellack and Antell, 1973). While Germans practice corporal punishment in the schools, the Danes and Italians do not. Their rate of interchild aggression on the playground was much less than that of Germans.

While the study is limited, it reflects the belief by some scientists that some of man's inhumanity to man may be revenge for the indignities suffered in childhood, and that children do model aggressive behavior as a method by which to solve problems.

Several American studies indicate that a large percentage of parents and educators favor the use of corporal punishment in the schools either as a regular method of discipline or as a last resort (Hyman et al, 1977). Everyone, in fact, seems to strongly favor corporal punishment except those who receive it. And among those who receive it, perhaps the best explanation is given in another study by Elardo, who interviewed elementary school children. Most said that some kids would prefer paddling to other forms of punishment in order to "get it over with." They also felt it did no good in changing behavior. One articulate child said, "Sometimes you get accused falsely of doing something. If you get paddled and later prove you did not do it, you can't get unpaddled. But if you lose an activity, maybe by the time the activity should occur you can prove your innocence and still get your activity" (Elardo, 1977, p. 18).

To the present writer it is clear that the legal use of corporal punishment in the schools has led to actual physical acts which are abusive to school children. How can we expect parents to not use this type of force when we officially sanction its use in education? Although we haven't measured the extent to which school corporal punishment encourages family use, it is reasonably clear from the evidence presented that there is a relationship. We can't answer the "chicken or egg" question of which comes first. However, a modest and reachable goal for child abuse workers would be the elimination of the use of corporal punishment in the schools. Our center, within the limitation of its modest funding, will offer legal, research and historical data to support this cause. We also offer workshops on alternatives. I believe that a concerted drive by interested educators, legislators and child care workers could result in almost total elimination of officially sanctioned corporal punishment in schools within five years.

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A Study of Attitudes of Caregivers Toward Use of Physical Force

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INTRODUCTION

Injury to children resulting from use of physical force is a social phenomenon that has attracted intense public and scientific interest in the last 10-15 years. While use of physical force in child care has been seen primarily as occurring within the home, Gil (1975) argued that physical force is also to be found at the institutional and societal levels. The institutional level includes settings such as day care centers, schools, courts, child welfare agencies, welfare departments, and correctional and other residential child care settings.

State reporting laws have typically adopted a narrow definition of which caretakers can be considered child abusers. These laws have focused attention on force used within the home. Studies of the incidence and causes of child abuse have typically omitted child caretakers outside the home.

This study focused on child caretakers outside the home. Respondents were direct caregivers in child welfare institutions. The task assigned to these institutions has evolved since colonial times. This evolution of purpose is reflected in the century-long debate over the relative merits of foster family care and group care. Popular and professional preference for family care and concern about alleged negative effects of group care gave support to a movement to de-institutionalize the substitute care of children in this country. Since the 1920's, many orphanages have adopted psychologically oriented programs and have shaped their acceptance criteria to exclude non-disturbed children. Nationally, the number of such residential treatment centers increased markedly between 1945 and 1965.

De-institutionalization of substitute care has led to a decrease in the number of children in institutional care. In Ohio on January 1, 1928, there were about 140 public and private children's homes with a total population of 11,470 children in residence. As of January 1, 1976, there were 33 private children's homes and 46 public children's homes with about 3800 children in residence.

For over 100 years, the state of Ohio has had a program of visiting certification, and more recently, of licensing of children's homes to achieve two general objectives: (1) to secure protection from abuse and exploitation for those children who require care away from their own homes; (2) to secure specialized treatment in group care settings for those children who require it.

To achieve these objectives of protection and quality group care, the Ohio Bureau of Licensing and Standards holds licensed child caring institutions responsible for following a number of guidelines in the operation of their programs. Among these guidelines is one in particular that is concerned with the treatment of the child. This guideline, or rule, prohibits the following practices:

> "There shall be no form of physical abuse, using such things as implements, restraints, straps, whips, sticks, paddles, utensils, tools; no physical manipulation of a child to hurt him, including forcing things into his mouth, striking, pulling, twisting of ears or limbs; causing severe physical discomfort through prolonged exertion by requiring him to run, jump, stand, hold limbs in strained and/or awkward positions and similar punishments." (ODPW)

SOCIAL PSYCHOLOGICAL CONTEXT

Caregiver-child relationships were viewed in this study as a form of social exchange. When what caregivers receive from children over a period of time is seen by them as not roughly proportioned to what they have given, feelings of distress gradually build up. We call this distress "injustice distress". Sense of injustice is a dynamic through which use of force is generated. This factor was seen as exerting a direct influence on the level of force espoused by caregivers. Respondents were asked how much resentment they would be likely to feel if they were the caretaker in the hypothetical situation. Responses were made on a five point scale from "none" to "a great deal".

We were interested in understanding what social factors evoke a view of physical force as a justifiable method of coping with challenging child care situations. Secondly, to what extent do organizational factors influence variation in the attitudes of direct caregivers toward use of physical force?

THEORETICAL BACKGROUND AND HYPOTHESES

Goode's (1973) analysis of "violence between intimates" was used as a frame of reference for this study. Underlying the relationships predicted between variables derived from this model were several assumptions:

1. All social systems require a minimum degree of control and order if they are to survive and physical force is one of several means that can be used to achieve them.
2. Those who control service organizations make a distinction between the wishes and interests of their beneficiaries. A divisiveness exists between beneficiaries and organizations which sometimes results in hostility and conflict.
3. Service organizations must develop mechanisms to cope with the self activating properties of clients in order to insure that change activities are not rendered ineffective.
4. Children's homes are, in part, force-based structures and use of physical force is a legitimate resource available to them as they seek to achieve their objectives.

The causal factors in this study were those which accounted for varying predispositions to use of force in caregiving. They are the status variables which available demographic analysis suggests are characteristic of certain violence prone collectivities. They constitute the socio-cultural context within which force use occurs:

1. Length of time employed in present job;
2. Length of time employed in previous job;
3. Work schedule;
4. Sex;
5. Age;
6. Race;
7. Region of residence;
8. Community size (early);
9. Community size (current);
10. Marital status;
11. Social position of respondents' fathers;
12. Education;
13. Income.

Those factors which Goode defined as resulting from social pressures and structural position were represented in this study by certain potentiating components of organizational life. These components are: (1) the extent to which living unit management practices are institution or resident oriented; (2) the degree of staff participation in organization decision making; (3) the degree of caregivers' control over their immediate work environment.

The caregiver-child interaction was viewed as a form of social exchange. The resulting feelings of caregiver distress were seen as exerting a direct influence on the outcome variable.

The dependent (outcome) variable is an attitude—level of force. In this study, five hypothetical care-giving situations were presented to the respondents. They were asked to indicate how often they would take each of six possible actions. One of the actions was to take no physical action at all. A force index was derived for each respondent from data which reflected the severity and frequency of the actions they chose.

The null hypotheses affirmed that all variables proposed in the model were independent of the outcome variable, level of force. The variables in the following two way combinations are independent of each other:

1. The extent of felt injustice and the level of force.
2. The scores by living unit on resident management practices and level of force.
3. The extent of centralization due to direct care staff participation in decision making and level of force.
4. The extent of centralization due to hierarchy of structure and level of force.
5. The age of direct care respondents and level of force.

6. The sex of direct care respondents and level of force.
7. The race of the direct care respondents and level of force.
8. The early town residence size of direct care respondents and level of force.
9. The region of residence (0-17) of direct care respondents and level of force.
10. The social position of fathers of direct care respondents and level of force.
11. The formal education level of respondents and level of force.
12. The town size (current) of direct care respondents and level of force.
13. The marital status of direct care respondents and level of force.
14. The income of direct care respondents and level of force.
15. The length of time of direct care staff in their positions and level of force.
16. The work schedule of direct care respondents and level of force.
17. The length of time of direct care staff in previous direct care jobs and level of force.

METHODOLOGY

This study was designed to explore the relationship between a number of factors (20) and attitudes toward use of force by caregivers in children's homes for dependent, neglected and disturbed children in central and southwestern Ohio. One hundred caregivers in 15 children's homes served as respondents. They represented 42 living units.

SUMMARY OF FINDINGS

Background characteristics of the respondents can be summarized as follows: Forty-one percent of the respondents held their present jobs one year or less; another 30 percent held their jobs four years or more. Of the 100 respondents, 37 were men and 63 were women. Fifty-nine were in their first jobs. While 58 worked a shift schedule, 40 were on a "live in with relief" schedule. Thirty-five percent of the sample were under 25 years of age. Another 38 percent were over 45 years of age. Forty-four percent of the respondents were single and had never married. Fifty-six percent were married or previously married. Fifty-seven percent of the respondents were single and had never married. Fifty-six percent were married or previously married. Fifty-seven percent of the respondents' fathers held jobs classified as working class and below. Forty-two percent of the respondents had completed high school or less.

Forty-one percent of the respondents had level of force scores in the 4-6 range. Another 29 percent had scores in the 6-12 range. The level of force mean score was 5.49 on a 12 point continuum.

Felt injustice mean scores for the 100 respondents ranged from 2.6 to 3.74. The mean felt injustice score for all respondents on the five situations was 3.2.

The mean score of 42 living units on resident management practices was 14.9. The lowest living unit score was 5 and the highest score was 35.

The mean for hierarchy of authority was 1.94 on a scale ranging from 1 (low) to 4 (high). The mean for participation in decision making was 3.39 on a scale ranging from 1 (low) to 5 (high).

We next determined the strength of associations between a number of variables expected to be related to level of force. A number of these variables were found to have a strong or moderately strong degree of association with level of force: age of respondent, education of respondent, marital status, work schedule, early community size, resident management practices, participation and felt injustice.

Levels of force selected by respondents to manage challenging child care situations could be expected to increase if a direct care staff member was older, had a lower level of education, was or had been married, was reared in a smaller community, experienced higher degrees of felt injustice, participated seldom or never in decision making, "lived in" on a 24 hour basis, and worked in a living unit where resident management practices are more organization centered.

A number of other variables were found to have a weak association with level of force: current community size, length of time in job, length of time in prior job, sex of respondent, income of respondent, hierarchy of authority, region of respondent, and race of respondent.

In order to build a larger structure of understanding, we determined how much of the variance in level of force was uniquely explained by each independent variable. We then combined the several variables into several sets and examined the relationship between each set and level of force. Next, we combined these sets to determine the amount of variance in level of force these sets in combination would be able to explain. This structure of explanation was then developed separately for sample subgroups based on categories of sex and education.

Several variables were found that uniquely explained larger amounts of variance in level of force: (1) felt injustice, 17 percent; (2) resident management practices, 8.3 percent; (3) participation in decision making, 5.3 percent; (4) age of respondent, 4.4 percent; (5) early community size, 1.3 percent.

We examined the contribution each set made to explaining variance in level of force. Background variables in combination accounted for 34 percent of the variance in level of force. The organizational set accounted for 16 percent of the variance in level of force. Felt injustice variables accounted for 16 percent. When felt injustice was taken in combination with the organizational variables, 29 percent of the variance was accounted for.

We next determined how strongly the independent variables taken together relate to level of force. All of the variables taken in combination were found to account for 39.4 percent of the variance in level of force. This same analysis was developed for subgroups in the sample based on categories of sex and education. It was found that the multiple correlation coefficient obtained for all variables and level of force for the whole sample taken together was similar to the coefficient for women (.634). A multiple correlation of .788 was obtained for men and .704 was obtained for respondents with some college.

Overall, the variables listed above as most significantly associated with level of force occurred, in general, as expected.

The relative strength of background and organizational variables suggest that much of the former was probably mediated by the latter. However, background variables improved the predictive capacity of organizational variables by five percent.

The strength of the coefficient obtained for all variables and level of force confirms our premise that a multi-dimensional model would yield significant results.

IMPLICATIONS FOR POLICY AND MANAGEMENT

What are the practice implications of the general finding that knowledge of the age, organizational characteristics, and inequity distress of caregivers can improve our prediction of level of force by 40 percent? What implications do these results have for minimizing the use of physical force? Furthermore, what implications do the results have for improving the quality of specialized forms of group care?

The extent of societal support for force use was reflected in the strong degree of association between the background variables taken in combination and level of force (r=.580). The Supreme Court decision in support of state laws that authorized corporal punishment in public schools is reflective of this general tendency in our society to support force use. The extent to which respondents could be expected to enter a caregiving situation with a readiness to respond forcefully was reflected in the unique contribution of age and early community size of the respondents to explaining variation in level of force. A substantial proportion of variance explained by background variables seemed to be mediated by organizational variables (r=.554) and these in turn were mediated by felt injustices (r=.412) and then expressed as attitudes toward use of force.

Lower espoused levels of force by younger caregivers could be interpreted as an effect of uncertainty in their roles, of having come to maturity in a period of "permissiveness" and antiwar feeling, and of having higher levels of education. The higher force levels of older caregivers can be interpreted as an effect of their having come to maturity at an earlier period when use of force was widely supported in the society as a normal means in caregiving. It will be recalled that 35 percent of the respondents were under 25 and 38 percent were over 45. Another 41 percent were in their present jobs under one year and 38 percent were in their present jobs over four years. In addition, those who were younger tended to stay in their jobs for shorter periods of time (r=+.56). This data suggests that one segment of the children's home field may be attracting older caregivers. However, since the younger caregivers remain for shorter periods, the question should be posed as to whether the younger caregivers would espouse higher levels of force were they to continue in their jobs beyond four years.

Other studies (Krause, 1974; Raynes, 1975) have concluded that background variables were not significantly related to the caregiver behavior measured. In view of these findings the fact that older respondents tended to justify higher levels of force stands out as exceptional.

The Civil Service qualifications for the Houseparent II position (Appendix) are one year's experience in household management and the care of children at the family level. Since caregivers with less education are more likely to use higher levels of force, it would be desirable to establish a minimum educational qualification. High school completion would probably change the age distribution in the direction of the younger categories.

Lower centralization of decision making and resident centered management practices were found to contribute to lower levels of force. An implication of this finding is that efforts to increase caregivers' participation in decision making along with efforts to individualize children's care will probably lower the amount of force likely to be used.

Erlanger (1974) and Kohn (1969) analyzed the influence of stress on the levels of physical force used by caregivers from lower social segments. They agree that the conformity orientation of lower status caregivers can be viewed as a consequence of limited education and constricting job conditions.

Based on our findings about the influence of inequity distress on level of force, we suggest that caregiving may flow less from generosity and according to need, and more on the basis of feelings resulting from fairness in the exchange between the caregiver and children. It should be recalled that respondents were given the opportunity to indicate how often they would take each of six actions to deal with a given child care situation. One alternative was to take no physical action at all. Respondents could have chosen to do nothing or break off with the child. To the extent that respondents chose physical actions, we would suggest they perceived other alternatives as unviable given the situation as they experienced it.

Our data suggest that caregivers also deal with their inequity distress by leaving their jobs. The likelihood that respondents under age 34 would also be in their jobs under four years was very high. Our presumption in the care of younger caregivers is that inequity distress is a factor in their shorter periods of tenure. The influence of inequity distress on younger caregivers was illustrated by one respondent who reported that she was completely drained and would be leaving the home in three months. The expectation that she would be leaving her job at the end of one year on the job seemed to enable her to make it through her shifts.

The interrelation of these factors in the case of older caregivers is exemplified in an anecdote reported by one respondent:

> An older caregiver with over four years tenure used considerable force to control a boy in his living unit, thus violating a home rule. He took the boy to the Superintendent and said, "Support me in what I did; if you do not, the boy is yours; I'm leaving."

Some practical implications of our findings include but are not limited to the following:

1. Steps should be taken to deprivatize the living unit so caregivers are not given to feel they need to be masters in their own house.
2. Deployment of caregivers should be planned so that more caregivers are in the living unit at peak hours. Back-up should be provided at all times.
3. To counter caregiver feelings of being drained and burned out, some equivalent of the military's "rest and rehabilitation" could be considered.
4. Efforts to recruit and retain caregivers in the 25-35 age range should be undertaken.
5. A distress scale, similar to the one used in this study, might be employed as an aid in staff selection.

In summary, use of a research approach that analyzes the relationship between a number of factors taken together and level of force should be of considerable assistance in extending our understanding of the sources and dynamics of violence against children. This research approach should also help in the development of effective approaches to preventing and managing this phenomenon, especially as it is manifested at the institutional level.

APPENDIX I

LEVEL OF FORCE IN RELATION TO ORGANIZATIONAL AND BACKGROUND VARIABLES

Variable	r
Felt Injustice I	.196
Felt Injustice II	-.119*
Felt Injustice III	.129
Felt Injustice IV	.369
Felt Injustice V	.117*
Resident Management Practices	.322
Participation	.341
Hierarchy	.272
Length of Time in Job	.253
Length of Time in Prior Job	.257
Work Schedule	.308
Age of Respondents	.518
Sex of Respondents	-.193
Marital Status	.414
Education of Respondents	.404
Income of Respondents	-.010
Community Size (current)	-.279
Community Size (early)	-..301

*p .05

APPENDIX II

AMOUNT OF VARIANCE IN LEVEL OF FORCE EXPLAINED BY FELT INJUSICE, ORGANIZATIONAL AND BACKGROUND VARIABLES

	r	r^2	Percent Explained Variance
Felt Injustice (#4)	.369	.136	13.6
Felt Injustice (#5)	.409	.167	3.1
Felt Injustice (#3)	.411	.169	0.1
Felt Injustice (#1)	.411	.169	0.0
Felt Injustice (#2)	.412	.170	0.0
Resident Management Practices	.503	.253	8.3
Unit Participation	.553	.306	5.3
Work Schedule	.561	.315	0.9
Unit Hierarchy	.562	.316	0.1
Age	.600	.360	4.4
Marital Status	.606	.367	0.7
Community Size	.616	.380	1.3
Respondent's Education	.622	.386	0.6
Length of Time on Job	.627	.386	0.6
Community Size (current)	.627	.393	0.0
Father's Status	.628	.394	0.0
Time in Other Homes	.628	.394	0.0
Sex	.628	.394	0.0

APPENDIX III

MULTIPLE CORRELATIONS (r) BETWEEN SEVERAL SETS OF VARIABLES AND LEVEL OF FORCE FOR SELECTED SUB-POPULATIONS

	Total Sample (n=100)	Women (n=63)	Men (n=37)	12th Grade and under (n=41)	Over 12th Grade (n=59)
	r	r	r	r	r
Felt Injustice	.412**	.449*	.503	.499	.463*
Participation and Hierarchy	.372**	.322*	.398	.304	.118
Participation, Hierarchy, Resident Management Practices	.419**	.356*	.587*	.305	.355
Organizational Variables (3) and Felt Injustice	.554**	.572*	.681*	.611*	.533*
Background Variables	.580**	.552*	.683	.438	.511*
All (in combination)	.628**	.634	.788	.738	.704*

F ratio significance: *=p .05; **=p .01

APPENDIX IV

HOUSE PARENT II

NATURE OF WORK IN THIS CLASS

This is responsible work in supervising the care and training of dependent or physically handicapped children.

An employee in this class is responsible for a housing unit of children at a county institution, and in that capacity serves as a substitute parent for the children. Employee supervises the manners, morals, conduct, and physical cleanliness of the children and has responsibility for housekeeping functions of the unit supervised. Work is performed under the general supervision of a House Parent Supervisor.

ILLUSTRATIVE EXAMPLES OF WORK

Directs the household activities of a fairly large unit, and the training and supervision of boys or girls in assigned tasks.

Participates in religious, moral, and social training of the children and acquaints them with institutional rules in regard to discipline, personal habits, and living, eating, and sleeping arrangements.

Counsels and advises children on personal problems.

Advises superior as to necessary supplies, repairs, and equipment for the unit.

Supervises health and sanitary conditions in the unit; and renders aid in minor accidents or illnesses.

Conducts children to activities on the institutional grounds and accompanies them outside.

Performs related work as required.

ESSENTIAL KNOWLEDGE, ABILITIES AND SKILLS

Knowledge of the modern principles and practices of guiding and training dependent or physically handicapped children.

Knowledge of the materials, methods and equipment used in large-scale housekeeping.

Knowledge of simple health and safety precautions and of first aid methods.

Ability to secure cooperation of children and guide them in work, play and recreational activities.

Ability to appreciate the problems faced by children suffering physical handicaps.

Ability to prepare simple behavior reports.

QUALIFICATIONS

One year's experience in household management and the care of children at the family level.

The class specification which appears above is intended to be sufficient merely to identify the class and be illustrative of the kinds of duties that may be assigned to positions allocated to the class and should not be interpreted to describe all of the duties performance of which may be required of employees holding a position assigned to this class.

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Interventions into Child Abuse and Delinquency

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A model of the relationship between child abuse and delinquency is presented in this paper. This model is used as a framework for analyzing programmatic interventions that should be considered in dealing with this problem. That there is a relationship between child abuse and subsequent delinquency seems fairly well established by previous studies. The thoughts presented here are based on the belief that if we can analyze and understand those forces that maintain this relationship in individuals and in groups, we may be able to design our interventions to break down this support. Prevention of child abuse would, of course, resolve much of the problem, and interventions aimed at this goal are also considered.

There are three ways in which child abuse and delinquency may be related:

1. Abuse as a child leads to subsequent delinquency.
2. The same set of factors that leads to child abuse leads to delinquency.
3. In some cases, child abuse contributes directly to delinquency, while at the same time factors that are supporting child abuse are also supporting the development of delinquent behavior. Clear cause and effect relationships are difficult to establish outside of a laboratory setting. Interrelatedness is less difficult to establish but more complex to analyze. (Table 1 below attempts to graphically illustrate some elements in this interrelatedness, using a conceptual framework of antecedents, behaviors, and consequences.)

ASSUMPTIONS OF THE MODEL

Two assumptions underlie this model. The first is that child abuse is a behavioral problem. The second is that child abuse is a community problem and responsibility. A quick review of some of the literature related to this topic may help clarify the assumptions made in this model.

1. Excessive physical punishment and aggression.
   Eron, Walder, and Lefcowitz (1971), as well as Sears, Maccoby, and Levin (1957), found positive significant relationships between the severity of physical punishment in the home and aggressive behavior in children.
2. Modeling.
   Bandura (1971) has shown the importance of modeling of aggressive physical behavior in adults in the subsequent adoption of such behavior by children. As the research indicates, our primary models during infancy will be imitated. These models are our parents. If parents deal with frustration by physical aggression, or if they show a tendency to react to stress by physically lashing out, children will adopt this behavior as their own if there are no countervailing forces.

   If we try to perceive child abuse as the infant would, we may get an interesting perspective on this relationship. A young child's perceptions of cause and affect can be assumed to be muddy at best. A child who has just been beaten will most likely remember little but that his parent was frustrated and/or angry and that he was beaten. The only association which can be firmly established on that basis is that when a big person gets angry or frustrated, physical aggression is the response.

   One obvious but significant implication of the modeling perspective is that child abuse will perpetuate itself and multiply as each generation teaches the next how it is done. This does not mean that child abuse will always beget violence. Bandura notes that:

> A person can acquire, retain, and possess the capabilities for skillful execution of modeled behavior, but the learning may rarely be activated into overt performance if it is negatively sanctioned or otherwise unfavorably received. When positive incentives are provided, observational learning, which previously remained unexpressed, is promptly translated into action (p. 8).

3. Lack of consistency in child rearing.

Becker (1964) found that children with problems most often came from households where parents exhibited a lack of consistency in their responses to various child behaviors. While successive physical punishment will seldom be a consistent response to children's behavior, we can assume that, where excessive physical punishment appears, there is also an inconsistency in the child-rearing practices in the home.

4. Teaching of verbal skills.

Hess, Brophy, and Shipman (1971) have shown differences among SES groups in the modeling of verbal skills by mothers of infants and young children. In our framework, given the alternatives of talking a problem out or responding physically to it, youths from homes where excessive physical punishment was used can be expected to act out physically.

TWO NOTES ON PERSPECTIVE

1. Importance of a behavioral perspective.

We will, in a sequel paper, be discussing the importance of the emergence of a managerial orientation in the development and maintenance of programmatic interventions. For now, it is important only to understand that this managerial orientation requires variables defined such that they are observable.

Over the years, one of the prime arguments for a behavioral orientation has been that it does not rely on inferred emotional states which cannot be observed or measured. The whole emphasis on accountability in government is going to require even greater emphasis on the observable and measurable. We are not speaking here of a "Clockwork Orange" type of behaviorism or even behavior modification. We are certainly not talking of control of behavior primarily through aversive conditioning, which in the mind of the public often appears to be firmly associated with behaviorism. Rather, our approach is to try to deal with human behaviors, complex patterns of behaviors, and the forces which tend to reinforce and maintain these behaviors. Behavior is lawful (Skinner, 1953). All learning follows lawful processes that can be known. Human behaviors are assumed to be a function of perceived reinforcers. Behaviors that are reinforced will increase in frequency. It is also true that it is easier to change behaviors than it is to reform characters (Eysenck, 1960). One reason is that under a behavioral approach, specific problem behaviors and specific objectives and goals to be reached can be defined.

2. Child abuse as a community problem.

In contemporary management science, it is axiomatic that the manner in which the problem is defined will determine what intervention is deemed appropriate. Rarely, if ever, in the literature is it still suggested that child abuse is simply a function of a pathology among individual parents. It is a social, or community, problem and one frequently related to a specific type of community. Literature on child abuse shows that abuse is most often associated with communities of low socioeconomic and minority ethnic status.

An individualized orientation to a problem like child abuse would lead to a problem definition that would tend toward individualized approaches developed by the caseworkers dealing with individual clients. On a statewide level, this would lead to shotgun approaches with interventions varying depending on the specific background, orientation, and skills of the caseworker. The view that child abuse is a community problem requires us to develop a comprehensive intervention strategy that considers and uses community forces rather than solely dealing with individual problems and dynamics.

TABLE 1

CAUSAL INTERRELATIONSHIPS OF CHILD ABUSE AND DELINQUENCY

ANTECEDENTS	BEHAVIORS	CONSEQUENCES
Frustration (caused by) —economic needs (poor housing, unemployment) —inability to control children's behavior through nonabusive means	Delinquency Child abuse	Delinquency
Poor impulse control by parents	Child abuse	
Modeling of poor impulse control by parents		Delinquency Child abuse (in subsequent generations
Poor verbal skills	Poor functioning in public schools (educational advantages)	
Subcultural values condoning/ encouraging physical aggression	Child abuse Delinquency	Delinquency

As mentioned above, Table 1 is based on an interactive model of child abuse and delinquency causation. This model is based on the belief that some child abuse, primarily through imitation, leads directly to the development of delinquent behaviors, while at the same time many of the same forces that support child abuse also support development of delinquency.

Sets of contextual situations that might lead to child abuse are presented in the chart. The first involves problems related to lower socioeconomic status. If one assumes, as Maslow (1968) has, that human needs can be ordered hierarchically, then we can also assume that people at the bottom socioeconomically will often have problems in meeting the most basic of needs. Problems in meeting basic needs may not only make life a frustrating, stressful experience but also leave little time (or money or energy) for self-development and other "luxuries" which might improve parental skills. There is no question but that insecurity with regard to food, clothing, and shelter lead to greater than average amounts of frustration and stress in the home. Together with a lack of education in child rearing, this frustration or stress could lead to child abuse.

Some child abuse has been linked to inability on the part of the parents to control their impulses (Helfer and Kempe, 1974). Lack of impulse control is often cited as a cause of aggressive physical behavior in a variety of settings in addition to child abuse (McKee and Leader, 1955). Many of us may often, in the middle of an excruciatingly frustrating day, feel like pounding the desk or slamming the door, or even hitting someone, but have the social skills necessary to control these impulses. Where this impulse control is lacking, and a crying or misbehaving child is being especially irritating, child beating may be seen as a "natural" learned response.

Particularly in lower SES groups, there may be a variety of cultural forces that tend to support child abuse. A partial listing of these forces would include the following:

1. Reinforcement of machismo or a distorted idealization of what manhood is may lead large groups of people to approve, or at least condone, aggressive acting out, particularly on the part of males.
2. Religious beliefs may cause some to condone child abuse. For example, among certain groups, the belief in a punishing god may be transferred to a belief in the appropriateness of physical punishment for misbehavior by children.
3. There is often a lack of education or lack of knowledge about (a) the fact that child abuse is bad and (b) other ways of controlling behavior. About five years ago, my

wife and I had to go to Houston while our car was in the shop, so we took a bus. Seated across the aisle from me was a young woman, perhaps 20 years old, with three small children. She was playing a little game with the youngest, who was about one year old. This game consisted of holding the child up in the air until he cried and then spanking him until he stopped crying. She would then caress him for a minute or two and then hold him up in the air again until he started crying. I observed this incredulously for a few minutes and then leaned across the aisle and told her that she really shouldn't be hitting her child like that. She looked up at me, very innocently, and said, "Why not?"

I told her that, first of all, she was the one who was making the child cry by holding him up in the air. It was not, therefore, fair for her to punish him for crying when it was her fault. I also told her that if she hit her child, he would tend to view hitting as an appropriate way of communicating with people and would, when he got older, probably hit people himself when he did not like what they were doing. I then asked her something like, "Do you want to raise a kid who goes around hitting people anytime they do something he doesn't like?" She said that she did not. About five minutes later, she looked over at me across the aisle and said that she was glad I had told her not to hit him because she really did not know that there was anything wrong with it. I asked her if her mother had beaten her when she was a child and she said that she, in fact, had. Being a good graduate student in educational psychology, I asked how she felt about that now. She said, "I hate my mother."

The point of this story is that this woman did not know that she was doing anything wrong. Ausubel has found that while middle and high SES parents show a decisive tendency towards following whatever is "in" or popular among trends in child rearing (Spock in the late 1940's, PET in the early 1970's), low SES parents tend to use the same child rearing practices as those under which they were raised. Families which rely on physical punishment to control others' behavior may be simply unaware of other means of controlling behavior.

4. The decline of extended families. Often cited as a major factor in the deterioration in American society is the decline of the extended family as mobility has increased and as the integration of older family members into family life has decreased. We are seeing the disappearance of the extended family. This extended family afforded some safeguards against child abuse. For example, older members of a family, who themselves may have had experience in child rearing, are no longer watching over the raising of new generations. Secondly, extended families provided an escape valve for periods of excessive stress and frustration. Under such circumstances, the extended family could be relied upon to care for the child for a few hours or even a few days while the mother, or mother and father, went through a period of stress. Thirdly, families have tended to become more and more isolated from those to whom they were close, which contributes to the general trends towards greater alienation in our society.

FACTORS DIRECTLY SUPPORTING DELINQUENCY

The national youth strategy developed by HEW (1971) has identified a set of factors that tend to support the development of delinquency in youth. Two of these variables are very closely related to low socioeconomic status and membership in a minority ethnic group. These factors are alienation and a lack of access to positive social roles. Those individuals who are furthest from the mainstream of American society are most likely to feel alienated. Low SES youths are also least likely to have access to jobs and other prominent social roles valued in our society. These factors, in themselves, without any child abuse, would tend to increase the frequency of delinquency in this group. Feelings of rejection by one's parents, which might be expected to accompany child abuse, would also most likely support alienation among youth. What we are left with is a whole set of social forces that tend to support both delinquency and child abuse at the same time. Having considered causal factors, we must look at the interventions these causes would dictate.

CULTURAL INFLUENCES AND INTERVENTIONS

Emphasis on cultural forces supporting delinquency leads to an examination of cultural differences between this group and the culture of our community which has deemed child abuse

to be both wrong and illegal. It is especially critical in light of the fact that our government and social service institutions are primarily directed and staffed by representatives of the dominant or mainstream culture. The result is a situation of our government attempting to enforce middle class values on a group which has another set of values. This predicament is certainly not limited to problems of delinquency and child abuse but is a critical factor in almost all of our social interventions. As long as models of individual pathology prevailed in dealing with a problem like child abuse, the question of cultural values could be ignored. Once we begin to deal with the problem as a social phenomenon and understand that this behavior endures because it is supported by cultural forces, the question of values and culture becomes critical.

There is an additional cultural value that must be considered in this situation. The sanctity of the family has been an important value in American culture since our society began to be formed. In fact, there still remains a great resistance towards allowing the government to interfere in the internal affairs of the family.

In the past, since child abuse so often involved no one except the members of the family, it was not felt to be a community responsibility. The community has become more and more aware of the extent of child abuse as we have become more aware of the causes of social problems. As child abuse has become identified as not just a danger to the health and safety of young children, but also as a source of delinquency in our society, concern over dangers of government interventions into family life have become considered to be secondary to concerns over protecting our society from the problems of child abuse and delinquency. As seen in Table 2 below, most of the interventions proposed would harness whatever community forces are available, at the same time considering those individuals involved as individuals.

TABLE 2

THREE FOCI OF INTERVENTIONS

PROBLEM	CAUSAL EXPLANATIONS	FOCUS	INTERVENTION
Child abuse	Poor economic conditions	Community	Increase community resources —day care; job placement
	group/external	Parents	Offer skills —to get at resources (jobs, "hardware") —to deal with stress without aggression
		Children	Offer placement in day care, residential enrichment programs, after school activities; older youth groups, advocacy, jobs
	Poor impulse control	Community	Provision of crisis intervention centers for families, children
	individual/internal	Parents	Therapy aimed at —communication skills (verbal) —self-control (individual therapy) —appropriate models —communication skills
		Children	
	Poor verbal skills	Community	Schools; MHMR
		Parents	Communication skills training

PROBLEM	CAUSAL EXPLANATIONS	FOCUS	INTERVENTION
		Children	Communication skills training remediation program (school)
	Inability to control children through other means	Community	Day care; CINS residential centers —community schools/churches other parenting skills
		Parents	Parenting skills training (reality therapy, behavior modification, PET)
		Children	Individual therapy, alternate care
	Physical aggression as norm (cultural)	Community	School provide and support non-physical and non-aggressive values; provide positive outlet for aggression (sports) Churches
		Parents	Churches provide and support non-aggressive model Parent groups Peers
		Children	School; church programs; recreation; "Big Brother" - appropriate models

TARGETS FOR INTERVENTION

Three foci are identified as appropriate targets for intervention. Causal explanations developed elsewhere in this paper are treated individually and interventions based on each cause and each focus are proposed. The first two foci identified present an interesting contrast in intervention approaches. The first, poor economic condition, is an external, environmental factor, and the interventions proposed here are community interventions (such as making resources more accessible, offering day care or residential enrichment programs). Impulse control, on the other hand, is viewed as an individual internal problem, and interventions proposed here are aimed more specifically at the problems of individuals. Consideration of child abuse as a community problem is manifested repeatedly in the interventions proposed. Existent community resources, the schools, churches, recreation programs, and the informal supervision of Big Brother programs are emphasized. To the extent that a community can offer these interventions in those areas where child abuse is most prevalent, abuse should be decreased and subsequent delinquency should be minimized.

THE CHILD AS FOCUS

While the current password in social services seems to be "whole family" interventions, to some extent our focus must be on the child. Information on child-rearing patterns in a whole community, even if that "community consists of only a number of city blocks, is going to be very sketchy. Parents who are child abusers may often commit their abuses only within their homes, hold steady jobs, and never be recipients of what we call social services. Children, primarily through the schools, are always the recipients of social services. School teachers and neighbors noticing the effects of child abuse on a child (be these visible marks of abuse like bruises or

abrasions, or less obviously, a cowering personality) will most often bring child abuse to the attention of our social service intervenors.

Primary prevention is viewed as the most efficient mode of intervention into a social problem. Primary prevention in child abuse, it would seem, could be accomplished most easily by either preventing adults who would abuse their children from having children, giving all parents good parenting skills, or severely limiting exposure of children to potentially abusing adults. Of these choices, the only feasible alternative without a massive restructuring of society would be the provision of parenting skills on a broad level. Since parenting skills are so often passed on from one generation to the next, our interventions should begin as early in the child's life as possible to expose the child to models of good parenting. The child will not only be raised better, but will also learn from himself or herself positive ways of child rearing. Chart III outlines some interventions based on the child as focus. Deficits are identified, and interventions deemed appropriate at various age levels for the children are proposed. The problem is assumed to build the older a child gets. A developmental perspective would imply that problems not solved and needs not met will require more intensive interventions the older the child gets. The tree can be assumed to grow as the twig is bent. Trees and twigs are much easier to bend when they are young. It is easier to alter behavior patterns that are less firmly established. (See Table 3.)

Although this chart should be largely self-explanatory, some aspects of it should be emphasized. The intervention required becomes more and more intensive as the child gets older and his own behavior patterns become more firmly established. Consideration is given to the child's developmental needs. During infancy and early childhood, a loving, nurturing environment is most likely the child's greatest need. From ages four to ten, a positively-oriented, supportive environment will help the child develop the feelings of confidence and industry that are the main developmental crises during these years. As the child becomes a teenager, and perhaps more set in his ways, a more structured environment may be necessary to correct what are now fairly ingrained deficits.

TABLE 3

FOCUS ON THE CHILD AND HIS/HER NEEDS

AGE	DEFICITS	INTERVENTION
0-4	Consistent parent/child interaction Inappropriate model of frustration ➤ aggression	Remove child to more "loving" environment, work with parent —Self-control —Parenting skills Provide appropriate model to work with child and parent(s)
4-10	Poor verbal skills; Poor impulse control; These characteristics will often be developing but require parent models or other significant adult.	Remove child to more supportive environment; work with parent (same as above); offer enrichment through the schools, recreation programs
11 and above	Inappropriate peer models; Poor verbal skills; Poor impulse control;	Groups with "pre-delinquents": focus on communication skills, impulse control, structure after school programs. Work with parents —same as above —remove from the home to a more structured environment

Tender licensed care may be appropriate for this middle age group, but it is felt that much more than this will be necessary for the younger and older children. Coinciding with this pattern are cultural values which dictate that youngest children be treated with the greatest compassion and as children get older that they be held more and more responsible for their own behaviors.

At the same time, as the youth is getting older, particularly during the early teens, his mobility is much greater, more responsible behavior is expected of him, and the damage which he is capable of doing should he act out is much greater. Subcultural values supporting aggression would tend to reinforce the need for a more structured environment for this youth, often referred to as a predelinquent.

A causal model relating child abuse to delinquency has been developed. Interventions aimed at the community, parents, and the abused children are proposed. Three assumptions are made about the best conceptual frameworks for interventions. The first is that the problem should be treated as behavioral. If we can stop parents from abusing their children (behavior) we have solved the problem. Second, child abuse is supported by cultural and community forces and is therefore a community responsibility. Third, the effects of child abuse are more severe and become more firmly established the older the child gets. Child abuse should be treated as a developmental problem. The interventions proposed follow from these assumptions. For many years, social service interventions have been based on assumptions similar to these. Often these assumptions were tacitly made and emphasis on one variable or another varied from time to time and place to place. Current programming requires the development of models based on problem analysis. Evaluation should tell us if these models are more functional than those of the past.

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Research

Maximizing the Impact of Research in Child Abuse and Neglect: A Practitioner Views Research

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The title of this panel, "Research: Too Much or Too Little?," prompts consideration of a series of very significant but until recently infrequently asked questions about the value of research. For example, what has been the impact of research on complex, multifaceted social and clinical problems such as child abuse and neglect? How do we evaluate the productiveness of research in dealing with social problems? Just what might we realistically expect the contribution of research to be, given the vast array of sociological and psychological factors contributing to complex social problems, and how rapidly might we expect that contribution to be made?

Although a combination of cautiousness and cowardliness prevents me from attempting to answer these questions in a brief presentation, I want to examine several issues that seem to bear on the answers. I choose to do this believing it will provide a useful starting point from which to then review research in child abuse and neglect, and offer recommendations about priority areas for future research.

EVALUATING THE IMPACT OF RESEARCH ON SOCIAL PROBLEMS

In order for research to have a significant impact on a social problem, that research must influence the actions of others. There are three basic target groups that researchers hope to influence: social policy makers on all levels of government as well as citizen and special interest groups who may influence the policy makers; practitioners who deal directly with the problem; and other researchers and theoreticians. While a single research undertaking may be directed at more than one target group, it has impact only to the degree it affects at least one of these groups.

After research has been conducted, the first step in successfully influencing these target groups is effective dissemination of research findings. Traditionally, the predominant means of dissemination has been through publications in professional journals and presentations at professional meetings. Such forms of dissemination, while presumably effective in communicating findings to other researchers, are notably less effective in reaching social policy makers and practitioners. Techniques of successful dissemination to these two target groups are not as well developed and serve to severely limit the potential positive impact of research on a social problem.

In attempting to overcome this problem, researchers interested in influencing social policymakers have begun to testify more frequently before government bodies, meet formally and informally with nongovernment groups of influence, and prepare more readable and less technical reports for government groups, private groups, and the mass media. Researchers interested in reaching practitioners have resorted more and more to workshops, consultations, the preparation of manuals, workbooks, and audiovisual training materials, as well as the mass media. The impact of these attempts to improve effectiveness of dissemination remains to be determined.

Given the limitations imposed upon the contribution research might make to social problems by the dissemination issue, the next important question is what type of research will have the greatest sphere of influence. In this regard, the potential impact of research directed towards social policymakers is great, for these policymakers exercise control over substantial resources. Indeed, to the extent that a problem is judged to require action on a social or economic level as opposed to a clinical one, then it is only through influencing social policymakers that significant progress with the problem is likely to be made.

Although for different reasons, the potential impact of research directed towards other researchers also seems great. Such research has potential for ultimately producing findings that radiate beyond just one social problem to have positive effects on several. For example, research into cognitive development in early childhood may conceivably impact one day on educational problems, retardation, behavior problems, and antisocial behavior. Research aimed at practitioners is likely to have more limited effects. It has neither the potential of influencing people who control substantial resources, such as policymakers, nor of impacting on a series of social problems such as in more basic research.

To this point, the discussion has looked at general factors that affect the contribution research makes to complex social problems. The questions of the target group to whom the research is directed, the effectiveness of dissemination efforts to that group, the sphere of influence of that target group, and the potential breadth of influence of the research findings themselves have all been briefly discussed. With this background, it is now time to consider some special factors in research in child abuse and neglect that stand to affect the positive contribution to be made in these fields.

SPECIAL PROBLEMS OF RESEARCH: DEFINITIONS OF ABUSE AND NEGLECT

Probably the first special problem that must be mentioned about research in child abuse and neglect deals with the definition of the phenomenon under study. Debate on definitions has focused on several different issues. One of the issues has been the degree of comprehensiveness of the definitions, with some researchers opting for very broad definitions. For example, Gil (1973, p. 7) has proposed a definition of child abuse as:

> Any act of commission or omission by individuals, institutions, or society as a whole, and any conditions resulting from such acts or inaction, which deprive children of equal rights and liberties and/or interfere with their optimal development.

Child abuse typically has been defined in terms of specific physical injuries inflicted upon a child by a caretaker. Furthermore, most definitions have required that the injuries be "intentionally" inflicted. Since intentions cannot be observed directly, their presence (or absence) can only be determined through inference. This imposes a special burden on researchers to demonstrate that the phenomenon they are studying under the name of abuse is a "reliable" phenomenon—that is, that there is a high degree of agreement between judges on the appropriateness of that label. Few researchers, however, have discussed the question of interjudge reliability (see Friedman, 1976 for a review of this issue).

Further, it has been pointed out by several researchers (Gelles, 1975; Giovannoni, 1975; Parke and Collmer, 1975) that one way of conceptualizing abuse is not as a set of behaviors, "but rather a culturally determined label which is applied to behavior and injury patterns as an outcome of a social judgment on the part of the observer" (Parke and Collmer, 1975). From this important perspective, the researcher is burdened with describing the social judgment process by which the label of abuse came to be used.

The problem of definition is equally serious in the study of child neglect. The most significant and extensive attempt to tackle this problem has been made by Polansky and his colleagues (Polansky, Borgman, and DeSaix, 1972) who developed a childhood level of living scale which yields separate scores in the physical care and cognitive/emotional care sphere. Other researchers, however, have enumerated many more different categories of neglect. For example, Webb and Friedman (1976) proposed nine different forms of neglect in trying to arrive at a series of reliable operational definitions for a proposed national study of incidence of abuse and neglect. Probably, the type of neglect most difficult to define adequately has been emotional neglect (Whiting, 1976).

PRIVATE NATURE OF THE PROBLEM

While child abuse and neglect are not restricted to the family or the home, most of the research conducted has focused on abuse and neglect at home. Most of what goes on in homes, including much child neglect and most acts of abuse, are private family events. Further, since these problems represent acts for which legal action may be taken, they tend not to be acts which are voluntarily brought to the attention of individuals outside the family by members within the family. This private nature of abuse and neglect presents a serious problem for researchers. It is an obstacle that is shared somewhat by researchers into other illegal or private phenomena, like crime, or aberrant sexual behavior.

The private nature of child abuse, as well as its potential seriousness, makes it unsusceptible to direct observation and requires that heavy reliance be placed on the verbal reports of participants who are typically asked to reconstruct events after the fact. Given their own direct or secondary involvement in the situation and the speed with which events preceding abusive acts may escalate, these participants are often not in a position to report accurately on the events that occurred. This lack of direct or at least accurate information presents a serious

problem, particularly to researchers who are interested in the effects on abuse of factors in the immediate family situation.

In the case of abuse, a related problem results from the infrequency of abuse. This makes it difficult to analyze the events preceding and following the abuse to determine if there are patterns of interaction which regularly accompany it. The researcher who is interested in studying and/or modifying a behavior problem such as noncompliance by child to parents, for example, will typically have an opportunity to observe several such incidents within just one hour of observation. The researcher who is interested in studying a low-frequency behavior such as abuse will typically never observe the behavior in question, and will receive only reports of questionable accuracy of the circumstances surrounding the abuse.

Because abuse and neglect are private events for which legal action may be taken, an additional problem created for researchers is the difficulty found in obtaining representative samples of subjects. Most research in the field has been conducted with families from low socioeconomic backgrounds. To what extent this is because such families are more likely to be involved in abuse and neglect, vs. simply being more likely to be detected, is difficult to determine. At best, however, sampling biases make it difficult to generalize the results of studies. At worst, when the extent to which sampling biases exist is unknown, the generality of findings cannot be ascertained. The problem of sampling biases has already been demonstrated in child abuse research where victims of abuse seen in hospital samples have been shown to differ from those seen in agency samples (Friedman, 1976). The extent of differences in lower class abuse or neglect vs. middle class vs. upper class cannot yet be determined.

One more problem related to the private nature of abuse and neglect is that the incidence of the problem cannot be readily estimated. Without the availability of such data in local communities, the effects of community-based prevention efforts cannot be readily determined. Agencies that seek to evaluate the effects of their program in preventing abuse or neglect are hindered in doing so by absence of accurate, low cost, easily attainable data on which to base their evaluations.

VARIED FORMS OF ABUSE AND NEGLECT

Another problem for researchers in abuse and neglect is the multitude of forms the problem behavior takes. Even where individuals agree that particular acts or conditions constitute abuse or neglect, the behaviors they discuss may vary considerably. In studying causes of abuse, for example, can we generalize from findings about parents who use their hands to injure children to those who deliberately inflict burns or those who use instruments?

A related issue deals with the fact that while legal considerations typically require a yes or no judgment be made about the presence or absence of abuse or neglect, this dichotomous formulation represents a gross conceptual oversimplification. It is more accurate to conceptualize a continuum of abusive or neglectful behavior rather than a dichotomy. (See Young, 1964, for one of the few studies that included comparisons of mild and severe abusers and neglectors.) By looking at abuse or neglect as an all or none variable in their studies, researchers may make interpretation of their results more difficult.

In addition to the different forms abuse and neglect may take, the age of victims varies across the full range of childhood. The individual and family dynamics that contribute to abuse or neglect with very young children may differ considerably with older children.

This brief discussion of several special problems within research in child abuse and neglect does not exhaust the topic. Rather, it was intended to focus on a few of the more prominent special problems, particularly as they limit or slow the contributions that might reasonably be expected to be gained from research in these fields.

DIRECTIONS FOR FUTURE RESEARCH IN CHILD ABUSE AND NEGLECT

Given the varying potential impact of research directed towards policymakers, practitioners, and other researchers, and the special problems of research in this area, what are the directions for future research that should receive priority attention?

First, there is a serious need for efforts that help define the scope and seriousness of the problem. A part of this is certainly to continue efforts to determine the overall incidence of these problems. Without this information, it is difficult for policymakers to determine how many resources should be allocated to the problem, and what the effects of interventions have been.

Manus (1974) has pointed out that the question of frequency or incidence is only one step in defining the seriousness of a problem. A second step involves assessing the severity of the consequences of the acts. In abuse and neglect the immediate severity of the consequences has

all too frequently been dramatically illustrated. However, there is far less information available about the more long-term consequences of abuse and neglect. Available information tends to have been gathered through ex post facto analyses in which it was difficult to determine causal relationships, and without adequate control groups (see Friedman, 1976 for a review of the research on long term effects of child abuse, and Polansky, Hally, and Polansky, 1975, for a similar review on child neglect). A recent study by Elmer (1977) clearly points to the need for control groups. While longitudinal studies are slow, costly, and beset by high attrition rates, they provide the best potential for yielding clear information—information about the probability that children exposed to particular acts or conditions of abuse or neglect, or raised in particular types of family environments, will have severe problems or engage in dangerous behavior at a later time.

Second, to help guide policymakers there is a need for research that studies the effects of social, economic, and educational programs and policies on families. Too often in the past, programs or policies have dealt with a particular problem but, at the same time, have had unintended and unexpected effects on other problems. As important as education is, its effects on families are often disruptive despite the best efforts of educators.

Third, a strong need exists for research on programs aimed at preventing child abuse and neglect. In fact, for maximum efficiency in view of the relatively low base rate of occurence of abuse and neglect, such programs should focus on preventing other types of serious family disorders as well as abuse and neglect. In a very lucid discussion of prevention in mental health, Cowen (1977) recently suggested that primary prevention efforts might well be directed towards the measurement of environments, such as family environments, and an assessment of their effects on behavior within the family and on the development of competence in family members. In addition, research on the effects of quality service opportunities made available to high-risk families who are identified at an early time, and programs to prevent unwanted pregnancies and to prepare teenagers for family life should be increased.

Fourth, at the same time broader research efforts aimed either at guiding policy decisions or preventing abuse and neglect are occurring, efforts should also be strengthened to look for causal factors within family units. Researchers might examine problems such as the skills and knowledge needed for effective parenting, the effects of physical punishment procedures and alternative child-rearing practices, the sequential patterns of interaction between family members, with particular emphasis on the escalation of aversive exchanges into violent behavior, and the problems involved for families in making the transition when a new member enters the family. These research efforts should involve direct measures of family interaction patterns wherever possible. Up to this point, most of the research on causes of abuse and neglect has focused on identifiable characteristics of individual members rather than studying patterns of interaction and other situational influences (Burgess and Conger, 1977; Panyan and Friedman, 1976; and Reid, 1976).

Despite the discussion that routinely takes place about the importance of the family unit, and the stresses placed on it, there has been relatively little research on families. For example, while there exists large amounts of information about developmental norms for children, and intellectual and personality norms for adults and children, there is little in terms of behavioral or psychometric norms for families. Further, our diagnostic systems all tend to be individual-rather than family-oriented. Research efforts, both within and outside the fields of abuse and neglect, would be well directed towards obtaining information on functioning of effective and ineffective families.

Fifth, since child abuse essentially represents an act of violence perpetrated against a child, another area of importance for additional research is the study of violence. In particular, research into causative factors from a sociological and psychological perspective, and means of controlling and modifying violent behavior patterns is needed. The emphasis by several authors on studying violence within the family (Steinmetz and Strauss, 1974; Lystad, 1974) is a positive step in this regard. From a conceptual standpoint it appears more beneficial to group child abuse with other forms of intrafamily violence rather than grouping it with child neglect.

Sixth, despite greater difficulties in disseminating research effectively to practitioners than to other researchers, it is important to continue efforts at answering questions of great consequence for people who regularly deal with these problems. There clearly is a need, for example, for more research in identifying abuse and neglect, particularly when the types of abuse and neglect, such as emotional, are hard to define. Also, research on the social judgment process by which labels such as abuse and neglect are applied should be conducted. More research is needed on the effects of various types of interventions. In what circumstances does foster care

placement prove valuable to youngsters, and when should youngsters be left at home, for example. Continued rigorous evaluation is also needed for direct service programs and innovative treatment procedures. An important component of such research should be attempts to replicate findings at new program sites, and with different treatment personnel.

With all the research, but particularly with that which is directed towards practitioners, it is important that input into the formulation of the problem and the methods be obtained from practitioners. This will increase the potential usefulness of the findings for workers in the field while also providing researchers with ideas and information from those who daily deal with the problems of abuse and neglect. To the extent that research ultimately directed towards practitioners can be tied into ongoing service efforts, then the findings are likely to realistically reflect the problems as faced by practitioners. While it may be impractical for service personnel, overburdened as they typically are in child welfare, to devote large amounts of time to data collection, such personnel frequently will willingly support the research effort if their input has been sought, the project realistically presented to them, and they see some benefit from the study.

Seventh, there exists a need to integrate and synthesize the existing body of knowledge concerning abuse and neglect. Unless this is systematically and regularly done, policymakers, researchers, and practioners will have difficulty keeping up with new information in the field, and there will develop a large collection of unconnected findings and unsupported myths. Further, there is a great need to integrate the knowledge concerning abuse and neglect with the knowledge gained in other related fields. To the present, abuse and neglect have been studied relatively in isolation from such relevant fields as the study of aggression, family process, personality measurement, and child development (see Friedman and Friedman, 1976 for a discussion of the relationship between social work research on abuse and psychological research on aggression). It would also help to bring scholars in these related areas more directly into research efforts in abuse and neglect. This would be a relatively low cost way of reducing the existing overabundance of unconnected findings in the field, and substantially increasing the empirical and theoretical base of several fields.

Eighth, the field of child neglect has been neglected too much. Greater attention has clearly gone to studying child abuse despite the fact that the frequency of neglect is considerably higher than abuse (Polansky, 1976). Research efforts to study neglect in its various forms should be substantially increased.

This list of areas deserving special attention for further research in abuse and neglect is brief and selective. It clearly does not include all the important areas requiring more study but rather only selectively highlights what seem to be some of the most critical ones.

CONCLUSION

To this point we have discussed issues pertaining to the impact research might make on social problems and examined special problems of research in child abuse and neglect. A number of priority areas for further research have been presented. Given the multiple factors that contribute to child abuse and neglect, and the preliminary state of knowledge, the priority areas have been diverse and have included both basic and applied research, prevention and treatment, and societal-and family-oriented research. It clearly seems too early in the study of abuse and neglect to ignore any of these key areas.

In a sense, this brings us back to much the same kind of question examined earlier. Were the research described here to be implemented, what should we expect the impact to be on the problems of abuse and neglect?

Among the positive outcomes to be expected from such a research program are that both policymakers and practitioners would find themselves with a more objective basis for making important decisions. For policymakers this would come from having more accurate information on the seriousness of the problem, the effectiveness of existing programs, and the effects of supposedly unrelated programs on the problems. For practitioners this would come from having more of a data base from which to draw in making the critical treatment and placement decisions they continually confront.

Furthermore, it is anticipated that the results of research into prevention and family functioning would increase knowledge that would be of value not only to the fields of abuse and neglect but to the broader areas of child and family problems. While much of the knowledge to be gained from the more basic research would not be of immediate use, such knowledge should add to existing social and behavioral science knowledge to ultimately enhance the effectiveness of both preventive and treatment programs.

It must be emphasized, however, that given the multiple forms of abuse and neglect, the various factors that contribute to it that are beyond the control of researchers, the definitional difficulties and other special problems hindering research in the area, the slowness of the research process and the need for findings to be replicated, plus the problems in effectively disseminating findings to target groups, it would be unduly optimistic to expect substantial impact from much of the research for several more years. All too frequently in the past researchers have generated problems for themselves by creating unrealistic expectations of the immediacy and magnitude of the gains that might come from their work. This has been done out of their own concern for social problems, or to try to get a foot in the door, or to keep a one-up position with funding sources, policymakers, and practitioners, but has served to create a growing disenchantment with research by the public as well as by practitioners.

To the extent that this disenchantment unduly restricts the opportunity researchers are given to contribute to important social problems, this is unfortunate. While it may be appropriate for expectations concerning the potential impact of research on complex, multifaceted social problems to be lowered, ultimately it is most likely to be through slow, painstaking, but careful programmatic and cumulative research that our knowledge will be increased. By focusing research at those issues most likely to have a high impact, by soliciting input from knowledgeable nonresearchers as well as other researchers in and out of the field of abuse and neglect, and by not overselling the promise of research, our effectiveness in reaching critical audiences with our findings while minimizing cost and delay can be maximized.

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Treatment and Research: One Enterprise or Two? A Behavioral Perspective

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In his opening remarks, Dr. Bill Philips used an analogy of a supertanker making a relatively small 15 degree change in course. The point of the analogy was that to make such a small course change the officer of the deck must order a hard right turn of the rudder. This fairly drastic response will still require a full 15 miles for the desired change in course to take effect. In the spirit of this analogy, I will argue that a similarly drastic change in the research behavior of students of child abuse and neglect is necessary if we are to improve, even a little, our ability to predict, control, and explain the occurrence of abusive and neglectful behaviors.

In suggesting the need for a change in our research activities, I will orient my discussion around four topics: the relationship between treatment and research; current problems in research; what we have learned so far; and the focus for future research.

TREATMENT, RESEARCH, OR BOTH

There is a widespread assumption that research and treatment (or practice) are inherently different enterprises. In contrast, I shall discuss the possibility that research and practice can usefully be considered as one set of behaviors. This possibility is real, for the field of applied behavior analysis or behavior modification provides us with a case study in the collapsing of the roles of the scientist and practitioner.

By 1968 this approach to scientific analysis of socially significant behavior grew to such proportions that a new journal was founded, the *Journal of Applied Behavior Analysis*. In the first issue of the new journal, Baer, Wolf, and Risley (1968) outlined the major distinguishing characteristics of the research which would be published in the journal. The title of their classic paper was "Some Current Dimensions of Applied Behavior Analysis." Let us consider each of these dimensions.

Applied Research

Whether research is designated as basic or applied is not to be decided by the research procedures used but by the interest which the larger society shows in the problems studied. As with the concepts of abuse and neglect, we are faced again with the importance of social definitions. Applied research is that which studies behaviors considered, at that historical period, to be socially important or relevant.

Both applied as well as basic research may be concerned with discovery. Applied research is simply constrained to examine variables which have some hope of being effective in improving the behavior under study. Indeed, as with basic research, we can engage in applied research for several reasons. One, the researcher may simply try to apply existing theoretical or general principles to solve problems of a practical nature. The theoretically alert practitioner is especially able to exploit the serendipitous finding and contribute to knowledge generation as well as its use. Two, the applied researcher may attempt to extend deliberately and systematically the generality of established principles to new domains. This active concern for the question of generalizability of research findings produces findings of a theoretical as well as applied nature. Three, the researcher may try to utilize the natural ecology to discover new principles. Such discoveries very often are not anticipated by theory. In such cases, the familiarity of the researcher/practitioner with his or her subject matter is invaluable. Applied behavior analysts generally assume that the individual researcher can be concerned with application, extention, and discovery simultaneously (Burgess and Bushell, 1969).

Behavioral Research

Useful and effective applied research is practical. Thus, it should focus its attention on deeds rather than just words. It should focus upon what people can be brought to do rather than what they can be brought to say about what they do. As I shall point out in the section on problems in research, students of abuse and neglect have placed undue emphasis upon verbal reports about behavior rather than upon the behavior itself. Yet, Baer et al noted:

> ...there is little applied value in the demonstration that an important man can be made to say that he no longer is impotent. The relevant question is not what he can say, but what he can do.

Analytic Research

The analysis of behavior requires a believable demonstration of the conditions responsible for the occurrence and nonoccurrence of the behavior under study. We achieve such an analysis when we can exert systematic control over the behavior. Analytic behavior applications, then, achieve or strive to achieve experimental control of the processes under study.

Research of this kind must address numerous difficult problems. First, the behavior under study must be reliably quantified. This is of major importance when we deal with emotionally charged topics such as child abuse and neglect. The fact is, however, the social significance of the behavior under study cannot be allowed to absolve us of this important task. Our failure to deal adequately with the demands of reliable measurements will doom our best efforts to failure.

Second, we must identify and describe the procedures we use as precisely as possible. The applied researcher's or therapist's path to hell is paved with imprecise procedures. Third, our procedures must be subject to replication. In fact, the best criterion to use in assessing the adequacy of procedural descriptions is whether or not they can be replicated by a trained reader. And, surely, the efficacy of any intervention program must rest on its successful replication.

Four, when a set of procedures has been found to produce successful results, we then need to analyze those procedures into their effective components. Which of the procedures are necessary? However, given the current state of our knowledge about the causes of child abuse and neglect, our primary concern at this time should probably be with getting reliable results rather than with component analysis.

Finally, we should focus our efforts on getting results which can be generalized over time and across settings. The likelihood of our success here depends considerably on our successfully dealing with the first four problems mentioned.

In answer, then, to the question of whether we need more research or more practice, I suggest we need applied behavior analytic studies which will make obvious the importance of the behavior changed, its quantitative characteristics, the experimental conditions which isolate what was responsible for that change, the exact description of the procedures responsible for that change, and the conditions which must be met to assure the durability of that change.

CURRENT PROBLEMS IN RESEARCH

In keeping with the previous sections, I have selected three problems to comment on in this section.

Words vs. Deeds

In the area of child abuse and neglect, there has been far too great an emphasis upon what people say about themselves rather than on what they do. A considerable amount of our uncertainty as to the principal determinants of abuse and neglect may be attributed to the research methodologies employed in most studies. Most of this research has relied upon secondhand information, clinical assessments, rating scales, survey questionnaires, and the secondary analysis of official statistics.

Undoubtedly, these indirect assessment procedures have their place and I am not suggesting they be discontinued. By themselves, however, they simply may not be capable of yielding the kinds of unbiased, highly detailed accounts of behavior necessary in the search for determinants of abuse and neglect, for design of effective treatment programs, and for evaluation of those programs. Moreover, major discontinuities have been discovered between interview reports and the actual behavior of parents and children during home observations (Jones et al, 1975).

For these reasons, we need to restore some balance to our research efforts by encouraging studies which employ direct observations of behavior and which make those observations in ecologically valid settings (e.g., the home) at the time those behaviors occur, not retrospectively.

Low-frequency Behavior

A second problem centers around our focus on dramatic, sensational behaviors—behaviors which typically are low-frequency events. Low-frequency behaviors are difficult to study for several reasons, such as our inability to be present when they occur and to predict their occurrence with any accuracy. Basically, we must address ourselves to higher frequency behaviors—behaviors

which can be specified precisely, which occur on a day-to-day basis, and which can be modified. Family interaction patterns, physical as well as verbal, meet these requirements. Family members interact daily, and the quality of these interactions as they occur day-to-day, week-to-week, indeed year-to-year, may be far more significant to a child's and a family's development than the drastic but seldom occurring physical assault leading to severe injury (Burgess and Conger, 1977). Moreover, by focusing on patterns of family interaction we can, then, examine the full range of child abuse from relatively mild psychological abuse such as sarcasm, ridicule and disparagement, to common forms of physical punishment such as spankings, all the way to excessive and violent physical attack.

Component Analysis

A third problem with much of the research on child abuse and neglect has been the failure to assess carefully the components of the various procedures used. This especially applies to demonstration studies. While the "shotgun" approach may be defensible at an early stage of research, we eventually must determine the necessary and sufficient procedures for effecting behavior change.

Component analyses require not only precise specification of procedures and behavioral events but, to be effective, they also need carefully designed longitudinal studies to assess the effectiveness of our procedures over time. Recent developments in sequential-longitudinal strategies make this need even more imperative (Nesselroade and Baltes, 1974).

WHAT WE HAVE LEARNED

Most of the recent excellent reviews of research literature indicate that abusive and neglectful behaviors have multiple determinants—psychological, sociological, and situational—and that these are learned behaviors which are transmitted from one generation to the next (Belsky, 1977; Parke and Collmer, 1975). Moreover, these behaviors are often symptoms of a more fundamental problem involving the lack of effective social skills. These behavioral deficits become especially critical during times of stress and when the parents are trying to effect some change in their child's behavior (Burgess and Conger, 1977). Finally, it is becoming increasingly evident that the problem is interactional in nature. The assignment of blame is simply irrelevant, for the child may be an active agent in his or her own abuse and neglect.

These research findings; i.e., the multidimensionality of abuse and neglect; the fact that they are learned behaviors transmitted intergenerationally, that they are symptomatic of general social deficits, and that they are basically interactional in nature, all have implications for our future research and treatment efforts. I will outline some of these implications in the next and last section.

FOCUS OF RESEARCH

Clearly, we still have so much to learn that we should foster as much diversity as possible. Within this framework of diversity we should, however, place much of our emphasis on the analysis of parent-child, indeed family, interaction. This emphasis is dictated by the fact that this is where the action is. Abuse and neglect do not occur in a vacuum. Instead, they occur within a social matrix and that matrix consists of the recurring behavior exchanges taking place between various members of the family.

Given this, special emphasis should be placed on the isolation of the causes or determinants of these deviant styles of interaction. If we are to do this effectively, we must design studies which have experimental and longitudinal components. In this way our research efforts will not only be socially significant, i.e., applied and behavioral, but will also be analytic.

It is my view that a concern for service delivery systems, treatment modalities, preventive programs, even massive social change, independent of the search for causality, will be futile and costly in human as well as economic terms.

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Research: Too Much, Too Little?

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INTRODUCTION

Many of you may know a children's story entitled "The Emperor's New Clothes." The emperor, so the story goes, asks his tailors for a new suit of clothes, and his tailors oblige with an "invisible" new suit. This is really a bit of consumer fraud. However, the members of the emperor's court, rather than tell him that he has been hoodwinked, exclaim the beauty of the new clothes. Led on by this social support the emperor declares there is to be a royal parade. He participates dressed in his new suit of clothes. During the parade, the emperor's subjects comment about the beauty of the new clothes; all, that is, except one little boy who exclaims that the emperor has on no clothes at all.

The story ends there. However, recently, it has been found that there is more to the story. Actually, the new information was unearthed in archaeological diggings in the old Moravian community in Bethlehem, Pennsylvania, where I live.

The additional parts of the story pertain to what happened at the emperor's parade. There were, in fact, two other persons at the parade who realized that the emperor had on no clothes. One was a social worker and the other a social researcher. Now, it happens that not one but two versions of what occurred were found. Experts have analyzed them and cannot determine which is authentic. Thus, I must leave it to you to decide.

One version says the social worker and the social researcher were on different sides of the street. Seeing that the emperor had no clothes, both went into action. The social worker obtained some clothes, rushed to the emperor, and began arranging a home visit to determine if other members of the family were in a similar state. The social researcher, coming from the other side of the street, asked that no services be provided until a matched control equal to the emperor in income, education, and occupation could be found, then began an in-depth interview to determine how the emperor came to be in this situation.

The second version says the social worker and the social researcher were standing on the same side of the street. They had worked together before, and when they saw the emperor's situation, moved into action together. The social worker made provisions for meeting the emperor's needs for clothing. The social researcher, without impeding the provision of services, set out to determine ways to prevent recurrence of the fraud, to assist the social worker to determine the effectiveness of the services provided, and to follow up on the family after services were terminated.

I do not know which version you feel is the real one, but I know which one I would like to think is the real one—the one in which there is cooperation. It also seems to me that the title of this panel, "Research: too much or too little?", implies that the two activities come from different sides of the street. By contrast, I suggest that the real concern should be to encourage more cooperation between service and research.

Undoubtedly, service and research represent different perspectives. The former meets immediate human needs and works to resolve serious human problems. The latter seeks answers to questions about the same human problems: Why do they occur? How can they be resolved? Do they recur once they have been resolved?

I wonder, however, if we have become too focused on the differences in perspective. Have we lost sight of the advantages of cooperation? Those advantages affect not only the quality of our professional activities but also the quality of life of the families that are the focus of those activities.

DESCRIPTION OF THE SERVICE PROGRAM

I want to describe a child abuse demonstration program in which research is part of a multidisciplinary child abuse team. The service agencies involved are two county child welfare programs, two county mental health programs which provide group and family therapy, and Head Start, which provides parent education services. Research and evaluation are parts of the

multidisciplinary team and are provided by a research team from the Lehigh University Center for Social Research. In addition to developing and assisting with evaluation of the service program, the research team also conducts two projects. One is a follow-up study of families serviced by the local child abuse program since 1967. This study is funded by the Office of Child Development. The other, funded by the National Institute of Mental Health, examines family coping behaviors (both parent and child) by comparing families cited for abuse with families of similar backgrounds who have not been cited for abuse. In short, there is a cooperative relationship between service delivery and research staff.

EXAMPLES OF COOPERATIVE INTERACTION

How does this cooperative relationship work?—not only through our working together, but most importantly, through opportunities to exchange ideas and to share results from research. For example, the child abuse casework staff and supervisors meet monthly with members of the research team for discussions. We also have a research advisory group, comprised of liaison members from each service component, which meets regularly to discuss policy issues. For example, the advisory group discussed at length questions of confidentiality and related issues before research was initiated.

There are several examples of the type of research we do, and the kinds of results we provide service deliverers.

Study of Stresses on Families Cited for Abuse

One part of our research involves recontacting families cited for abuse to determine what their lives are like now, after service, compared with what they were at the time of abuse. This takes us into homes over a two-county area to interview parents. While we have not yet done analyses comparing past to present, we have documented the sizeable amount of stress under which these families live. We work with a list of 39 sources of stress. To date, we have determined which occur most frequently. We have also calculated the number of different stresses within each family. Thus, we can provide to the service staff a systematic picture of stresses these families experience. We have also found that they use our list to identify stresses during the early phases of intake. In one instance, a caseworker by using our list found several areas of stress not previously identified.

Table 1

Percentage of 128 Families Having Different Sources of Stress

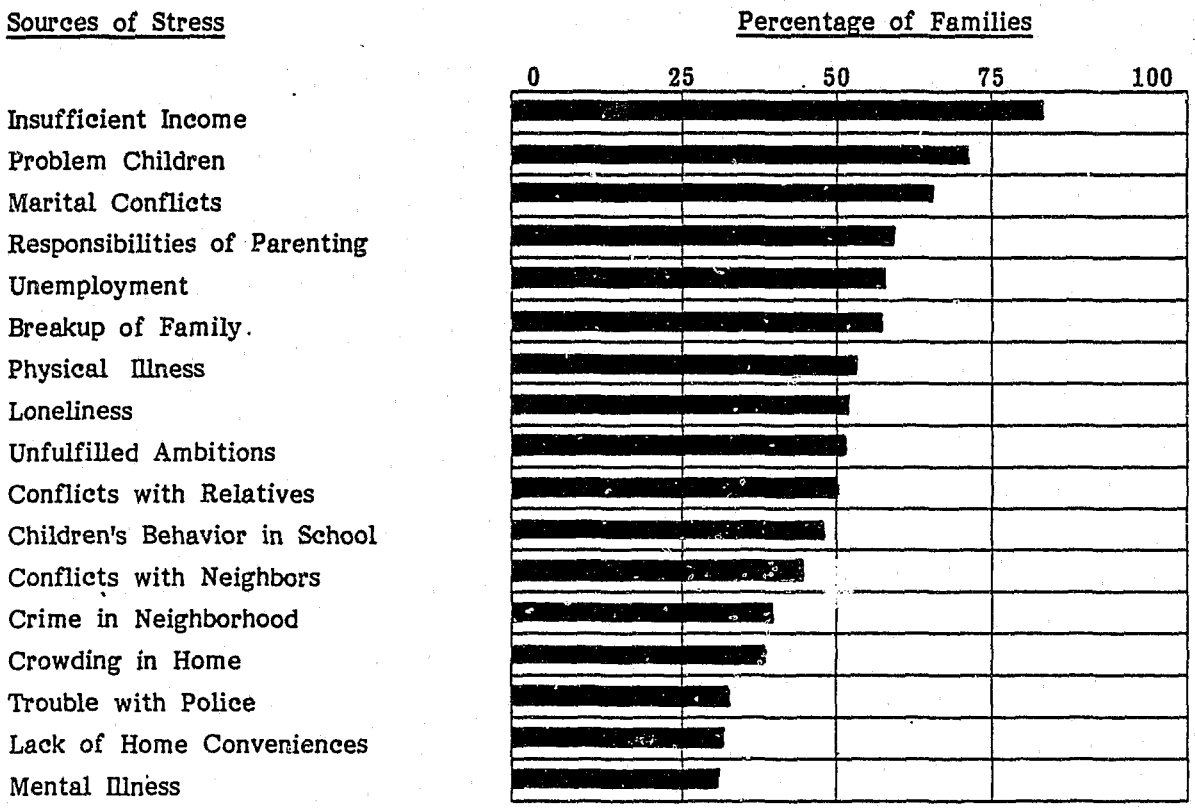


Table 2

Frequency and Percentage of 128 Families Having Different Numbers of Stressors Per Family

Number of Stressors Per Family	Number of Families	Percent
1-10	46	36
11-20	56	44
21-33	26	20
	128	100

Study of the Quality of Parent-child Interactions

Another area we study is the quality of parent-child interactions. Members of the research staff observe a mother or father playing with his/her young child in four types of activities. Some results show that abusive parents give less help to their children and express less approval of their child's performance than nonabusive control parents.

Table 3

PARENT-CHILD INTERACTION
Percent of Intervals in Which Parent Helps Child

ABUSE	CONTROL	TYPE OF TASK
16.6%	24.8%	Puzzle
6.8%	5.3%	Playdoh
10.0%	17.5%	Felt Board
0.3%	0.0%	Book
N=10	N=10	

Table 4

PARENT-CHILD INTERACTION
Percent of Intervals in Which Parent Shows Approval Toward Child

ABUSE	CONTROL	TYPE OF TASK
11.2%	23.5%	Puzzle
4.7%	13.2%	Playdoh
14.1%	19.1%	Felt Board
15.3%	32.7%	Book
N=10	N=10	

Children from abuse families express less affection and indicate less pleasure than nonabusive controls.

Table 5

PARENT-CHILD INTERACTION
Percent of Intervals in Which Child Expresses Affection Toward Parent

ABUSE	CONTROL	TYPE OF TASK
7.8%	17.4%	Puzzle
0.6%	1.3%	Playdoh
1.0%	2.5%	Felt Board
12.3%	21.3%	Book
N=10	N=10	

Table 6

PARENT-CHILD INTERACTION
Percent of Intervals in Which Child Expresses Pleasure

ABUSE	CONTROL	TYPE OF TASK
5.6%	8.3%	Puzzle
19.0%	30.7%	Playdoh
11.2%	18.5%	Felt Board
12.7%	30.7%	Book
N=10	N=10	

As part of this study, we have developed a videotape illustrating positive and negative qualities of parent-child interactions, and have used it for in-service training of caseworkers and Head Start home visitors. We are currently examining ways in which Head Start home visitors can work with parents to improve the quality of parent-child interactions.

Study of Family's Progress While Receiving Service

Another area of study is monitoring a family's progress during its participation in the service program. The service staff helped us develop a list of issues which reflect where progress could be expected. We developed scales to measure change related to these issues. These scales are then completed by each service component on each of their families. Scales are redone every six months. Comparisons of ratings from the beginning and end of each six-month period can be made in different ways. One way is simply to determine whether there was positive change (that is, progress), negative change (that is, deterioration), or no change at all. Then, each of the three types can be tallied. There are different numbers of changes that could occur, depending on the number of family members. In the two families depicted here, a total of 40 changes are possible. Fifteen positive changes occurred in the family with only one negative change, a net positive change of 14. The second family had three positive and two negative changes, a net positive change of one.

Table 7

PROGRESS EVALUATION
Changes Over 6 Month Period

	Family 1		Family 2	
	Child 1	Child 2	Child 1	Child 2
1. General Status of Children				
Physical Health	NC	NC	NC	NC
Educational Status	NC	NC	NC	NC
Nutrition	NC	NC	NC	NC
Social Skills (withdrawn)	NC	NC	NC	NC
Social Skills (aggressive)	NC	NC	NC	NC
Self-Concept	NC	+	NC	NC
Developmental Status	NC	NC	+	NC
2. Abuse/Neglect (Children)				
Physical Abuse	NC	NC	+	+
Physical Neglect	NC	NC	NC	NC
Emotional Neglect	NC	NC	+	+
3. Home Environment (Family)	Family		Family	
Violence	+		+	
Stimulus Deprivation	NC		+	
4. Family Standard of Living	FH	MH	FH	MH
Physical Health	-	NA	NC	NA
Employment	+		+	
Retard/Educ. Disability	NC		NC	
Vocational Limitation	NC		NC	
Financial Status (Family)	NC		+	
Housing (Family)	NC		-	
5. Parent's Social Relatedness				
Community Participation	NC	NA	NC	NA
Use of Comm. Resources	NC		+	
6. Parenting Skills	NC		NC	
7. Family Stresses				
Alcohol Use/Abuse	NC		NC	
Drug Use/Abuse	NC		NC	
Legal Problems	NC		NC	
Coping with Stress	NC		+	
8. Family System				
Marital Conflict	NC		+	
Extended Family Conflict	NC		+	
Functioning	-		+	
Adequacy of Family Goals	NC		-	

+ = positive change NC = no change
- = negative change NA = not present

Study of Service Accounting

Another area of study focused on determining the type and amount of services provided to families. One objective is to determine which services and how much service are instrumental in families making progress. The result is a "service accounting system" which provides information on the number of times a family receives a specific service, such as home visits, and how much time is spent providing each type. A listing of the services provided one family over a seven-month period looks like this:

Table 8

SERVICES PROVIDED TO FAMILY
7 Month Period

	Type of Service	Time Spent		Number of Interactions
		HRS	MIN	
MARCH:	Telephone Contact Related to Family		30	2
APRIL:	None			
MAY:	Supervisory Session		15	1
	Transportation		50	1
JUNE:	Casework Services (Other)		45	1
JULY:	Telephone Contact with Family	2	30	5
	Case Conference		10	1
	Home Visit	1	15	1
	Group Therapy	2	50	2
AUGUST:	Transportation		25	2
	Home Visit	1	--	1
	Telephone Contact with Family		20	2
SEPTEMBER:	Transportation	6	25	12
	Home Visit	5	45	5
	Conference with Family in Agency	1	--	2
	Case Conference		30	1

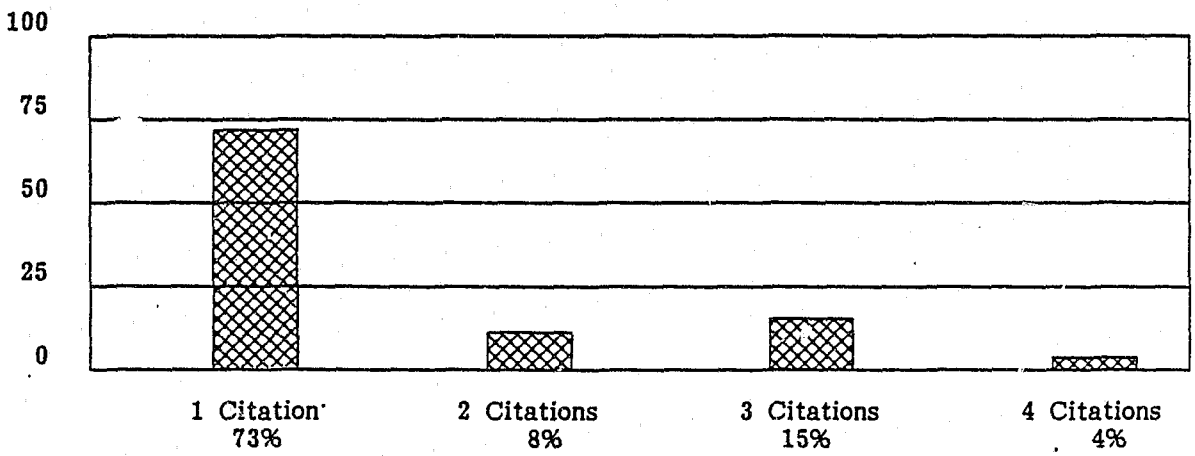
In addition to the research use of these data to examine the effects of service on progress, the service providers use the data to prepare for court hearings and to write reports. We are also asked to assess issues such as how much time caseworkers spend in "transportation" (i.e., getting to and from home visits, clinics, etc.) to help them decide whether to add a transportation aide.

Study of Recidivism

Another example involves a central theme of our research activities, the identification of recidivism or recurrent abuse, and the determination of conditions associated with recidivism. This is proving to be an interesting undertaking. We have read and analyzed the case records of families cited for abuse since 1967. From this has come an analysis which shows that 73 percent of these families have only one citation. This is shown in the following bar graph:

Table 9

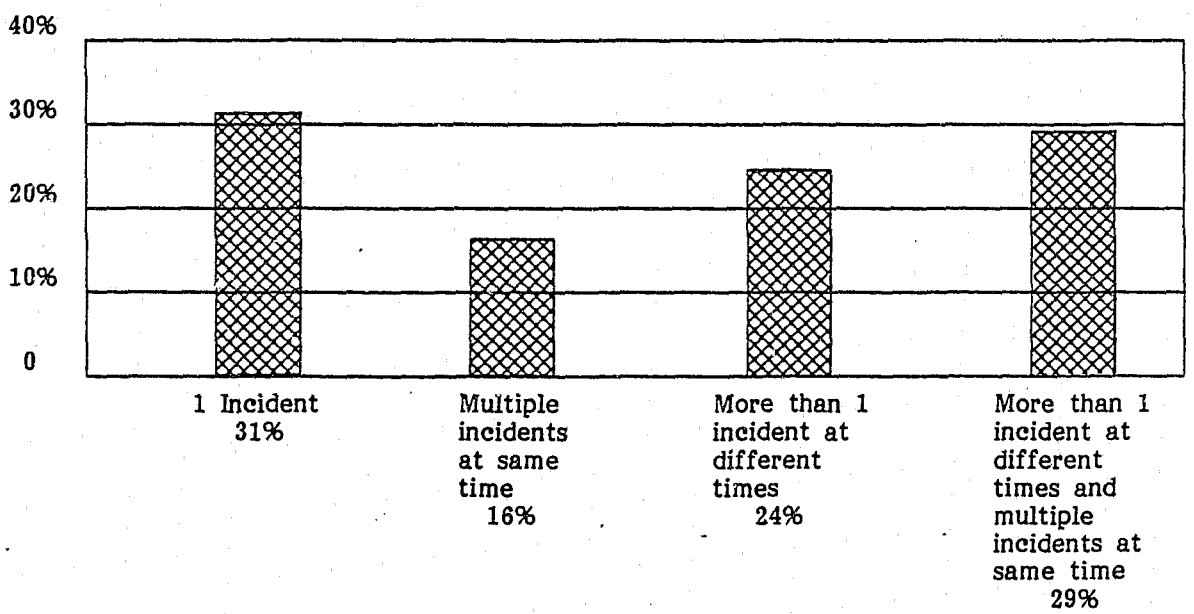
Percentage of Families Having Different Numbers of Abuse Citations
(246 Families)



However, as the next bar graph shows, only 31 percent of the families with one citation have only one abusive incident recorded in the case record:

Table 10

Percentage of Families Having Different Numbers of Abusive Incidents
(246 Families)



Our current estimate is that of the families with an abuse incident, 53 percent will have one or more incidents at a later time. This figure was surprising to the casework staff until we began discussing who these families are. These statistics stimulate curiosity and further exploration of the reasons for repeated abuse, and the characteristics of families who have repeated incidents of abuse.

One aim of our study of recidivism is to pinpoint the characteristics of families in which abuse is likely to recur and to make this information available to service providers. If this can be accomplished, it will then be possible, when a first contact with a family is made, to estimate the likelihood that abuse will recur. Such information would, in turn, be available when making decisions about what services to provide.

In essence, we are working to develop a new role for the researcher, that of a working member of a multidisciplinary service team with the responsibility to gather, systematize, and where necessary, interpret results that will enhance the effectiveness of services. The key to cooperation is communication between service and research staff. Rather than information going only to funding agencies and professional peers, it must also go to the service team. In our case, it generally goes first to the service team. Our experience has been that such communication is beneficial to both service and research.

There are, to be sure, different perspectives held by service and research components. In the long run, however, when there is cooperation, researchers may be able to avoid many dead ends and blind alleys, and service deliverers may be able to focus their efforts in directions that are most effective in reducing the problems of their client families and enhancing the quality of family life.

Evaluation of an Ongoing Treatment Program: Initiations, Problems, Implications

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This paper will discuss service evaluation as implemented at the Panel For Family Living, Tacoma, Washington. The authors' over-riding concern is to effectively spread the concept of evaluation throughout social services.

Most workers, of course, affirm the principle of evaluation. We are willing to judge, by one standard or another, whether the services we provide are adequate or effective. At the Panel, for example, one good measure of our service is whether or not our clients continue to abuse or neglect their children. But while we can estimate in this rather crude form the success or failure of our service program, we are in no position to examine particular aspects of that program or make more than the most subjective judgments about which facet of our services is most suitable for an individual client.

We feel that to be useful, an evaluation program ought to help us answer these types of questions. A good evaluation program can, we think, be useful in several ways:

1. It can provide an objective measure of the change in clients as they participate in services.
2. Information gathered for the evaluation can be used to help workers make more accurate diagnoses.
3. An objective evaluation program can help agencies be more accountable both to the client and to the community.
4. Service evaluation can help the agency decide whether it is meeting its goals and help it determine ways to improve its services.
5. And, finally, a good evaluation program will generate data that is useful to the field as a whole.

SETTING

The Panel For Family Living grew out of a need identified by a juvenile court worker and a legal aid attorney about six years ago. They felt that Tacoma and Pierce County offered insufficient services for parents either accused of being or adjudged to be abusive or neglectful. These two workers began to organize other professional volunteers and slowly a coherent organization began to take shape.

The Panel is a private non-profit agency governed by a board of directors. Since May, 1974, the Panel has been supported by a demonstration grant from the Department of Health, Education, and Welfare.

The Panel's current full-time staff includes an Executive Director, a Training Specialist, a Direct Services Supervisor, an Outreach Worker, an Office Manager, and a Research Assistant. Current funding also supports Dr. Perry's work as a part-time Research Consultant.

Our activities fall into five general categories: community coordination, community education, professional training, client services, and, of course, research.

Client services include group therapy, parent education classes, outreach services, and parent aides. Group therapy and parent education sessions are run by consultants employed on an hourly basis. The parent aides are volunteers paid a modest stipend. The outreach work is done by two of our paid staff and includes counseling, referral, and informational services provided almost exclusively in the client's home.

AGENCY PITFALLS

The Panel's initial funding application included a research component, but that overly-ambitious effort showed meager results and left some continuing hostility toward research or statistical evaluation.

About 18 months ago, when Dr. Perry joined us, the Panel was perhaps ready for a new research project. It had a new executive director and a new supervisor of client services, both committed to service evaluation. There was, however, that lingering hostility toward any research that might disrupt ongoing activities.

Hostility continues in a muted fashion, and it indicates one of the lessons we have learned: unless there is a genuinely open attitude on the part of the agency, a real willingness to question current methods or techniques, it is really impossible to carry on decent research. If all the agency wants is a justification of current practice, it had best avoid research altogether. The authors have tried to make the research effort as non-threatening as possible, although we have been quite open about the fact that we hope it will suggest changes to be incorporated in our service program. And we have worked to involve both the staff and the board in the initial design process.

Unfortunately, however, it seems as if the process of research and the process of serving clients are destined, at times, to clash. Service agencies are always overburdened, and in this particular field are overburdened with clients needing immediate help. The workers who have been asked to administer questionnaires or do observations must continually negotiate the fine line between the demands of the research and the overwhelming needs of the client for rapid service. Thus, it frequently happens that a client is receiving services before the full intake interview—including the battery of tests necessary to the research—has been completed.

All this should not be taken to imply that meaningful research can't be carried out in a service agency working with abusive or neglectful parents. We must, however, warn that there will be traumas and that everyone involved should be aware of this at the outset. Goodwill from both research and service personnel is absolutely critical to the success of such projects.

In light of this, Dr. Perry designed a research project to fit the realities of the Panel's day-to-day operation, one that would evaluate the Panel as it is, not redesign it in accordance with some research scheme. And that, of course, was difficult, for services are seldom offered in a style that falls into a neat research design.

For example, random assignment to services is both impractical and, perhaps, clinically undesirable. The Panel's clients often are referred by other agencies, and frequently are sent for a particular service. The Panel outreach staff also wants to retain the option to exercise clinical judgment in assigning clients to services. As a practical matter, this traditional assignment pattern could not be altered. But without random assignment it is difficult to compare the various services offered by the Panel.

For similar reasons, a random group of clients could not serve as a control group. This would involve withholding service, unacceptable for many reasons. This control group problem also is complicated by the fact that the clients are both relatively heterogenous and few in number. So characteristics within the group could not be studied because the number available for analysis became quite small.

These examples suggest the perils of research design within the strictures of a small agency. Most workable designs fail to control many rival hypotheses, and therefore fail to provide definitive answers about the effects of a particular service. But careful planning and hard work can lead to a design that will yield systematically greater detail about clients and what is happening to them—if not the ultimate answer as to "why" it is happening. The research also can raise questions that may lead to new ideas on treatment and to new insights about the clients and the agency itself.

Having designed an evaluation project, however, it was still necessary to avoid or dispell the lingering distaste for research. Dr. Perry studied the Panel's stated goals and elicited the workers' views of these goals as they governed everyday operations. She created a design and selected measures that would provide information that was directly relevant to the staff, and then met with the staff, the board, and others to explain the design and relevance of the measures.

Her clinical experience was a real advantage. She was able to talk with the staff and the consultants on the basis of her experience in dealing with clients, and was able to understand their concern about the utility of the data to be collected. In fact, as the data collection began, she provided interpreted summaries of test scores to workers, and was able to make tentative treatment suggestions. This quick response was extra effort for her, but it helped to win the staff's support.

Although a firm believer in the utility of statistical information, she readily acknowledged that objective data may not be the total answer to questions of case management or evaluation. This affirmation of clinical skills also helped increase cooperation.

Having created the design and chosen the measures, she began a series of training sessions for the workers who would administer the battery of tests. She pretested the measures with several clients and administered the tests to the initial group of children. She was thus assured that the plan was workable and was able to provide useful suggestions to the workers about administering the tests. She worked to help the workers understand the measures and the utility of the data derived from them, since they would be more apt to put in the necessary time and effort if they believed the results would be worthwhile.

THE DESIGN

The basic design is quite simple. The plan was to evaluate each new client just prior to service, again three months later (having documented the kind and amount of services received during that time), and finally upon termination. In reality it has been a bit sloppier than that. Sometimes services began before the first evaluation had taken place. The interval between pretest and the second evaluation varied from 2 to 7 months. And, finally, termination data proved difficult to get—clients had a tendency to "disappear", and workers a tendency to "forget" this final evaluation. Nevertheless, in a year's time we collected sufficient evaluation data to provide useful and provocative information.

One other aspect of our evaluation project may be of interest. Although there are many descriptions of child abusers, there are few controlled studies that indicate unique characteristics of parents who abuse their children. It is not clear that these descriptions do any more than identify a lower socio-economic class population, where abuse and/or neglect may or may not be found. Since the Panel would be accumulating considerable data on lower social class abuse clients, we decided to take the next step and compare these clients with a carefully matched group of non-abusers.

The data was to perform two major tasks: (1) describe in detail the characteristics of our clients and their families, tapping especially those characteristics identified by others as related to child abuse; and (2) document changes in clients, including both changes specified by the treatment staff and changes in areas that were not necessarily singled out for treatment.

We also included measures of some characteristics that we did not expect to change. This was important, since there is a danger that extreme scores—which we expected in many areas—will become less extreme at post testing regardless of what intervenes simply because of unreliability in procedures. Including non-changing variables measured by the same or similar procedures guards against this difficulty.

These goals and the practical problems of working in a clinical setting guided the selection of measures. The result was a multi-method procedure which utilized interview, paper and pencil questionnaires and inventories, observation, and child testing. The entire evaluation takes from 1½ to 3 hours, depending on whether two parents are in the home, whether the child of concern is in the home, and whether the parents can read. The worker handles the interview and questionnaires; trained graduate students do all observation, the child testing, and the entire evaluation for control subjects. The many categories of Panel clients were collapsed into three basic groups. The "Abuse" group includes those labeled as having physically abused their children, regardless of degree of severity, and those labeled as both abusing and neglectful; 59% of the clients included in the analysis have this label. "Neglect" includes all severities of neglect; 17% of the clients fall here. "High Potential" includes those labeled at high risk for abuse, neglect, or both; 24% of the clients are high potential. The small number of sexual abuse and emotional abuse clients are not included, nor are the few families whose target child is over age 12.

Table 1

Demographics

Client Referral Characteristic	Control	Abuse 59%	Neglect 17%	High Potential 24%
Sex				
Female	66%	64%	74%	85%
Male	34	36	26	15
Marital Status				
Married	84%	80%	42%	50%
Single	16	20	58	50
Mean Age				
Females	26.5	26.4	28.5	25.2
Males	28.6	28.8	30.2	28.3
Unemployed				
Females	81%	76%	86%	86%
Males	18	24	25	25
Social Class[1]				
3	6%	6%	0%	4%
4	56	48	26	31
5	38	34	58	54
Unknown		12	16	11
Number of Children				
One	43%	32%	50%	46%
More	57	68	50	54
Age of Children				
Under 5	47%	39%	53%	69%
5 or older	53	61	47	31
Referral Source				
Medical		14%	26%	13%
Public Agency		48	47	29
School		3	0	13
Court		6	21	0
Self		23	5	38
Other		6	1	7

[1]Hollingshead, August B. "Two Factor Index of Social Position." Mimeographed, 1957.

DATA

The data presented here are selected from two of our studies. Last fall we did an interim analysis of the intake information on our client groups compared with each other, and each compared with the control subjects we had tested. These comparisons are of group data, and are identified in the tables by the word Group. More recently we have done a partial analysis of our matched control study. This analysis utilizes a pair-wise matched comparison of abuse clients and controls, and is labeled Match in the tables.

A number of people have proposed that parent characteristics are important in defining an Abuse group. We included several of these. A consistent finding has been a history of parental abuse and neglect in Abuse groups, and our data support this finding. In our group, however, the non-abusing spouse (the "Passive abuser") was as likely as the abuser to have been abused as a child, which suggests that previous history may dispose one to tolerance of abusive behavior.

Self-esteem was included as a variable of interest to clinicians because an earlier study (Melnick and Hurley, 1969) found significant differences between controls and abusers on this variable. However, we did not find differences for the Abuse group overall. Our High Potential clients differed from both the Abuse clients and from the Controls.

On the other hand, anxiety, as measured by the Spielburger (1968) trait measure, consistently differentiates Abuse from Controls, as well as the High Potential group from Controls.

Table 2

Parent Characteristics

	Control	Abuse	Neglect	High Potential
Abused or Neglected as Child				
Group	13%	50%	28%	43%
Matched N=27	16	44		
Resp. N=16	18	44		
Not N= 7	25	43		
Self-esteem[1]	N=32	N=32	N=13	
Group	72.0	67.3	63.8+	57.4***
Matched N=32	67.0	63.3		
Resp. N=16	64.3	60.1		
Not N= 8	67.6	60.2		
Anxiety[2]	N=32	N=31	N=12	N=13
Group	36.4	42.8*	39.7	48.2**
Matched N=26	40.0	46.4*		
Resp. N=15	42.7	48.0		
Not N= 8	37.1	47.4		

\+ p<.10 ** p<.01
* p<.05 *** p<.001

[1]Eagley, A. H. "Revised Janis-Field Scale" in J. P. Robinson and P. R. Shaver eds. *Measures of Social Psychological Attitudes*. Ann Arbor: Institute for Social Research, 1973, pp. 76-80.

[2]Spielberger, C. D., Gorsuch, R., and Lushene, R. E. *State-Trait Anxiety Inventory*. Palo Alto, California: Consulting Psychologists Press, 1968.

In the Family Environment Scale developed by Moos (1974), three scales (Cohesion, Expressiveness, and Conflict) make up what is called the relationship dimension. The High Potential group differed from the Controls on Expressiveness and Conflict, and approached a significant difference in Cohension. Abusive males, in the group study, and th ose responsible for the abuse, in the matched study, were significantly lower than Controls in Expressiveness. The significant difference in Conflict between Abuse and Control groups appeared only in the group analysis. The apparent "normality" of the Neglect group on these scales is surprising.

Table 3

Family Environment: Relationship Dimension

		Control	Abuse	Neglect	High Potential
Cohesion		N=32	N=31	N=12	N=13
Group		54.2	48.7	60.7	45.5+
Matched	N=27	53.1	49.2		
Resp.	N=16	53.7	47.4		
Not	N= 8	50.0	52.0		
Expressiveness					
Group		53.9	48.9	54.3	47.1*
Matched		55.6	49.0		
Resp.		57.2	44.2*		
Not		52.1	55.8		
Conflict					
Group		39.7	45.6*	40.3	50.5*
Matched		42.9	47.3		
Resp.		43.6	48.1		
Not		42.0	46.9		

+ $p<.10$
* $p<.05$

Another aspect of family relationships is how discipline is carried out. To tap this, we developed an analog measure we call the Situation Interview, a 15-item interview in which a typical and frustrating home situation is read to the parent. The task is to verbally role play the response and to describe what actions, if any, would be taken. The interviews are tape recorded and later coded.

Table 4

Situation Interview: Negative Verbals

		Control	Abuse	Negative	High Potential
Attack		N=32	N=32	N=14	N=16
Group		1.4	1.3	.69+	1.1
Matched	N=26	1.3	1.6		
Resp.	N=12	1.2	2.2		
Not	N= 8	1.1	1.3		
Blame					
Group		1.9	1.9	.69	.86
Matched		1.4	1.7		
Resp.		1.2	2.1		
Not		1.1	1.0		
Challenge					
Group		3.3	3.2	2.4	2.4
Matched		3.0	3.5		
Resp.		3.2	3.7		
Not		3.4	3.5		
Attack, blame, and challenge combined					
Group		6.7	6.3	3.6**	4.7*
Matched		5.5	5.7		
Resp.		5.1	6.1		
Not		5.6	5.8		

+ $p<.10$
* $p<.05$
** $p<.01$

Table 4 includes negative verbal codes. There are no significant differences on Attack, Blame, or Challenge individually, but when these are grouped, both the Neglect and High Potential groups are lower than the Control. It also looks as if spouses of abusers may be slightly lower than the abusers on the "direct negatives," Attack and Blame.

A possible explanation for these findings may be found when we look at the other verbal codes. In Table 5, we find that all client groups are less likely than Controls to Command or Direct the child, and that the Abuse and Neglect groups also reason less. These findings do not hold for the Abuse group in the matched comparison, although those not responsible for the abuse are lower in both than those who are responsible. In other words, the Neglect and Abuse groups (particularly the spouse not responsible for the abuse) are more passive and unwilling or unable to verbally take charge of the situation. The person responsible for the abuse takes more command of the situation, but tends to be more negative in doing so.

Table 5

Situation Interview: Verbal Codes

	Control	Abuse	Neglect	High Potential
Command, direct				
Group	6.9	4.7**	3.9***	4.1**
Matched	6.0	5.2		
Resp.	6.4	5.2		
Not	6.0	4.8		
Reason				
Group	5.7	3.3**	3.5*	4.3
Matched	5.1	3.7		
Resp.	4.7	4.3		
Not	6.1	3.6*		
Other verbal				
Group	1.8	2.1	2.5	2.6
Matched	2.3	2.3		
Resp.	2.4	2.2		
Not	1.5	2.6		
No verbal				
Group	.72	1.7**	2.9*	1.1
Matched	1.0	1.4		
Resp.	.83	1.3		
Not	1.4	2.4		

* $p<.05$
** $p<.01$
*** $p<.001$

The same interpretation for the spouses of abusers is suggested when actions are analyzed (Table 6). They tend toward "No Action" and slightly smaller amounts of both aversive and non-aversive discipline. Apparently they simply are more passive.

The failure to find differences between groups here is somewhat surprising. Perhaps the analog nature of the measure allows respondents to monitor their responses, particularly their statements about actions. However, we are accumulating independent evidence supporting validity of the measure. More likely, the groups are composed of different kinds of people—those who regularly use aversive discipline, and those who do not, but may fly off the handle occasionally. The distribution of scores seems to support this view.

Table 6

Situation Interview: Action

	Control	Abuse	Neglect	High Potential
Non-aversive discipline (D+)				
Group	5.7	5.0	4.7	5.8
Matched	5.7	5.3		
Resp.	6.0	5.8		
Not	6.4	5.0		
Aversive discipline (D-)				
Group	3.8	3.7	3.5	3.6
Matched	4.0	3.9		
Resp.	4.2	3.3		
Not	4.1	2.1		
D+/D-				
Group	2.2	2.5	2.4	2.5
Matched	1.7	1.8		
Resp.	1.2	1.8		
Not	3.1	2.8		
Other action				
Group	1.7	1.7	1.8	1.9
Matched	1.9	1.3		
Resp.	1.4	1.3		
Not	1.8	1.4		
Nothing	4.8	5.0	5.6	4.4
Matched	4.5	5.4		
Resp.	4.2	5.6		
Not	4.3	7.0+		

+ $p<.10$

Some other findings from the Family Environment Scale bear mentioning. Five scales make up the Personal Growth dimension. On two of the five--Independence and Active Recreation Orientation--all groups, including Control, score significantly lower than the norm. We equate the Active Recreation Orientation, in some respects, with the isolation that is hypothesized to be related to child abuse. This aspect of the isolation, at least, appears to be a social class phenomenon, as does the failure to provide independence for individual family members.

Table 7

Family Environment: Personal Growth Dimension

	Control	Abuse	Negative	High Potential
Independence	N=32	N=31	N=12	N=13
Group	42.8	42.0	44.8	44.0
Matched N=27	42.8	41.0		
Resp. N=16	42.0	38.4		
Not N= 8	44.6	47.7		
Achievement orientation				
Group	46.3	46.0	50.8+	44.2
Matched	45.8	46.7		
Resp.	43.8	49.0		
Not	46.0	39.0		
Intellectual cultural orientation				
Group	45.3	43.7	42.8	44.4
Matched	44.0	42.9		
Resp.	44.3	40.3		
Not	41.5	44.0		
Active recreation orientation				
Group	40.2	38.0	43.5	38.9
Matched	38.6	35.9		
Resp.	35.9	35.1		
Not	45.3	38.5		
Moral religious emphasis				
Group	57.8	53.0+	51.6+	51.3*
Matched	56.7	53.3		
Resp.	55.6	52.3		
Not	55.6	53.6		

+ $p<.10$
* $p<.05$

It has been suggested that abuse families are poorly organized. Our data indicates that they do not perceive themselves this way. This raises an interesting ethical issue: perhaps we impose our standards on these families and thus condemn them for being poorly organized, when they neither perceive themselves so nor differ from others in their social class.

Table 8

Family Environment: System Maintenance Dimension

	Control	Abuse	Neglect	High Potential
Organization				
Group	52.1	50.4	55.3	46.6
Matched	49.3	51.0		
Resp.	48.3	49.4		
Not	51.3	51.3		
Control				
Group	51.7	48.4	47.2	54.5
Matched	53.0	48.8		
Resp.	53.6	48.8		
Not	52.5	49.1		

SUMMARY

Let us summarize what is emerging from these studies.

First, it is important for agencies to note that different client populations may differ in their needs. At the Panel, as we have analyzed our services, we have discovered that the service provided does not vary for either group classification or for individual profile. It should.

Second, both abusers and spouses receive the same services, but the services do not attend to their differing needs. Both clinicians and researchers should pay more attention to such differences.

Third, our High Potential group fits the classical description of child abusers more closely than does the Abuse Group—and of course it would, since its members are labeled on that basis. But this raises an issue of identification and labeling. We would not argue that these people do not need treatment, but perhaps they should receive it in a setting which does not label them and which directs its services more specifically to their needs.

Finally, while we do find some differences between our Abuse group and our carefully matched Control group on anxiety, expressiveness and appropriate direction in discipline situations, we do not find differences on some factors one would expect them based on the clinical lore—self-esteem, a family environment of independence, recreational resources, family organization, and negative verbalizations. Perhaps this lore needs to be more critically examined.

We do not present these as definitive findings, but as initial attempts to discover better ways of serving our clients. The research project has been difficult and time-consuming, but we feel it has been of great value to the Panel. We believe that other small agencies would find the endeavor equally rewarding.

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A Practitioner Views Research

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"In order to treat, one must first understand." From this premise, stated by Norman A. Polansky in *Roots of Futility*, comes the rationale for our research. In addressing this panel's topic, "Research: Too Much or Too Little?" I want to base my remarks on my dual role: first, as the field director of a major research study into child neglect; and secondly, as a practitioner in an institution for boys who have been placed there because of neglect and deprivation.

Because I have held these two jobs simultaneously for the last two years I have, perhaps, a unique appreciation for both the importance of research and the importance of direct practice. Children and their families cannot wait for researchers to find out what needs to be done. The practitioner must go ahead.

In working with children in placement, I am confronted daily with making decisions about their treatment, working with child care staff, and involving natural families in planning for the future of their children. One quickly learns how useful theory is in working with neglected children, their parents, and their caretakers, and yet theories are incomplete. Obviously, a practitioner cannot afford to be immobilized by the incompleteness of his knowledge. At the same time, he can be aware of what he does not know.

Addressing what we do not know about the causes of neglect is the attempt of our research effort, "The Apathy-Futility Syndrome: An Urban View," under the direction of Dr. Norman A. Polansky. In part, it is a replication of the 1972 study published as *Roots of Futility*. Fifty low-income, white, Appalachian families having a child in Head Start participated in that study. The mothers of these children were rated in terms of the level of child care given.

In our recent study we replicated this sample in an urban setting. In addition, 46 low-income white families, all of whom have a child between the ages of four and seven living at home, were referred to the study as "neglectful" by social service agencies. One more group was also studied. This was a sample of single, white, low-income mothers who had a child between the ages of four and seven.

To summarize, the recent study had two groups, a control sample and a neglect sample, both of which were comprised of intact and single-parent families. One hundred twenty-five families participated. The independent variable which distinguished the groups was the social service agency referral of the neglect sample.

In our research, we investigated the major influences affecting the level of care children receive. Our hypothesis is that the child's level of care depends upon the mother's functioning, which in turn is determined by her personality. Other factors, of course, enter in, such as the emotional and economic support she receives from her husband, the social and economic conditions of the family, the relationships she has with extended family, friends, and community, the level of her intelligence, and her physical health. An in-depth assessment was made in a series of interviews with the mother and in a single interview with the father, if he was present. All interviews were conducted in the family home. For these interviews, a structured format was followed and a narrative summary to cover each contact was written. All interviews were conducted by one of three staff members, each of whom holds a master's degree in social work. Additionally, a psychological evaluation for each parent and their four-to-seven year-old child was completed. A portion of the sample of mothers and children was medically screened.

Although we worked in several areas of Philadelphia and its surrounding communities, the predominant flavor was given to the study by our largest group, families living in Kensington. This section of the city is marked by block-long lines of brick rowhouses facing each other across narrow streets. Like so many other old neighborhoods, some blocks reflect the care and pride of their residents while others show severe neglect. Factories infiltrate residential areas so that the block where we had our office, which was in a converted house, faced a large meat packing plant which, incidentally, closed during our tenure in the neighborhood. Almost every corner has either a bar, grocery store, or doctor's office. Most neighborhood families were raised in a curious mixture of both pride in and hostility toward the community and the outside world. Kensington is a very large area and although parts are racially integrated, the area in which we worked is populated by white families.

Most families work in neighborhood factories or blue-collar jobs. The highest aspiration of men is to achieve a position within the city police and fire department. Unemployment is chronic, and numerous families are supported by the public welfare system. Single-parent families overwhelmingly depend on welfare for support. In fact, 72 percent of the single mothers in our study require public assistance.

In this neighborhood the education attained by people in our study is between the eleventh and twelfth grade. That our control sample completed high school either through school or through equivalency tests marks a significant difference between the two groups. The neglect sample as a whole shows less ability to complete high school.

Presently, all data has been collected and is being analyzed. Because of this, we can only speak about our impressions of the results, and only in very general terms. All research social workers were impressed by the enormous struggles of the families studied. Even when a family was intact and functioned relatively well, the parents often revealed an almost desperate worry about the children, the marriage, money management, and themselves. The families did not see themselves in control of their lives, and the social worker viewed most families as quite fragile and barely hanging on.

Although, in general, we saw struggling families, those that were identified as neglectful and were referred to the study by social service agencies were in far worse straits. Simultaneously, several major problems were seen, only one of which was child neglect. For most families, their own individual needs were so overwhelming that children became only one more worry in a long list of concerns.

During the study, a mother was asked to assess her child's learning ability. Even in making this assessment most mothers in the neglect sample believed their children were average to slow, while most control sample mothers believed their children to be above average. It appears mothers in the neglect sample cannot even allow themselves the pleasure of bragging about their child.

Neglectful mothers frequently could not recall important developmental milestones in their child's life, whereas control mothers almost always could. In fact, 50 percent of the neglectful mothers responded "don't know" or "can't remember" to at least one of three developmental questions. Only 3.8 percent of the control mothers responded similarly. This appears to be another indicator of the neglectful mother's inability to be in touch with her child's life and, indeed, to enjoy his growth and development.

In the neglect sample we see evidence of pathology and social problems which existed in the parents' own families and still continue in this generation. Many neglectful parents were themselves neglected, never having had a parent to nurture them or to provide a suitable role model. Although the pattern of intergenerational neglect is present, it does not account for all problems.

In making preliminary personality assessments, we feel safe in saying that neglectful parents, in particular, evidence character disorders, severe neuroses and psychoses, and mental deficiency. In the control sample we also find these problems, but there is a difference in the intensity and extent to which these traits are exhibited. Analyzing this data to see how significant these differences are is the task currently underway.

In terms of social relationships the two groups report quite differently. The neglect sample ranks very low in social participation. Fewer belong to social organizations or religious groups, they attend fewer activities in the community, and their relationships with others are few and sometimes nonexistent.

Previously, I mentioned that the intergenerational cycle of neglect operates in some families. Confirmation of this is illustrated in our finding that 31 percent of neglectful parents were themselves placed outside their families of origin while only 8 percent of control parents were placed. Overall, 37 percent of our neglect sample currently has at least one child in placement while only 6 percent of the control sample has placed a child. Single mothers in each group are responsible for 80 percent of placements. While it is obvious that single parents must resort more frequently to placement of children, we see a much stronger relationship in the neglect sample between those who were placed in childhood and adults who now place their children.

From our preliminary work we recognize that most neglectful families are those often termed "multi-problem families." Experience shows that work with these families requires long-term intervention. Changing the life pattern of these families is never easy. Even removal of children from their poor home situations does not guarantee the children will become good parents.

In the past there has been a fair amount of discussion about and recognition of the fact that family life has not been given adequate priority. In acquainting ourselves with the families in our study, it is apparent that many family needs are not met. Families who are managing to survive but who desire help (usually counseling or psychiatric help) often cannot get what they need. Sometimes lack of money is a factor, but more often families do not fit into categories prescribed by service agencies.

Although neglectful families were involved with various agencies, the resources required to do the necessary long-term intensive work were not present. When considering that the jobs which rated lowest in complexity in a recent University of Wisconsin study were foster mothers, child care attendants and nursery school teachers, it is safe to say that society's best efforts are not being directed toward helping the most difficult families.

At this point in our research, we cannot say that there is only one cause of child neglect. The causes are many and the solutions take many forms. Knowledge cannot evolve and people cannot be helped to change and grow unless money is allocated for the advancement of theory. Before any discussion about funding further research can take place, we must be convinced that research has a function in social work and do more to convey its priorities. As researchers and social workers we must first be convinced research is necessary, then a priority must be established within the government, within the agency, and within ourselves to insure its successful beginnings and ultimately its dissemination and use. We are only at the beginning of research into child abuse and neglect, so we must realize that many more questions will be asked than answered. Nevertheless, we are obligated to the profession to ask them.

Speaking as a practitioner as well as a researcher, to me the answer to the question is unequivocal: we clearly need more research to guide our practice.

Emotional Abuse

On Defining Emotional Abuse: Results of an NIMH/NCCAN Workshop

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The issue of emotional abuse was the topic of a pre-conference workshop held in conjunction with the Second Annual National Conference on Child Abuse and Neglect, April, 1977, in Houston, Texas. This workshop was co-sponsored by the National Institute of Mental Health and the National Center on Child Abuse and Neglect. The participants were leaders in the fields of child development, mental health, child abuse, and law.

The participants met for two days as a full committee in an attempt to define emotional abuse from the perspective of mental health and child development. Given the projected difficulty of that task, a lower level objective was also stated in which the task was to explore those issues that needed to be clarified before such a definition could be determined.

This report is written so as to reflect the process of the workshop. The overlap and repetition of ideas mirrors the problems that this group had in coming to grips with numerous vital issues.

INITIAL CONCERNS AND VIEWS OF EMOTIONAL ABUSE

Mental health professionals have avoided the topic of emotional abuse. This avoidance is the result of the profusion of seemingly insoluble dilemmas regarding the accuracy of mental health evaluation of children's disorders and the legal restraints which are particularly present in any definition of abuse. Each participant made an initial statement about his or her own picture of these dilemmas. A summary of these ideas is a study in dichotomies. The process of the workshop was then to work with these dichotomies until some resolution could be found.

A primary dichotomy was the issue of definitional scope. Should there be, as some participants advocated, a broad definition of emotional abuse or, as the others advocated, a narrow one? Proponents of a broad definition spoke of service intervention focusing on the protection of the rights of the child. Those favoring narrowness spoke of the criminal aspects of the reporting process and their concern for the protection of the rights of the parents. Ultimately, any definition must serve both of these ideals. For this reason, a distinction was made between the construction of a mental health definition and one for use in the fields of social welfare and law.

A second dichotomy concerned the focal point of this definition—child behavior or parental actions? Should this definition be based on manifestations of mental injury in the child, or should it concern parental actions which are injurious or potentially injurious? In other words, should it be based on (1) the actual observed disturbance in children (i.e., clinical diagnosis of a mental injury); (2) a high likelihood that abuse will occur, given the familial environment; or (3) observed parental behaviors that are clearly abusive regardless of the effect on the child? The major objection to using behavioral manifestations of mental injury in the child as the only basis for definition is that we would then exclude the child who does not exhibit a typical behavior, who remains invulnerable even though victimized by a clearly abusive situation (the Oliver Twist syndrome). On the other hand, if only parental behaviors are considered as the basis for the definition, we are equally limited, for the same reasons. The current state of diagnostic knowledge cannot clearly predict that any set of parental actions will directly cause emotional damage in children. Thus, can such actions in themselves be called abusive? Consensus was that further discussion must consider both parental actions and child behaviors.

With further regard to parental actions, several other dilemmas arose. One concerned the inclusion of acts of commission along with acts of omission. Secondly, the question of intent raised greater debate. While some participants felt that parental intent to injure was a necessary parameter in calling a situation abusive, others felt that it should not enter into our

definition so that abuse of unconscious origin would not be excluded. Simply stated, if we do observe deviant behavior in the child can we, or must we, trace these behaviors back to parental action or inaction? Further, these points were extended to consider whether or not we can distinguish between an environmentally abusive situation in which the family may find itself (i.e., poverty) as opposed to a personally motivated abusive situation.

The need for mandatory reporting of emotional abuse by mental health professionals and its effect on the therapist-client relationship was also seen as a problem for discussion. Some participants felt that mandatory reporting was necessary; others felt that it could destroy a working relationship with the client and would serve no useful purpose for those already seeking professional help. This led to the question of who should be the person who identifies and labels emotional abuse. While it was generally agreed that an evaluation would probably be conducted by a mental health professional, the initial, and often more critical identification of emotional abuse would probably be made by a child welfare worker or other community agent. The implications of who had the qualifications to identify abuse involving mental injury were considered to be a vital issue in the development of any intervention system.

Abuse by society was another important concern. Some participants felt that not only parents, but also society should be held responsible for the abuses in our institutions, such as schools, foster homes, and detention facilities. This includes consideration of the popular feeling that greater abuse often occurs when children are taken out of the home and placed in institutions or foster homes. With current child abuse laws, the identification and reporting of abuse does not necessarily lead to help. Do we want to just identify and label more families and not be able to help them? And, even if we had the resources (i.e., money, staff), do we really have the professional expertise to change emotionally abusive parents into loving parents?

Further, it was felt that any definition of emotional abuse would need to be formulated taking into consideration the system of intervention in which it would be used, in order to safeguard against further abuse by that system. When looking at the current system of intervention in child abuse, some felt that current law is unjustly applied to one segment of society, specifically, the unjust scrutiny and condemnation of the poor. In formulating a definition of emotional abuse, allowance must be made for cultural and class differences to avoid this unjust application of the law.

DISCUSSION OF ISSUES

Following the initial statement of concerns and views of emotional abuse, several of the issues were discussed in further detail. In considering these expressed views and concerns this work group chose to deal only with a clinical mental health definition of emotional abuse and not a legal or social welfare definition. However, after a mental health definition of emotional abuse is formed, consideration must be given to the legal application of such a definition, with its needed safeguards. This clinical definition must also be expanded into the social welfare realm through consideration of the special service delivery systems necessary for its application.

In attempting to define emotional abuse, discussion centered around an examination of the dichotomy between viewing parental or child behaviors. Any definition must recognize the dynamic relationship between parental and child behaviors. It is not just an isolated behavior of parent or child that defines abuse, but rather a balance between parental behavior (taking into account is severity, causation, and duration) and the child's reaction to this behavior. We must therefore look beyond the parental behaviors to their influence upon the behavior of the child. Any behavior alone cannot be looked upon as a sign or symptom of emotional abuse, but must be looked at as part of an interrelational system between parent and child.

With these safeguards in mind, parental behaviors which might result in mental injury to a child were listed including both acts of commission and omission (Appendix I). As it was being constructed the list began to look like the outline of a lecture on child pathology. This fact further strengthened the impression that such behaviors alone do not constitute emotional abuse. In an attempt to define emotional abuse we had indeed "reinvented the wheel" of assessing the developmental dynamics between parent and child. It then follows that, when defining emotional abuse, the severity and causation of these behaviors must be considered. In addition, the matter of patterning and the repetition of behavior are important considerations. It is also necessary to consider both the timing and the developmental context of these behaviors. For example, a parental behavior may be identified as abusive with a child at age 6 but not at age 12; for a boy but not for a girl.

The concept of intent to cause injury was discussed at length. Cases of accidental or incidental physical injury—unless related to gross neglect—are not seen as being the result of

abuse. The current concept of abuse is described by the term inflicted injury. The intent to harm or injure, whether for punishment or in anger, is necessary in the definition. If this concept is extended to mental injury, the observer would have to prove that a parent had intended to harm or injure before a diagnosis of emotional abuse could be made. However, the causality of mental injury is not as direct as with physical injury, and intention is not often visible as a desire to cause mental injury. It was, therefore, decided that parental intent must be excluded from a definition. When intent could be demonstrated it would be important diagnostically, but its absence could not be similarly used. For example, when a parent displays severe and repeated scapegoating behavior that leads to severe depression in the child, the situation is emotionally abusive regardless of whether or not the parent intended to be abusive toward the child.

Attempting to list child behaviors which might indicate that these children are victims of emotional abuse proved to be an even more difficult task than the listing of parental behaviors. It seemed that the best way to link child behaviors to commissive and omissive parental acts was by assessing the impact of the magnitute of parental behaviors (Appendix I). Again, it must be remembered that these child behaviors serve only as tools to help in assessing the dynamic system between parent and child. It is necessary to look at these behaviors within the context of the developmental stage of the child to allow for the exclusion of transient or age-appropriate symptoms. Allowances must also be made for the invulnerable child who does not exhibit any atypical behavior even though exposed to what is considered a clearly abusive situation. We have all come in contact with children who appear to be living in intolerable conditions but do not seem to exhibit any atypical behavior. So again it seems that we cannot direct our definitions to either child or parental behaviors exclusively.

Therefore, the balance between parental behaviors of sufficient duration and intensity and child psychopathology that could be attributed to these observable parental behaviors was seen as an essential element of any clinical definition of emotional abuse. The strength of the causal link between parental action and child behavior must be brought into perspective. This definition must distinguish between emotional problems in children to which we can find some causal parental relationship, and emotional abuse. Otherwise, a case could be made that every disturbed child who walks into a mental health center is emotionally abused.

We cannot just observe the child and/or parental behaviors. Instead, we must examine the severity, duration, balance, and causation of parental behaviors, taking into account the environmental conditions surrounding the family. Only in this way will we be able to distinguish the invulnerable child, the emotionally ill child, and, most importantly, the emotionally abused child.

From the discussion above, the group attempted to set forth, for discussion, a definition of mental injury as the basis of emotional abuse with due consideration to the needs of the child and the rights of the parents. This definition included actions by parents which cause or permit mental or psychological injury or abnormality in a child, and was stated: *"An injury to the intellectual or psychological capacity of a child, as evidenced by an observable and substantial impairment in his or her ability to function within his or her normal range of performance and behavior with due regard to his or her culture."* In discussion, however, this definition of emotional abuse was found to be deficient. While it met the needs of the mental health professional, it was too broad to fit certain legal constraints, namely the rights of the parent and the best interest of the child. In order to include both mental health and legal concerns, a dual set of definitions was proposed. This two-level definition would help to allow for a broad area of service intervention at the same time allowing for a narrow area of legal intervention to protect the rights of the parents and to insure the best interests of the child.

Our present system of managing abuse and neglect does not allow for the flexibility required by a two-level definition of emotional abuse. Therefore, a process must be developed for implementing this definition through evaluation and intervention while at the same time attempting to safeguard against the possible negative consequences of this intervention. This intervention system must also be a two-level system which will serve to operationalize the two-level definition of emotional abuse.

TWO-LEVEL DEFINITION AND SERVICE SYSTEM

A primary principle in the definition of emotional abuse and neglect appears to be a two-level definition integrated into and made operational by a two-level service system. Throughout the workshop, as presented above, the need for these two levels was pervasive.

As stated earlier, a two-level system for defining emotional abuse appears to be the best way to allow for maximum service intervention with minimal legal intervention. Through this

type of system, mental health services could be offered to many families, with legal intervention used only as a last resort.

It was felt that the evaluation of the mental health aspect of the definition should ultimately be made by a mental health professsional. This professional would take the issues mentioned above, such as the nature and severity of both parental and child behaviors, and put them in the context of cultural norms as well as extenuating environmental conditions of a familial situation. Any decision regarding emotional abuse would require evaluation of past, present and future treatment intervention for the family, including any past treatment attempts the family may have made or is now making. In the decision to diagnose, one must ask what types of resources are available or will be available to a family labeled "emotionally abusive."

The need for a broad definition to include all these considerations is clear. However, it was readily admitted that the initial, and perhaps more important, evaluative decision would most often be made by the child welfare worker who first comes in contact with the family. And, further, our present protective service systems are not flexible enough to accept such a broad definition without the high probability of negative consequences of the evaluation and intervention, and the alienation of parental rights. Therefore, a newly designed intake system must be designed, modeled to fit the need for both a broad definition and protection of parental rights.

The mental health definition of emotional abuse and a system of service delivery that allows us to operationalize this definition must be created concurrently, relying on the identification of certain service elements within the community to offer aid to emotionally abusive families. The first level would be a non-judgmental intake system based on the evaluation of child development in relationship to parental actions—a mental health level.

The second level of this system would require community intervention at a legal level and would be reserved primarily for families who are uncooperative at the mental health level or for those situations requiring immediate controls. It is here that a narrow definition of emotional abuse—one that would require community intervention into family life—would be used. This definition would demand a legal setting for evaluation. The choice of the legal evaluator is not easy. The present court system could serve this purpose. Our judicial system offers certain options for intervention which range from court-ordered observation of the family to termination of parental rights. However, with each step there must be time for mental health consultation and evaluation, taking into consideration the family's reaction to intervention. Some argue that our present system cannot handle emotional abuse and, instead, legal evaluation regarding intervention should be based on community standards. Perhaps community standards setting can be seen as more just, in that it would allow for cultural and social economic influences. A community-based committee to set standards would hopefully help to safeguard against the discriminatory judicial application of current child abuse laws. A third alternative is the introduction of a community-based committee into court procedure.

In an attempt to operationalize some of the current concerns at the mental health and legal levels, a model system for reporting , evaluation and intervention was presented by Lauer and Hall (Appendix II). The model shows that we are first and foremost concerned with providing services to the family at the mental health level. However, if the family refuses to cooperate at this level, a system of legal intervention must be invoked. This legal system hopefully serves to persuade the family to accept mental health treatment. The system allows for time to evaluate the treatment progress of the family and to assess any changes that may be occurring in the parent-child relationship. Through the system of legal intervention both the rights of the child and the parents are preserved. It is only as a final step, when all other forms of intervention fail, that severing of parental rights is considered.

RECOMMENDATIONS

Time constraints did not allow for a further discussion of the definition of emotional abuse, nor the process by which this definition would be implemented. However, through the presentation of current concerns and views of emotional abuse, a discussion of the issues that must be considered in attempting to define emotional abuse, and an examination of a two-level definition and service system for emotional abuse, recommendations for defining emotional abuse were generated. They are:

1. Emotional abuse and neglect must be defined by the mental health professional.
2. The definition of emotional abuse and neglect must be determined on two levels: clinical and legal.

3. The definition must take into consideration the service system in which it is used.
4. A new intake, investigation, and service procedure must be developed to handle emotional abuse cases differently than physical abuse and neglect cases.
5. The reporting of emotional abuse and neglect should not interfere with treatment families may be already receiving.
6. Reporting must not be discriminatory by race or social standing.
7. Institutional and societal abuses must be considered.
8. Federal funds should be made available for training and research into the impact of emotional abuse and neglect statutes.
9. NIMH and NCCAN should follow up on this work group by holding further meetings and by attempting to change federal standards.

The opinions expressed are those of the authors and do not necessarily reflect the official policy of the National Institute of Mental Health and the Department of Health, Education, and Welfare.

APPENDIX 1

Parental Behaviors Which Threaten Mental Injury to a Child

PARENT BEHAVIOR	CHILD BEHAVIOR	
ABUSIVE IF CONSISTENT GROSS FAILURES TO PROVIDE	TOO LITTLE	TOO MUCH
1. Love (empathy) (Praise, acceptance, self-worth)	1. Psycho-social dwarfism, poor self-esteem, self-destructive behavior, apathy, depression, withdrawn	Passive, sheltered, naive, "over self-esteem"
2. Stimulation (emotional/cognitive) (talking-feeling-touching)	2. Academic failure, pseudo-mental retardation, developmental delays, withdrawn	Hyperactivity, driven
3. Individuation	3. Symbiotic, stranger and separation anxiety	Pseudo-maturity
4. Stability/permanence/continuity of care	4. Lack of integrative ability, disorganization, lack of trust	Rigid-compulsive
5. Opportunities and rewards for learning and mastering	5. Feelings of inadequacy, passive-dependent, poor self-esteem	Pseudo-maturity, role reversal
6. Adequate standard of reality	6. Autistic, delusional, excessive fantasy, primary process, private (unshared) reality, paranoia	Lack of fantasy, play
7. Limits, (moral) guidance, consequences for behavior (socialization)	7. Tantrums, inpulsivity, testing behavior, defiance, antisocial behavior, conduct disorder	Fearful, hyperalert, passive, lack of creativity and exploration

8.	Control for/of aggression	8. Impulsivity, inappropriate aggressive behavior, defiance, sadomasochistic behavior	Passive-aggressive, lack of awareness of anger in self/others
9.	Opportunity for extrafamilial experience	9. Interpersonal difficulty (peer/adults), developmental lags, stranger anxiety	Lack of familial attachment, excessive peer dependence
10.	Appropriate (behavior) model	10. Poor peer relations, role diffusion, (deviant behavior, depending on behavior modeled)	Stereotyping, rigidity, lack of creativity
11.	Gender (sexual) identity model	11. Gender confusion, poor peer relations, poor self-esteem	Rigid, stereotyping
12.	(Sense of) (Provision of) security/safety	12. Night terrors, anxiety, excessive fears	Oblivious to hazards and risks, naive

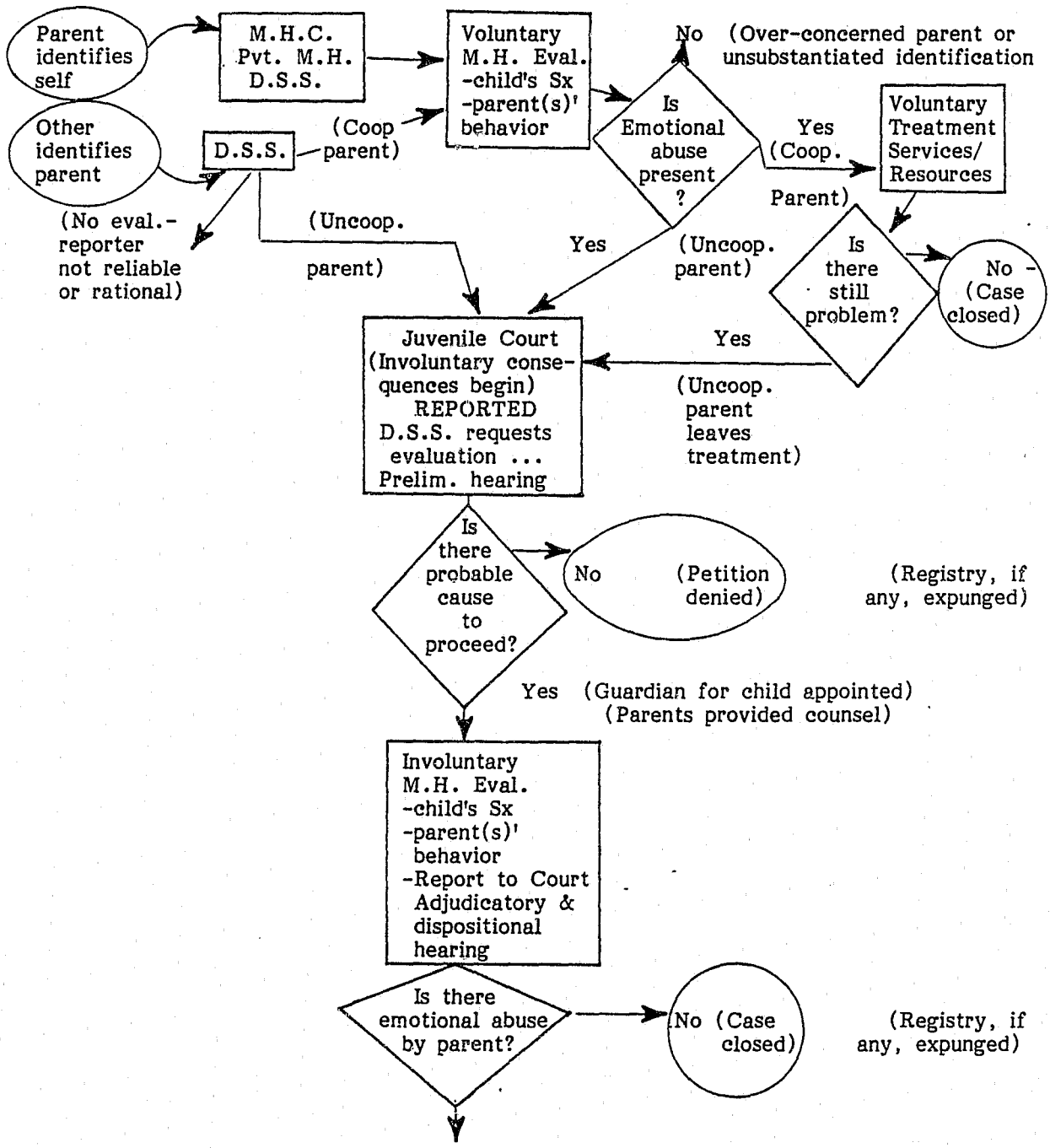
ABUSIVE IF PRESENT TO A SEVERE DEGREE

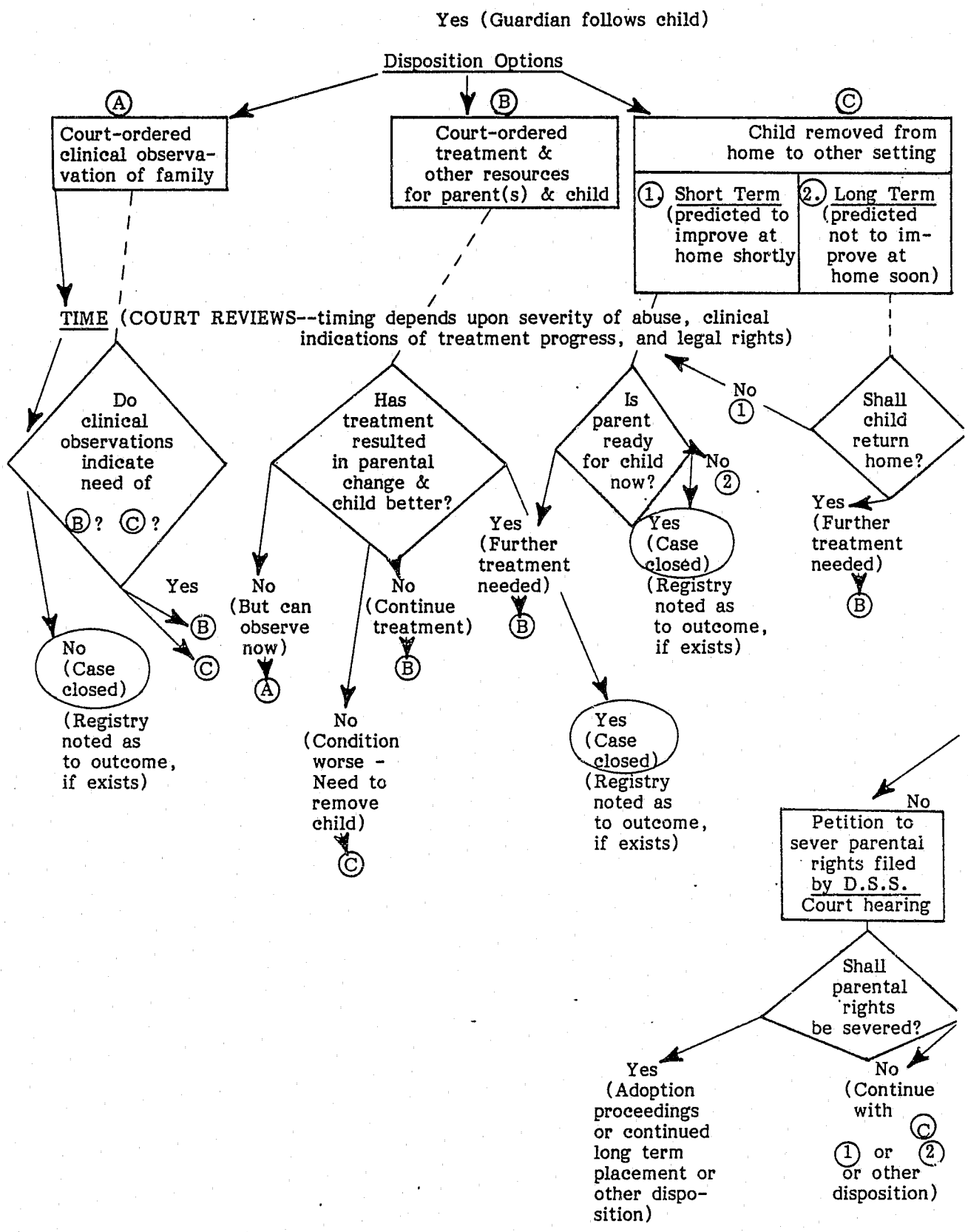
1.	Scape-goating, ridicule, denigration	1.	Poor self-esteem, depression
2.	Ambivalence	2. Rigidity	Lack of purpose, determination, disorganization
3.	Inappropriate expectation for behavior/performance	3. Poor self-esteem, passivity	Pseudomaturity
4.	Substance abuse	4. (Depends on behavior while intoxicated)	
5.	Psychosis	5. (Depends on behavior/type/frequency)	
6.	Threats to safety/health	6.	Night terrors, anxiety excessive fears
7.	Sexual abuse	7.	Fear, anxiety, withdrawn, pseudosexuality, hysterical personality
8.	Physical abuse	8.	Sadomasochistic behavior, low self-esteem, anxiety, passivity, anti-social behavior, self-destructive dangerous behavior
9.	Threatened withdrawal of love	9.	Anxiety, excessive fear, dependency

10.	Shaming	10.	"Lack" of superego, conscience — Excessive superego, self punitive
11.	Exploitation	11.	(Depends on behavior/frequency)

APPENDIX 2

Example of a System/Law
Developed by Lauer and Hall




Yes (Guardian follows child)
Disposition Options
A
Court-ordered clinical observation of family
B
Court-ordered treatment & other resources for parent(s) & child
C
Child removed from home to other setting
1. Short Term (predicted to improve at home shortly
2. Long Term (predicted not to improve at home soon)
TIME (COURT REVIEWS--timing depends upon severity of abuse, clinical indications of treatment progress, and legal rights)
Do clinical observations indicate need of B? C?
Yes
B
C
No (Case closed)
(Registry noted as to outcome, if exists)
Has treatment resulted in parental change & child better?
No (But can observe now)
A
No (Continue treatment)
B
No (Condition worse - Need to remove child)
C
Yes (Further treatment needed)
B
Is parent ready for child now?
No
2
Yes (Case closed)
(Registry noted as to outcome, if exists)
No
1
Shall child return home?
Yes (Further treatment needed)
B
Yes (Case closed)
(Registry noted as to outcome, if exists)
No
Petition to sever parental rights filed by D.S.S.
Court hearing
Shall parental rights be severed?
Yes (Adoption proceedings or continued long term placement or other disposition)
No (Continue with C 1 or 2 or other disposition)

Emotional Neglect of Children

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Of all situations confronting those who work with children, perhaps the most difficult to deal with is emotional neglect. Physically abused children can be identified more easily because of the signs of physical trauma they often bear. With increasing visibility of children's problems over the past five to ten years, more adults are willing to report physical abuse to the authorities. Those who work in the child protective field know, however, that even reports of physical abuse frequently are difficult to substantiate. Often a neighbor may observe a physical assault on a child, but later investigation reveals no outward evidence such as bruises, broken bones, or lacerations, and in situations like these, child abuse often is not found.

The protective service worker investigating such a report, however, all too frequently finds severe family dysfunction, that parents and child are having family problems. These parents frequently feel inadequate, and may handle their child or children inappropriately in ways which are, if not actually harmful to the child psychologically, at least not conducive to the child's maximum psychological growth.

Even when abuse is substantiated and clearly evident, the child rarely suffers only physical abuse. What usually accompanies the parent's physical abuse are angry shouts such as: "You dumb idiot, you never learned not to spill the milk!"; "You never listen to me. I have to teach you how to listen!"; "You're thick headed. You're pig headed, just like your father!"; "Stop crying! Don't you know all the neighbors will hear you? Stop crying! If you don't stop crying this instant, I'll give you something to cry about!"; "I have never seen such a pig sty! I have told you 75 times to clean up your room! You never do what you're told! You are a lazy slob!"; and, "I have to spank you to teach you how to behave!" Endless examples can be added, and usually this emotional abuse is continuous. Sometimes it is more subtle. There may be no shouts or reprimands, but a withholding of emotional warmth, which also stultifies the child.

In hearing about abusive parental behavior, we learn that parents who physically abuse their children feel poorly about themselves, lack conviction of their own self worth, were treated in the same fashion when they were children, have poor impulse control, learned violent ways of expressing themselves, are easily enraged, and cope poorly with stress. Parents who emotionally abuse their children are basically the same kind of persons. They may have greater control over physical impulses or, for some reason, what they learned early in life was not a physical expression of violent feelings. Basically, the psychological pattern is, however, extraordinarily similar.

It is rare to find a physically abused child who also has not suffered severe emotional trauma or abuse. As with physical abuse, emotional abuse runs the gamut from children who suffer such severe emotional damage that they withdraw into schizophrenic isolation, to very mild forms of emotional disturbance which may never find their way to the nearest child guidance clinic or family counseling agency.

Since no one knows how prevalent emotional abuse is, one can ask if it is important enough to require action. In many communities the definition of child abuse covers the broad spectrum from emotional neglect to physical abuse, with emotional abuse almost as an afterthought, often under the umbrella concept of "child neglect." Most public welfare agencies investigate reports of physical abuse and neglect as well as emotional abuse, and generally the numbers seem to run 2-1 or more in favor of neglect. That is, for every case of physical abuse, two cases of neglect are reported. Also, many cases not substantiated as physical abuse are substantiated as neglect or emotional neglect. Public agencies, therefore, delegated with the responsibility to receive mandated reports, experience problems in identifying and legally substantiating emotional neglect, and then deciding what to do about it.

Since we know emotional and physical abuse are based upon an intergenerational cycle, where children, in a sense, catch this disease at their parents' knees, how then can we intervene? Additionally, that which is regarded as emotional and physical abuse is relative to the community. Within a state, that which is considered abuse may differ in rural and urban areas. As with physical abuse, emotional abuse respects no socioeconomic class.

I attended a recent workshop devoted to identifying emotional abuse of children in which workshop participants, almost all of whom were direct service providers, found great difficulty in distinguishing between emotional disturbance and emotional abuse. The emotionally abused child was not easily distinguishable from the emotionally disturbed one. Once a child is hurt, the parent becomes the key factor in deciding whether the situation is reportable; that is, when the emotional disturbance is pointed out to the parent, perhaps repeatedly, and the parent refuses to remedy it despite support, then he or she may be reported as being emotionally abusive. However, community psychiatric clinics, child guidance clinics, and family agency waiting rooms are filled with people who, sometimes in spite of themselves, raise their children as they themselves were raised, and now have emotionally disturbed children. These children have been subjected to emotional abuse, almost none of which was inflicted maliciously or deliberately by the parent or caretaker. Given these parent's own feelings of inadequacy from lack of adequate nurturing when young, coupled with the increasing stress of today's life, we have an increasingly severe situation regarding the child's mental health.

How then can we identify emotional disturbance? We must carefully assess the child's psychological, physical, and social development, the parent-child relationship, and how the family functions. It may be that protective services can only help in extreme cases.

Society today is reluctant to intervene with families which may use objectionable methods to raise children, and mild abuse often may occur due to this reluctance. Certainly, we cannot say, "We know better" to each family where we suspect mild dysfunction exists. A careful line of distinction must be drawn between a family which is moderately dysfunctional and one in which a child desperately needs help and protection of rights.

Although passionate feelings such as horror and rage are more likely evoked with physical rather than emotional abuse, parental outrage at being reported and "investigated" for emotional abuse are factors with which to contend. Parental hostility and resistance often make it impossible for them to accept any services offered. Lest you think emotional abuse of children is less damaging than physical abuse, and that society has no right to protect children from such nonphysical violent behavior, I refer you to research documenting the permanent, damaging effect of early parental emotional deprivation on human beings and other mammals.

Maternal deprivation means many things, and there may be some who say, "Why not talk about 'paternal' deprivation as well?" It is because for most mammals, the mother must care for the infant until it becomes somewhat self-sustaining. It is the mother who nurses, washes, and grooms the kittens until they can drink from a bowl or find their own mice. In any case, it certainly is true that human fathers can give the same kind of loving care to an infant, and certainly with regard to human children it is clear "parental" can be substituted for "maternal" deprivation. A father who provides the same loving, tender care to an infant would not eventually raise a damaged child just because he was not a "mother." The high suicide rate among adolescents and young adults is related directly to their earlier emotional deprivation, just as juvenile delinquency has a direct relationship to early childrearing practices. As with physical abuse, emotional deprivation has serious, life-threatening, long-range, and irreversible effects on the emerging person.

I want to cover briefly some ways we hurt children through a system designed ostensibly to help them. Two systems commonly used are the juvenile or family court, and foster care. These systems are related closely to problems of abuse and neglect since a child cannot be removed to a foster home without court approval. Although sometimes useful, foster care can be a source of additional and severe emotional abuse to a child. It is important, therefore, for the local department of social service and local courts to coordinate efforts, for judges to acquaint themselves with departmental procedures and views concerning the removal of a child from his home, and also for the court to devise methods to support the department in its efforts to maintain the family with needed, supportive, continuing services. It equally is important that social workers learn how to conduct themselves in court, what constitutes admissible evidence, and how to gather material and present it persuasively. Judges are, like all of us, victims of their culture. Sometimes a local department seeks court intervention in order to provide a period of watchful waiting with a family. Sometimes it wants the judge temporarily to remove a child, and yet hopes the child will be returned home if the family cooperates with the local department in resolving some of their problems and improving their functioning. You can view this as "constructive coercion." Sometimes the local department wants the court to uphold the decision to remove the child to foster care for an indeterminate time period, or requests the court to permanently remove a child from his home, to terminate parental rights, and to declare the child a ward of the state so that release for adoption can be effected.

Removing a child to a foster home can be a very traumatic, abusive experience for the child even if his or her own home was, by community standards, inadequate. It was the child's own home with parents the child loved, whether they were "good" or "bad," a home where the child understood some of what was expected, and had a rough idea of what would be likely to happen as a result of certain behavior. The meaning of the attachment between a child and his or her parents cannot be underestimated. When we break that attachment we risk serious psychological damage to the child.

Additionally, children have their own built-in time sense and perspective. Something which seems passing to us may seem lengthy to an infant. For a slightly older child (a toddler), a week seems more like a month. We must think in terms of the child's time frame. What we perceive as "short term foster care" (i.e., six months) for the child can be a significant part of his or her experience, where significant, new emotional ties are formed. If they must leave that care, they will again suffer deprivation from the loss of emotional ties they formed. A child under six years, in foster care six months, may have lived away from home for a significant proportion of his or her life. Upon returning home, he or she now has lived in three homes. That can be a very difficult experience, and the ability to form positive relationships with others, even if good to start with (which is unlikely), is now damaged.

Children are not adults, and we must remember their emotional capability differs greatly from adults. They cannot give rational form to or reach conclusions about their difficulties. They respond to threats to their emotional security with increased anxieties, or they distort their reality while pretending it is not true. How often do you hear a very small child on his or her way to some unpleasant experience reasuringly talk about how it is not really happening? Parents sometime share this inability to cope with stress by doing the same thing. Sometime parents "pretend that it is not so" to a child. Parents who feel anxious about their child having his tonsils taken out, for example, will say that they are going to visit "Aunt Martha." With both child and adult this sometimes is viewed as lying, and seen as a most undesirable characteristic. It is, however, a response to stress and an attempt to make an unmanageable situation more manageable. Lying, or other behavior, always serves a function, and to be helpful we must understand its function, rather than unthinkingly criticizing the particular symptom. The difficulty children experience in foster care emanates from their need for permanency and the damage they suffer as a result of broken emotional ties.

Taken from their own homes, children experience feelings of shame, guilt, and confusion, and tend to express this through defiance and anger. They become mistrustful. Most children, removed from their homes because of the danger there, think they are being punished. No matter how well prepared the child is for placement—and often a protective placement allows for little or no preparation—separation from parents is traumatic, and children will utilize, as do all of us, whatever defenses they have to shield them from this very painful experience.

In placing children, therefore, it is very important to allow them as free and full expression of feelings as possible. As adults, we often have difficulty seeing a child in pain and try, therefore, to convince the child and ourselves that it really is not happening. Children take their cues from adults, and quickly learn to suppress unacceptable feelings. These subsequently may be expressed in other forms, such as hostility, bed wetting, stealing, and other symptoms. Children, for whom society decides placement is needed, already are the victims of situations where they could not develop good coping mechanisms. Therefore, their ability to deal with the pain of placement is minimal.

The way most foster care homes are organized results in children being unable to develop healthy psychological traits. Most agencies make it clear to foster parents that having a foster child is only temporary. Sometimes foster parents must sign contracts in which it is clearly stated the child can be removed at any time, either by the agency or at the foster parents' request. Foster parents, therefore, go into this relationship knowing the tie eventually will be broken. Usually, a background of shared experiences with a child develops parental tolerance and devotion which helps parents and child weather rough spots during growing years. This is unavailable in foster family situations, therefore making it difficult for foster parents to invest themselves in a warm, giving relationship, especially during the initial, rough, testing period. The older the child, the less endearing he or she will seem to foster parents. The older child will have had more opportunity to develop undesirable characteristics as a result of living longer in a difficult, nonnurturing environment. Therefore, no matter how kind and generous foster parents are, there is something inherent in this situation which results in a very tenuous relationship. This relationship may barely meet the child's incredibly complex needs for permanency, consistency, and love. Also, if the biological parents visit the foster home, it becomes even more

complicated for the child to relate and react to two sets of parents, and then feelings of loyalty and disloyalty are activated which sometimes paralyze the child's ability to function. Children's developmental needs can thus rarely be met adequately by foster care placement.

Special situations exist in which foster care obviously is the best answer, such as when a child's life is endangered either by physical or emotional abuse. However, in order to avoid further institutional abuse and neglect early and permanent planning should be completed, so that parent, foster parent, child, and worker can all know what lies ahead. Only in this way can chances for further emotional abuse be minimized. Foster care should only be a last resort. All efforts should be made to make the child's natural home more protective.

Considering all this, therefore, if a home can be made safe and if the parents can be helped in some way, it is preferable to leave the child at home with careful supervision and continual, supportive help. Economically and psychologically, it is less expensive to provide this service to a family, even over several years, than to provide foster care service. It also is cheaper to provide outpatient psychiatric care, which many of these children seem to need.

The second best alternative is short-term foster care with natural parents closely involved with the placement, and working hard to become more protective and nonabusive, followed by the child's return home with continual supervision and careful counseling. If a child must be removed permanently, the quicker he or she can be released for adoption and placed in an adoptive home, the better. However, this is not a reality for many cases. Many courts will not terminate parental rights quickly, even when the evidence proves this is in the child's best interest.

Many children are too old or too disturbed to be adoptable. However, if long-term foster care is necessary, the foster parents should know this and be committed to retain the child on a long-term basis or permanently, and encouraged to invest themselves in helping raise the child as their own. This obviously is not as good as a child's natural home, but at least everybody knows what to expect. Also, there is no expectation that the child will return home, thereby abruptly breaking another relationship in its formative stages, and so the foster parents can invest themselves in the relationship.

In working with emotionally abused children, one must never forget that parents, too, are vulnerable people and often need help. Supportive services necessary for physically abusive families are necessary also for emotionally abusive families. Upon hearing case presentations, consultants often realize families seem unskillful in parenting techniques, and sometimes the suggested remedy is to "teach" parents how to be more effective, using demonstrations, parent education courses, parent effectiveness training groups, and other instructional programs. All these programs can be useful for a certain group of persons. However, to parents who already feel inadequate and incapable of parenting, and who do such a poor job that their children are damaged, such attempts usually succeed only in convincing them of their inadequacy. When a parent cannot hold a crying child because of feelings of revulsion or helplessness, to tell him or her: "Oh, why don't you pick him up and cuddle him? Let me show you how," is to say subtly, "You are an inadequate and helpless parent, and do not know how to care for your child."

Selma Fraiberg of the University of Michigan has worked on an infant mental health study and demonstrated an effective technique of "reparenting parents" rather than teaching them how to be more effective parents. Reparenting is not teaching parents more parenting skills, it is empathizing with parents who cannot hold a crying child because they had no one give them attention when, as children, they cried. You talk with parents about their feelings of helplessness and rage when no one hears their cry, when no one responds to their pain. It is a careful, skillful way of helping parents. It can be more effective after a child has been emotionally abused to suggest, for example, a day care center for the child, not on the basis of being better for the child but because it gives the parent an opportunity to do something he or she likes and wants, which would gratify his or her needs.

People who have their needs gratified are better able to gratify another's needs. A person sometimes can be a better part-time parent when he/she is not constantly at the beck and call of a child with whom he/she feels inadequate. But to suggest day care placement for a child's own sake sometimes can turn off parents to the extent that they no longer want to listen. Suggesting that a homemaker help a parent cope with children is more effective if the homemaker is viewed as someone who will not simply shuffle off the kids to school each morning, but instead help the mother feel better about herself, and assist her.

Casework or psychotherapy will not be effective if the client is approached from the point of "teaching" him or her how to be better. Only if they are approached with skillful understanding, compassion, and a willingness to allow the parent to become dependent in order to

relive some of his or her childhood deprivations can social workers or therapists successfully accomplish their goals. Social workers have long been taught they must not allow their clients to become dependent on them, that this will engender lifelong dependence and helplessness. Dependence and independence are relative, and people who are incapable of functioning independently did not become so because a professional "fostered" their dependence. The professional may need to use this dependence to help parents become independent, and this is not done by rejecting dependent needs, or by telling them their dependent needs and demands will not be tolerated. Allowing clients to test the professional's concern, and the worker's willingness to deal with parental dependence needs sometimes can help them improve better and faster. This is better than telling them, at the beginning, that dependence is something that will not be tolerated.

SUMMARY

Children who suffer emotional neglect or abuse are the hurt children of hurt parents. We must identify and help these children and their families whenever possible, because damage caused by emotional abuse is devastating and can affect the child permanently. The complex issues involved in defining emotional disturbance and emotional abuse may be resolved in terms of parental response to the identification of the problem: that is, emotional abuse occurs when a parent refuses to recognize or obtain help for a child's identified emotional disturbance. Family assistance should be planned carefully, and children should only be removed from their homes when life-threatening situations occur, since the removal may be more damaging than remaining in an unsuitable home. Homemakers, supportive casework services, referral for psychotherapy, day care, and special education programs may all be appropriate forms of intervention, and should be coordinated carefully.

Emotional maltreatment is perhaps one of the most difficult areas to define. Do we label this as some definable or indefinable harm to a child? Do we mean there exists some specific gap in the parent-child relationship or some defect or problem of the parent? Should this be a "reportable offense?" If it is, we need careful means of assessing individual situations and, even more, a way of "preventing" the crime and intervening in such a way that further "offenses" will not be committed. The range of parenting behaviors must be explored, and societal values clearly perceived in order that parents can be encouraged to raise children in accordance with these values.

Child Neglect

Neglect—Is It Neglected Too Often?

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This is the question with which we will deal: "Is neglect neglected too often?" This is similar to the man who was asked, "How is your wife?" and answered, "Compared with what?" The logical comparison for neglect is with "abuse," and the question can be reformulated, "Is neglect neglected too often as compared with abuse?"

As I see it, a review of the relevant material results in a resounding and unequivocal answer: yes, neglect is neglected far too often as compared with the attention and focus given to abuse.

State abuse and neglect reporting laws reflect this: for many years every state required the reporting of abuse. For a long time, however, many states did not require the reporting of neglect, and as of April, 1977, three states still do not require neglect to be reported.

The literature which reflects what is being studied, discussed, researched, and practiced overwhelmingly reflects this. A conscientious tally of publications over the last 10 years shows 19 books published on child abuse. By contrast, only three books were written on child neglect—and all by the same authors, Norman Polansky and his colleagues. This is roughly a 6:1 ratio in favor of child abuse.

Periodical literature is even more heavily weighed in favor of abuse as compared with indifference to neglect. The *Journal of Clinical Child Psychology*, for example, offered a special issue on child abuse (Spring, 1975) but not on neglect. In special issues of *Children Today* (May, June, 1975) devoted to child abuse and neglect, six of 10 articles exclusively focused on abuse. The other four are concerned primarily with abuse although they devote some consideration to neglect. As a consequence of the preponderant concern with abuse as compared with neglect, the Library of Congress has a special entry for abuse but not for neglect.

A review of the latest available Child Abuse and Neglect Research Projects and Publications (May, 1976) also shows an equally unbalanced listing of projects and publications concerned with abuse.

There is, in recapitulation, no index which one sensibly can employ to assess the time, energy, and resources devoted to abuse and neglect, and which does not confirm that abuse receives the overwhelming share of such time, energy, and resources.

The present conference program, once again, reaffirms the preponderant concern with abuse. Twenty-two different panels or workshops are concerned exclusively with abuse in one form or another. Only two workshops or panels are concerned exclusively with neglect—a 11:1 ratio in favor of abuse.

It might be argued that this unbalanced, lopsided state of affairs is justified—justified on the basis of the number of children affected by abuse as compared with neglect, and by the greater seriousness of the problem of abuse. However, the argument can be proven incorrect.

Every statistic we have available shows many more children are affected by neglect. Our most recent comprehensive national statistics are published by the National Clearinghouse on Child Abuse and Neglect which collates reporting statistics from each state. "Highlights of 1975 National Data," made available by the Clearinghouse in February, 1977, showed twice as many cases of neglect were reported as compared to abuse. The report says this 2:1 ratio in favor of neglect is biased to show a lower than true ratio because many states do not require neglect to be reported. It also shows that New York has a 5:1 ratio for neglect vs. abuse, and a 6:1 ratio in Michigan.

A 1976 report by the Standing Committee on Health, Welfare, and Social Affairs to the Canadian House of Commons shows a 7:1 ratio in favor of neglect.

It is difficult to demonstrate that neglect is a more serious problem than abuse considering the severity of harm inflicted. If one considers the number of fatalities as the most severe manifestation of harm, then an attempt can be made to demonstrate the severity of neglect. The National Clearinghouse Report published in October, 1976, shows that 631 children died in 1974 due to abuse; no comparable figures are given in the 1975 reports. By contrast, nobody has tallied the number of children who died due to lack of proper medical care, or who

fell out of windows or down stairs, or ingested poisonous substances, or were hit by cars—all because parents neglected to take reasonable precaution and care.

In contrast with the 631 child abuse fatalities reported by the National Clearinghouse in 1974, one could list the unnecessary fatalities caused by community neglect of infant needs. Our national infant mortality rate is higher than many other countries, and varies from state to state within the United States. In 1975, a U.S. Public Health Service report, "Reducing Infant Mortality: Are We Doing Enough?" noted that, "If every state in the nation had achieved the infant mortality rate as reported by the best states in the period 1968-1970, 53,000 infant deaths in that two-year period could have been prevented." About 26,500 preventable deaths occurred each year, not because of deliberate abuse but by community neglect to provide mother and child with necessary nutritional and medical care; 26,500 neglect fatalities as compared to 631 abuse fatalities. If countered by the well-worn "tip of the iceberg" argument, the argument is applied equally to possible statistics on neglect. In both cases, this may be the tip of the iceberg. The neglect iceberg is likely to be, however, considerably larger than the abuse iceberg when both are uncovered fully.

If a greater number of children are affected more severely by neglect while more time, energy, and resources are devoted to abuse, this raises another question. Since we are concerned with the sociology of social problems, why, and at what point in time do some conditions achieve community concern?

Durkeim once said, "An action shocks the community conscience not because it is criminal but rather it is criminal because it shocks the community conscience." We do not reprove it because it is a crime, but it is a crime because we deplore it. The objective situation may not have changed, only our perception of it—the subjective condition—changed.

Anyone who worked in the ghetto areas in the 1930s knew that drug use, particularly of marijuana (then called reefers), was frequent. Anybody working in these areas in the late 1940s and early 1950s knows poverty was a problem. Both "drugs" and "poverty" were "discovered" by the general community in the 1960s and only then became "social problems."

The objective reality regarding child abuse did not change much before the discovery of the "battered child syndrome" in the early 1960s. Child abuse was "discovered" before the late 19th century, and a whole network of child protective agencies were concerned with this problem long before the "battered child syndrome" emerged. The Children's Division of the American Humane Society published pamphlet after pamphlet and books were written about child abuse, but nobody appeared to listen. No fewer children were battered in the 1930s-1950s than in the 1960s and 1970s. Why the recent surge of interest in abuse?

It seems many factors fortuitously converged to supplement and reinforce each other, and helped explain the emergence of child abuse as a social issue of importance in the late 1960s and 1970s. Some of these factors are:

1. While child abuse and neglect was previously the primary concern of social workers, child abuse was rediscovered by the medical profession in the "battered child syndrome." The problem of child abuse, separated from neglect, then received sponsorship of a much more prestigous and politically powerful profession. Child abuse has medical implications and components; to a far less degree, so does child neglect;
2. Child abuse is more dramatic, more easily identified, and more easily defined than child neglect. The justification for community intervention is easier to defend in the case of child abuse, and opposition to such intervention is less intense.
   We are both repelled and fascinated by violence. We oppose it yet the mass media believe it provides the most compellingly interesting news. As contrasted with neglect, abuse involves much greater public affect and reaction;
3. The "battered child syndrome" emerged about the same time the children's rights movement began growing in strength. Support for child abuse legislation and programs also increased since such activity is interrelated with the ideology of the children's rights movements;
4. Child abuse provides an issue about which the community feels it accomplishes something significant for children at low cost to the community budget. Accurate cost estimates involved are difficult to obtain. It is estimated, however, that all child abuse problems funded by federal money has involved the expenditure of about $20 million. A serious attack on child neglect, which frequently involves

problems resulting from inadequate family income and resources would involve, in all likelihood, much higher public expenditures;

5. No vested interest group opposes child abuse legislation and activity. Nobody opposes taking action against child abuse.
   Emerging under the auspices of prestigous professional groups and being low cost, dramatic, and without vested interest group opposition, child abuse legislation has what can be described as an amazing atypical career. Within one 10-year period, legislation which had not previously existed in any state was adopted by all states—namely child abuse reporting laws. A federal child abuse prevention and treatment act also was passed.
   Contrast this with the bitterly fought campaign to get federal legislation against child labor—which adversely affected many more children than child abuse, or with the struggle to obtain passage of other socially progressive policy changes—mother's pensions, unemployment insurance, workman's compensation, or the current efforts to obtain passage of the Equal Rights Amendment. It is difficult to think of any social policy change which was adopted so widely so quickly as was child abuse legislation; and
6. There is an additional, more speculative, and more politically sensitive and converging consideration which must be noted. This is the need for the reorganized Children's Bureau to have a clearly acceptable and understandable function. The government was initially interested in child abuse through the activities of the old Children's Bureau, which sponsored a conference on the problem in 1962. When the Children's Bureau was reorganized in 1969 to become the Office of Child Development (OCD), most significant functions were reallocated to other units within the federal government. The newly established OCD needed a rationale for its existence, and child abuse became an issue which the office could develop. As a consequence of the need for and interest in a legitimate function and concern, the OCD, supported by appropriations from the Child Abuse Prevention and Treatment Act, sponsored much of the activity which gave visibility to the child abuse movement. The demonstration projects, research, training programs and materials, resource centers, and this conference are, to a considerable extent, offspring of the OCD. Support for these speculations can be found, for those interested, in the recent analysis of the history of the OCD in the Brookings Institution Report, *The Children's Cause* by Gilbert Steiner.

In recapitulation, it is true neglect is neglected when compared to abuse. This is true even though the relative number of children affected and the relative seriousness of the two forms of maltreatment do not justify such neglect. There are reasons which help explain the discrepancy between the high concern with abuse and lesser concern with neglect.

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Neglecting Neglect: The Dilemma of Labeling and Accountability

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Social welfare personnel long have been aware of the destructive consequences of negative labeling of people they attempt to serve (Cohen, 1966; Goffman, 1961). Being labeled a neglectful parent or a neglected child evokes a self-image that one is literally a bundle of odious and sinister qualities. Such demoralization may result in profound discouragement about attempting to perform necessary parental tasks.

Parents may react with embitterment about being regarded as neglectful. Their resentment may lead them to attack or defy those who have so labeled them by continuing or increasing the deviant child care about which the community complains. Prolonged protective services to neglected children may be necessary partly because of withdrawal by parents from their children as a consequence of their demoralization and embitterment about being labeled.

Children also may be demoralized by being regarded as neglected. Some refer to themselves as "welfare children", which means children who are abnormal and from whom the community can expect little that is desirable. For other youngsters, the label of neglect calls their attention to parental deficiencies, thereby stimulating them to attack the parent or the welfare worker. These expressions of child resentment further impair efforts of parents and practitioners to develop more adequate child caring.

Labeling also has negative consequences for social welfare professionals. The label of "neglectful" may block perception of the parent's assets, resources, and adequate child rearing practices which may be crucial in mobilizing the family to resolve its child care difficulties.

For these reasons, social service practitioners may prefer to provide services that protect children and increase parental skill without engaging in labeling activity, especially in a public degradation ceremony. Thus, services to families with problematic child care may be offered, if possible, on the basis of an informal agreement with the family, and in some instances without even certifying them as clients of the agency. Parents may be taken to court only as a last resort when they refuse to cooperate and child protection appears imperative. Only a fraction of all families against whom justifiable complaints have been made are ever taken to court (Kadushin, 1974). For example, a study in a small urban county of New York showed that only 20 percent of confirmed child neglect complaints were heard by a judge (Polansky et al, 1975).

Social workers also avoid negative labeling by providing protective services in contexts and for reasons that enjoy more socially positive value. For example, day-care, needed primarily to compensate for substandard parenting, is provided and justified in a context of enabling the parent to secure or maintain employment.

Practitioners, in doing diagnostic assessment, may focus upon the assets, resources, and skills of the parents concerned and attempt to encourage greater utilization of these rather than trying to correct their deficiencies. Professionals also may show more concern with identifying and encouraging constructive parenting skills, and in removing environmental and social obstacles that may prevent their practice.

Finally, some social service professionals attempt to "decertify" parents already labeled as neglectful, both to the client and to the complaining public. In doing so, treatment helps the parents to list their assets and accomplishments of which they are proud. The practitioner also advocates for the family concerned by encouraging others to recognize positive characteristics of the parents and socially desirable achievements of the children which can be ascribed to the parental rearing.

ACCOUNTABILITY

However, this treatment strategy presents difficulties with regard to professional, political, and financial accountability. Some might even say it is fatuous, hypercritical, or outright dishonest.

The nonclient constituency perhaps has the right to insist that social services be directed explicitly toward stated problems and objectives for which funds have been allocated and not toward other purposes, worthy though they may be. In fact, federal appropriations since 1970 increasingly have stipulated that population groups receiving funded services be publicly labeled according to specified criteria.

For example, use of AFDC funds to finance foster care requires children be adjudicated as neglected or abused. Thus, the welfare agency is faced with three options, none of which is desirable: the children and parents must undergo a negatively toned legal certification ceremony, thereby risking arousal of client embitterment and demoralization; the foster care plan must be discarded, although it is needed and has been agreed to by the family; or the foster care plan is financed entirely by state and local funds.

Another example includes a social work researcher who seeks a federal grant to study what intervention strategies and skills increase quality of child care by parents who are clients of a child welfare agency. The proposed research is judged by reviewers to be ethically and scientifically sound, and to be socially significant. However, the grant sought would be funded from allocations for child neglect and abuse research. Thus, the grant review committee insists, as a condition for receiving the grant, that the researcher study only those cases which courts or agency personnel have designated as manifesting child neglect or abuse. Hence, the researcher either must abandon the project, or engage in an activity that will direct the attention of the agency to negative characteristics or labels of their clientele.

Social service personnel experience an increasing burden of legal and professional accountability to clients and potential clients. Social welfare professionals often have been accused of straying into problems and population groups without a clear invitation to do so, and frequently without articulating their purposes and objectives (Polansky et al). Thus, there is some justification for both the client and nonclient public to expect those offering services to label potential recipients in ways that establish need for the service. This provides potential recipients opportunity to refuse the service as inapplicable to them, and to prevent unwarranted intrusions into their lives.

In summary, application of the neglect label, as a condition for providing protective services, may have such negative consequences for the families involved that it defeats objectives of these services. Yet employment of the neglect label is increasing in order to justify provision of needed protective services. Thus, requirements for financial and professional accountability run counter to practices known to facilitate improvements in the quality of parenting. There is no easy solution to this dilemma. The challenge is to find ways of achieving accountability without risking the negative consequences of labeling.

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Prevention

Perspectives on the Prevention of Child Abuse: Can It Be Done?

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Child abuse and neglect has emerged from its hidden "skeleton in the closet" status of past centuries. It is now recognized as a serious threat to the lives of today's children and tomorrow's adults. With the alarming rate at which reports of child abuse and neglect have increased, society can no longer afford to ignore these conditions. If effective methods of reducing and eliminating child abuse and neglect are not immediately found, society may well be contributing to its own demise. A high level of violent behavior in parents has the potential to increase its acceptability and serves as a model for children as they grow and develop. We should be concerned with children as both the victims of abuse now and as potential victimizers when they reach adulthood and parenthood.

Child abuse and neglect are not restricted to any particular socioeconomic class or racial group in America. While most of the reported cases are from low-income, nonwhite families, a significant number of cases from low, middle, and upper income white groups go unreported. The apparent differences between groups, in terms of the reported incidences of child abuse and neglect, have been attributed to: (1) discriminatory attitudes and practices of reporting sources; (2) higher incidence of social deprivation among certain ethnic/cultural and economic groups; and (3) ethnic group differences with respect to child rearing practices, values and attitudes. Usually, low-income ethnic minority group families are overrepresented as clients of agencies and institutions which report child abuse and neglect cases. Thus, they appear disproportionally in incidence data. The number of reported abuse and neglect cases involving nonminority and nonpoor families is an unknown quantity mainly because sufficient reported case data are unavailable.

The issue of who abuses and neglects children the most is not a basic point of this paper. Rather, the issue is whether or not effective methods can be developed, and strategies employed, which can help decrease child abuse and neglect in America. This question is a serious challenge to our society. Its resolution is the responsibility of all who have a concern for the well-being of children and parents. The results could have a significant effect on the quality and future of American society.

Child abuse and child neglect are of major concern today among those who work with children and their parents or caretakers. In this paper abuse and neglect are dealt with as one issue, although many experts in the field view them as two distinct and separate problems. However, many authorities express the viewpoint that if the causal factors which lead to physical child abuse can be effectively dealt with, the problems associated with neglect, malnutrition, sexual abuse, exploitation, and any other actions that hinder a child's normal mental and physical growth will be concurrently resolved.

DEFINING CHILD ABUSE AND NEGLECT

Agreement on a definition of child abuse and neglect has been difficult to achieve. Several factors seem to contribute to the inability of the authorities to arrive at one clear position. These include the following: (1) disagreement among writers in the field; (2) disagreement among agencies as to what should be reported as instances of child abuse and neglect; (3) disagreement as to whether or not to include physical, emotional, and sexual abuse in one definition; and (4) disagreement about associating abuse with neglect.

Some variations in the meaning of abuse and neglect can be observed through examining the following definitions:

(1) Walters (1975) Physical abuse of a child is action taken by a parent or adult caretaker that results in physical harm or injury to the child or failure to act on a child's behalf wherein death of the child will result from continued inaction or neglect. Neglect and abuse are not synonymous or interchangeable: neglect implies (a) failure to act; and, (b) inaction deemed harmful and deliberate. Sexual abuse is the utilization of the child for sexual gratification or an adult's permitting another to use the child in such a manner;

(2) Kempe and Helfer (1972) Nonaccidental physical injury (or injuries) as a result of acts (or omissions) on the part of his parents or guardians;

(3) Gil (1968) An occurrence in which a caretaker, usually an adult, injures a child, not by accident, but deliberately by (commission or omission);

(4) National Committee for Prevention of Child Abuse (1976) Nonaccidental physical injury, malnourishment, neglect, sexual abuse or exploitation of children; any other action that hinders the normal mental and physical growth and development of children;

(5) Gil (1970) The intentional, nonaccidental use of physical force or intentional, nonaccidental acts of omission on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring, or destroying that child;

(6) Justice and Justice (1976) Any nonaccidental physical injury inflicted on a child by a parent or other caretaker deliberately or in anger. Child neglect is a separate problem: neglect is omission; abuse is commission;

(7) Polansky, Hally, and Polansky (1975) Child neglect is a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience unavoidable present suffering, and/or failure to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities; and

(8) Zalba (1966) Child abuse is when physical injury has been inflicted on a child by his or her parents or parent substitutes to the degree that life and/or health has been endangered.

It is quite evident that there is no one clear cut and satisfactory definition of child abuse and neglect. Due to this lack of clarity of definition, there have been problems with respect to developing and carrying out comprehensive identification, treatment, and programmatic efforts. It is generally felt that a clear definition of what is meant by child abuse and neglect is a necessary precondition to dealing effectively with the problem. Workers in the field also seem to think that it is preferable to deal with abuse and neglect as separate entities because they involve different things. In doing so, better programs can be conceptualized and implemented.

SOCIOCULTURAL BACKGROUND

Elements long ingrained in our society provide some insight into the genesis, continuance, and increase of child abuse and neglect. The following is a brief discussion of these elements:

(1) Religious Origins. There are those who attribute the acceptance of child abuse and neglect to passages in the Bible and teachings of Judeo-Christianity. Both the Bible and Christianity have long been considered as guideposts for the conduct of our lives on earth. Many people use these two elements as the foundation of their relationships to others, especially children. Walters (1975) cited portions of the Bible which condoned the murdering, sacrificing, cannibalizing, threatening, physical abusing, and sexual abusing of children. Thus, the Bible and related religious teachings appear to have helped establish many of the beliefs held today concerning chidren's status, their rearing, and in some instances, their behavior and sexual relationships.

Walters (1975) stated that the biblical passages which appear to condone such wrongs upon children are subject to differing interpretations. Many clerics offer biblical and other religious citations which admonish parents to care for and love their children. But it is the interpretation by lay persons that seems to be the problem. Regardless of how clerics and others convey their messages, there are portions of the Bible which establish the grounds for punishment and even abuse of children. Thus, some parents and other caretakers make their own interpretations of biblical passages and justify the punitive measures they use in dealing with their children. As a result, child abuse and neglect are legitimized, internalized, and put into action when deemed necessary by parents and other adults.

(2) Literary Origins. Walters (1975) states that fairy tales, nursery rhymes, folklore, fables, songs, stories, and other forms of literature are often used to help children grow, develop and prepare for life. Such literary works, while aiding in the development of roles and relationships among people, also contain sections which

express varying degrees of violence to be administered to children and adults for not abiding by the wishes of others.

Many of these literary works are an integral part of the enculturation process parents provide to their children. The pictorial aspects, verbal messages, and adult interpretation of stories, tales, etc. have been used by adults to frighten or threaten children into behaving in desirable ways. While such efforts may have served their purposes temporarily, the long-range effects may create deep-seated fears and apprehensions in children about themselves and others. For adults, the effect has been to create a false rationale for heaping abusive and neglectful acts on children.

(3) Legal Origins. Historically, laws have only minimally protected children from adult wrath and abuse. Torture, cruelty, exploitation, and even the killing of children were considered milder crimes than these same acts against adults. Even laws protecting animals from cruelty were enacted before those protecting children (Walters, 1975). Thus, the law has only recently begun to recognize the special nature of childhood and to see a child as a special kind of human being whose protection has to be expressly attended to.

Given the long history of child abuse and neglect which has not until lately been expressly prohibited by law, it cannot be presumed that almost two thousand years of legal oversight will be significantly reversed overnight. New laws are usually built upon laws of the past. That being the case, the enactment of new legislation to protect children will, for a few years, still take a back seat to the rights of parents and caretakers (Walters, 1975). Laws reflect the cultural history and heritage of society. The lack of legal protection and sanction has to some extent contributed to abuse in our society.

CAUSES OF CHILD ABUSE AND NEGLECT

Many ideas, beliefs, and theories have been postulated in an attempt to pinpoint the causes of child abuse and neglect. An examination of some of these positions is presented in the following paragraphs.

Kempe and Helfer (1972) stated that parents who abuse their children share a common pattern of parent-child relationships characterized by a high demand for children to gratify the parents, and by the use of severe physical punishment to ensure the child's proper behavior. The stage for abusive acts appeared to be set by: (1) high vulnerability to criticism; (2) disinterest and/or abandonment by spouse or other important person; (3) affronts to their already inadequate self-esteem; and, (4) the demanding, aggressive, and emotionally deprived nature of their own childhood experience and learning.

An assessment of four major categories could be made: (1) to determine whether or not the potential to abuse or neglect exists and (2) to provide insights into the causes of abuse or neglect (Kempe and Helfer, 1972). The four categories outline:

(1) How parents were reared themselves;
(2) How parents create and hide behind a wall of isolation which prevents them from seeking assistance;
(3) How husband and wife (and other children or adults) interrelate, especially with respect to mutual support or lack of it; and
(4) What parents envisioned and demanded as expectations for their children's behavior.

The Children's Division of the American Humane Association (1963) found that: (1) uncontrolled father outbursts; (2) deep-seated emotional problems of mothers; (3) a wide range of internal family problems; (4) emotional immaturity of parents; and (5) families with no father living at home accounted for most of the child abuse cases reported. Delsordo (1963) reported that five types of abuse could be identified from his studies and that each type implied a cause for parental abusive actions: (1) abuse because of acute mental illness; (2) abuse due to the overflow from parents' aimless way of life; (3) abuse following nonspecific disturbances in parents' physical, emotional, or social state; (4) abuse resulting from parental harshness in disciplining children; and (5) abuse caused by parents' misplaced conflicts. Zalba (1967) stated that major contributors to abuse and neglect of children were parents': (1) personality system

(including psychotic, angry, abusive, depressive, passive-aggressive, or cold-compulsive-disciplinary parents); (2) family system (including impulsive but generally adequate parents with marital conflicts); and (3) person-environment or family-environment system (including parents with identity (role) crisis).

Kaufman (1959) states that: (1) uncontrolled aggressive and sexual behavior; (2) lack of relationship to the community; and (3) a psychotic core stemming from fear of annihilation leads to the externalizing of feelings through attacks on children. Kaufman postulated that many abusive parents are not continuously or overtly schizophrenic. Instead, many of them have episodic outbursts which include: (1) loss of self-control; (2) loss of reason; and (3) loss of judgment. It is during these outbursts that abuse and neglect of children are most prevalent, as parents seek to relieve these anxieties.

Gladstone (1966) found that seven factors collectively disposed parents to resort to the physical abuse of their children in order to spare themselves the conscious experience of their own intra-psychic distress: (1) reliance upon projection (of negative feelings) in defending against intra-psychic stress; (2) translating affect states into physical activity without intervention of conscious thought; (3) presence of intolerable self-hatred where child becomes scapegoat for parents' unconscious sense of guilt; (4) correspondence of children by sex, age, and position in the family to events in the parents' own life which occasioned great self-hatred; (5) relative lack of alternative modes of defense against conflict because of environmental factors (poverty, illness, domestic demands, social isolation, and housing problems); (6) compliance with the abusive act by marriage partner due to dependence and a reciprocal willingness to support projective defenses; and (7) relative absence of available authority figures (grandparents, religious or social authorities).

Milowe (1966) stated that children themselves may in certain cases be a contributing factor to their own abuse. Milowe thus concluded that a parent's childhood loads the gun; present life conflicts cause the parent to raise it; the child's specific needs help pull the trigger. Steele and Pollock (1968) reported that: (1) child rearing patterns; (2) intensity in the expression of these patterns; (3) lack of adherence to expected obedience and conforming behavior; (4) demand for high performance and parental need satisfaction; (5) breakdown in ability to "parent;" and (6) insensitivity to variation of children's needs were all provocateurs of the child abusing and neglecting actions of parents.

Makeover (1966) observed that conditions which cause physical abuse of children often differ in degree rather than in kind from those which result in neglect and deprivation. Physical abuse is usually precipitated by: (1) lack of impulse control; (2) mental illness (frequently in the form of chronic paranoid schizophrenia, psychopathic personality, severe passive-aggressive character disorder, agitated depression, unresolved postpartum depression); (3) alcoholism and narcotic addiction (these are usually precipitant actions due to parent inability to control and deal with impulses); (4) mental retardation; (5) social stress (poverty, overcrowding, etc.); (6) early marriage; (7) parental immaturity; (8) low educational level; (9) unemployment; and (10) provocative behavior of children themselves. Makeover points out that items six through ten may not be as much direct causes of child abuse and neglect as other items, but can contribute.

Merrill (1962) described four distinct clusters of personality characteristics which generated child abuse and neglect actions by parents. These clusters are: (1) hostility and aggressiveness—continually angry at someone or something; (2) rigidity, compulsiveness, lacking of warmth, reasonableness and pliability in parents' thinking and beliefs; (3) strong feelings of passivity and dependence—sad, moody and immature; and (4) physically disabled fathers who stayed at home while mothers worked and supported the family. A typology of abusing parents was developed by Morris (1965) which revealed personality traits which contribute to the abuse and neglect of children: (1) parents who experienced distress and guilty feelings about their relationship with and treatment of children; (2) undercontrolled and impulse-ridden parents who are angry about their relationship but blame the child for the trouble; (3) overcontrolled parents who feel correct in the parent/child relationship and plan the abusive actions; and (4) parents who respond to inner stimuli and events, rather than to the real world of the child.

Young (1964) proposed a theory of multiple causation, or a combination of factors that appeared to lead to causes of child abuse. Among them were: (1) the abuse that parents themselves suffered as children; (2) institutionalization; (3) "being different from other members of the family;" (4) an unpleasant childhood; (5) neglect; and (6) possible organic differences.

Walters (1975) states that the search for causes of abuse seemed endless, a position strongly reinforced by the above review. He presents three widely accepted explanations of the causes of child abuse. They are:

(1) Our entire heritage has led us to permit the abuse of children. It is our Judeo-Christian tradition coupled with our predilection for violence which makes abuse a natural, rather than unnatural, outcome;

(2) The cause of child abuse can be found in poverty conditions: lack of income, health care, and social services; run-down neighborhoods; and inadequate housing, education, cultural, and recreational facilities; all of which contribute to the development of deviant behavior, which results in child abuse; and

(3) The cause of child abuse is parental pathology, which assumes that parents or adult abusers are "sick" or have something psychologically "wrong." This opinion holds that, to greater or lesser degrees, the abusers of America are confused and employ abusive measures as a result of internal pathology.

Thus, some current thinking tends to view child abuse as a problem in itself, while others see it as a symptom of a deeper sickness or negative aspect of our society. At one time or another, poverty, alcohol, family stress, neglect, social class, individual pathology, and related "causes" all have been used to explain crime, mental illness, mental retardation, juvenile delinquency, and a host of other societal problems (Walters, 1975).

PREVENTION OF CHILD ABUSE AND NEGLECT: SOME PERSPECTIVES

Child abuse and neglect pose serious problems for the effective growth and development of children, as well as for the well-being of tomorrow's citizens. Unquestionably, an overwhelming need exists to address and resolve the problems which contribute to, and eventually cause, abusive and neglecting behavior. Many ideas, strategies, and programs have been proposed which attempt to deal with these problems. Again, there is a wide variety of opinions on how best to approach and bring under control the child abuse and neglect crisis in our society. Within this variety exists the potential to develop a comprehensive plan and program of action which could adequately serve the victims (children) and the perpetrators (parents, adults) of these two flagrant violations of human rights.

Unfortunately, the prevention of child abuse and neglect is not as easily accomplished, as many of the programs that have been developed seem to indicate. Some preventive efforts are at best cursory attempts to resolve the problem while others focus on specific aspects of the larger problem. Such programs are fragmented in their efforts and require revision and expansion if effective methods of coming to grips with the problem of child abuse and neglect are to be successful. A brief examination of some selected preventive measures is presented in this section.

Justice and Justice (1976) state that the optimal goal in child abuse is to prevent the abuse from happening—to prevent explosive elements in a potentially abusing family system or situation from ever coming together, so that the violence never occurs. This is called primary prevention. Once child abuse has occurred, the goal then becomes keeping it from recurring—to defuse the abusing situation so that the violent behavior is eliminated. This is called secondary prevention.

Secondary preventive approaches to solving child abuse and neglect problems have included the following: (1) group therapy; (2) lay therapy; (3) support services; (4) self-help groups; (5) casework counseling; and (6) psychotherapy.

The primary preventive approaches presented by these authors were as follows: (1) nonspecific strategies which involved intervention at all levels: host (parent), agent (child), environment, and vector (culture); (2) specific strategies which required identification of and intervention toward specific high risk groups or conditions; high-risk parents, children, environments, or a combination of all three; and (3) other strategies (intermediate intervention) such as in-service, pilot, pre-service programs, and public education and awareness programs.

Soman (1974) has proposed her own program of action to end the destruction of children by parents and adults. The elements of such a program include: (1) a National Children's Ombudsman Office; (2) mandatory high school counseling and parent education courses; (3) parent-child action movement on consumer products and national safety consciousness-raising sessions; (4) national health care and housing programs; (5) neighborhood community houses; (6) a decent income policy for all; (7) interagency knowledge pool; (8) on-the-job training for parenting; (9) central clearinghouse on child statistics; and (10) national 800 hotline number for troubled parents and children.

The National Committee for Prevention of Child Abuse (1976) has advocated a number of ways to prevent child abuse, all of which fall into two broad categories: (1) direct prevention and

(2) indirect prevention. NCPCA stated that direct prevention programs were designed specifically to control the problem of child abuse. Such programs could be aimed at either primary prevention: predicting and eliminating child abuse before it occurs, or at secondary prevention: preventing future abuse after a situation has once been identified. Indirect prevention programs focus on the factors that contribute to child abuse (e.g., housing, employment, child-care training, etc.).

NCPCA also emphasized that education must play an important role in efforts to decrease child abuse and neglect. The following means were proposed to accomplish this: (1) education for parenting through prenatal programs with parenting courses, group sessions, homemaking courses, and parental skills courses in high school; (2) education for coping to reduce the feeling of being unable to handle stress. This might be done through effective use of such parent support groups as Parents Anonymous, which often provides both crisis intervention assistance and support on an ongoing basis; and (3) education for self-worth to better understand oneself, and feel self-worth and acceptance. This would help parents to understand and interact better with children as well as adults, and aid in reducing the feelings of rejection experienced by many abusers.

Renvoize (1974) offered several suggestions for programs seeking to reduce child abuse and neglect: (1) cossetting and mother-centered gatherings could be of inestimable value to those who unexpectedly find themselves nervous and uncertain of their capability of rearing a tiny, frighteningly vulnerable infant; (2) a system of mothering aides; (3) night nurseries; and (4) involvement with Mothers Anonymous.

Renvoize concluded that alterations to child abuse codes were needed to help prevent child abuse and neglect. In addition, there has to be a change of attitude on the part of doctors, social service workers, the police, and every one of us. It is our job to learn how to pluck parents from the abuse and neglect ladder before they have progressed very far up the ladder. To do that we need knowledge, money to finance the acquisition of that knowledge, and endless compassion and understanding. Is that too much to ask of our society in order to preserve our most precious commodity—our children?

Walters (1975) proposed a set of short range, intermediate, and long range goals which must be undertaken to address the problem of child abuse and neglect. The basic goal would be to assist the "patient" (America) in recognizing the need for help, and to increase the valuation of children in American society and the observance of their rights.

A sample of Walters' goals are:

(1) Short-range goals
   a. A federal cabinet-level agency concerned with children and their rights;
   b. The abolition of institutionally prescribed abuse, especially where caretakers are responsible for children not their own; and
   c. Treatment of abuse by the mentally ill and victim-precipitated abuse;

(2) Intermediate goals
   a. Research conducted at the national level under auspices of the cabinet-level agency;
   b. Establishment of a National Parents' Institute under the cabinet-level agency and a State Parents' Institute in each of the fifty states; and,
   c. Establishment in each community of some central resource where anyone with family problems could go for help; and

(3) Long-range goals
   a. Implementation of a Children's Bill of Rights, constitutional guarantees, and increased rejection of violence as a means of resolving problems;
   b. Careful and systematic dissemination of rational information about violence, its origin, and its effect until the idea that violence is negative becomes ingrained in our national character; and
   c. Development of alternative roles for children, especially in education.

Walters concluded that addressing his set of goals would bring us full circle in our study of child abuse, starting and ending in the culture and society in which we live. Child abuse finds its roots in our heritage and is expressed through members of the society. When we change—and we will change for the better—the problem of child abuse will decline and then disappear.

Morris, Gould, and Matthews (1974) hold that constructive, preventive intervention is necessary in the cycle of violence, and punishment is necessary to prevent physical neglect and

abuse of children. They proposed that the following set of criteria was a necessary part of an effective program to prevent child abuse and neglect: (1) existing community services that work in a coordinated manner; (2) clear lines of accountability and coordination among agencies involved; (3) assistance to parents during the first few months of their child's infancy to ensure nurturing parenthood; (4) creative new uses and combinations of existing services; and (5) collaborative programs under public health and public child welfare agencies.

Morris et al concluded that preventing neglect and battering depends, in the long run, on preventing transmission of the kind of social deprivation which takes children's lives, damages their physical health, and retards their minds, and which contributes, through those who survive, to a rising population of next generation parents who will not be able to nurture children.

Gil (1970) stated that measures aimed at the prevention or gradual reduction of specified social phenomena cannot be expected to achieve their purpose unless they are designed and executed so as to intervene on the causal level. Therefore, he recommended the following measures:

(1) Systematic educational efforts aimed at gradually changing the prevailing child-rearing philosophy and development of clear-cut cultural prohibitions and legal sanctions against the use of physical force as a means for rearing children could produce, over time, the greatest possible reduction of the incidence and prevalence of physical abuse of children;

(2) Poverty, as has been shown, appears to be related to the phenomenon of physical abuse of children among the socioeconomically deprived. The multiple links between poverty and physical abuse suggest that one important route toward reducing the incidence and prevalence of child abuse is the elimination of poverty from America's affluent society; and

(3) Deviance and pathology in areas of physical, social, intellectual, and emotional functioning of individuals and of family units have been found to be another set of forces that may contribute to physical abuse. The following measures, aimed at the prevention and amelioration of these conditions and at the strengthening of individual and family functioning, should be available in every community as components of a comprehensive program to prevent the occurence of physical abuse of children and also to help individuals and families once abuse has occurred: (a) comprehensive family-planning programs; (b) family-life education and counseling programs for adolescents and adults; (c) comprehensive, high quality, neighborhood-based, national health services; and (d) a range of high quality, neighborhood-based social, child welfare and child protective services.

The three sets of measures proposed were aimed at different causal aspects of physical abuse of children. The first set would attack the culturally determined core of the phenomenon; the second set would attack and eliminate a major condition to which child abuse is linked; the third set approaches the causes of child abuse indirectly. Gil concluded that it would be futile to argue the relative merits of each of these approaches. Instead, all three are important and should be utilized simultaneously.

PREVENTION: CAN IT BE DONE?

The information presented in the previous sections of this paper has delineated some of the root causes and proposed strategies for dealing with child abuse and neglect in our society. Gil contended that a key element in physical abuse of children in the United States was that the context of child-rearing does not exclude the use of physical force toward children by parents and others responsible for their socialization. Rather, American culture encourages in subtle, and at times not so subtle, ways the use of a "certain measure" of physical force in rearing children in order to modify their frequently nonsocial inclinations. This cultural tendency was found in child-rearing practices of almost every segment of American society. It was supported in various ways by communications disseminated by the press, radio, and television, and by popular and professional publications.

Gil researched the kinds of forces that singly, or in various combinations, result at certain times in culturally unacceptable "excessive" or "extreme" use of physical force by caretakers against children. Findings from the nationwide surveys tend to suggest the following forces: (1) environmental chance factors; (2) environmental stress factors; (3) deviance or pathology in areas of physical, social, intellectual, and emotional functioning on the part of caretakers and/or the

abused children themselves; (4) disturbed intrafamily relationships involving conflicts between spouses and/or rejection of individual children; and (5) combinations of these sets of forces.

Judging from these elements, Gil concluded that the phenomenon of physical abuse of children needed to be seen as five-dimensional rather than uniform: (1) a culturally determined permissive attitude toward the use of physical force in caretaker-child interaction, and the related absence of clear-cut legal prohibitions and sanctions against this particular form of interpersonal violence; (2) specific child-rearing traditions and practices of different social classes and ethnic and nationality groups, and the different attitudes of these groups toward physical force as an acceptable means of achieving goals; (3) environmental chance circumstances, which may transform an otherwise acceptable disciplinary measure into an unacceptable outcome; (4) the broad range of environmental stress factors which may weaken a person's psychological mechanisms of self-control, and may thus contribute to the uninhibited discharge of aggressive and destructive impulses toward physically powerless children who are perceived to be causes of stress for real or imaginary reasons; and (5) the various forms of deviance in physical, social, intellectual, and emotional functioning of caretakers and/or children in their care, as well as of entire family units to which they belong.

Viewing the issue of child abuse and neglect across these dimensions indicates the need for a broad, comprehensive, well-defined program of activities to deal with these problems. Prevention requires the mustering of a cooperative effort from individuals, families, neighborhood communities, cities, states, regions, and the federal segment of our society. It means that parents and caretakers must work individually and collectively in the pursuit of ridding our society of a most damaging element—child abuse and neglect. Such an effort must at a minimum, include the following important elements in order to respond with a "yes" to the question of whether or not the prevention of child abuse and neglect can be accomplished:

(1) Short, intermediate, and long range intensive activities and efforts to make all citizens aware of the damaging effects, temporary and permanent, of child abuse and neglect;
(2) A mass infusion of children's worth and dignity, and their growth and developmental needs into the education and training experiences of all Americans at every level;
(3) A well-defined, closely-linked, cooperative program of prevention among all agencies which deal with people and their concerns and problems, to insure continuity in resolving issues affecting their clients;
(4) The enactment and implementation of legislation to protect the rights of children and provide the best possible situations for nurturing their developmental needs;
(5) The provision of the financial resources needed to alleviate all of the conditions which create the potential to abuse and neglect children;
(6) A redefinition and refocusing of the basic attitudes, values, and practices of members of our society in their intrapersonal and interpersonal activities; and
(7) Creation of new roles for children in our society so that they become truly prepared for future roles, with widened potential to develop into unique human beings instead of products from yesterday's assembly line.

What is proposed here is not new. Authors have at one point or another indicated all of these elements as necessary in the prevention of child abuse and neglect. The seven general preventive approaches presented here represent an attempt to synthesize the suggestions and recommendations discussed in this paper. Tomorrow, and maybe twenty years from now, these approaches should remain constant as bases for the prevention of child abuse and neglect. Newness must come in the form of our willingness to act with respect to these problems. It will be those new actions, new attitudes, and new directions concerning the young of our country that will be the measure of our success in dealing with abusive and neglectful acts toward children. As we move in those directions, the verbal yes will become a visual yes because we shall see the fruits of today's labors (preventive programs) in tomorrow's vineyards (future societies and generations).

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Recent Trends in Prevention of Child Abuse (Non-Accidental Injury)

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The future approach to the prevention of non-accidental injury (NAI) in children is stimulated by conferences such as this second national gathering of people from many disciplines and with varied interests. I would like to suggest some changes in emphasis and direction, will pose more questions than answers, but hopefully, the questions will be provocative and useful in considering future planning. Having been a chairman of the Committee on Accident Prevention, American Academy of Pediatrics, and presently involved in the field of child abuse, I am reminded of the similarities between the development of both programs insofar as prevention is concerned (Starbuck, 1958).

NATIONAL LEVEL INTEREST

P.L. 93-247, passed in 1974, provided money to develop programs in addition to those already supported by other government agencies. Consolidation of all these programs into a more cohesive one has not been accomplished. Four broad approaches in the attack on prevention of NAI/neglect by NCCAN have been education, research, prevention, and legislation, which is similar to those used in Accident Prevention. Professionals in the health, legal, education, law enforcement and social systems have been encouraged to increase their involvement in the field through additional training in all aspects of child NAI/neglect. Increased funds for research programs and large grants for demonstration programs to develop innovative ideas in prevention have been made available. Advice in changing state child abuse laws has been offered, model laws for termination of parental rights have been proposed, as well as changes in areas of legal importance: all in support of a second approach to legislating preventive measures.

EARLY IDENTIFICATION—RECOGNITION

The renewed drive to increase public and professional awareness could overexpose the population to the brutal aspects of the NAI and neglect problem. The low-key approach of sensitizing people to the need of early recognition by constantly being alert to possible NAI is essential; physicians especially should be more quizzical in their approach to the diagnosis and treatment of patients. It is the leading question in history taking that will often reveal a clue.

One impressive fact the study of NAI and neglect has highlighted is the erroneous inclusion in accident statistics of a large number of NAI and neglect cases. Accidents are still the greatest killer up to the age of 35 years. They are socially acceptable; NAI and neglect are not. This pollution has concerned workers in the field of accidental injury for a long time. Of the 2000 children under 15 years of age who die in house fires annually, about one-third are left unattended. Death from clothes being ignited by small children playing with matches is also due to lack of supervision (Wheatley, 1973). What about the child who wanders into the next yard, falls into a pool and drowns, or the child who wanders into the street and is hit by a car? What about death from ingestion of medication left within easy reach of a child, or of poisonous substances stored under the sink? What about injuries found in an emergency room? Kempe (1971) states that roughly 25 percent of all fractures in children under age three are inflicted. I am certain that many accidents, including deaths, are properly being classified as NAI and neglect cases, which removes them from accident statistics.

RESEARCH PROGRAMS

In the past few years, many studies have been initiated and articles written on every imaginable aspect of abuse and neglect. In reviewing Child Abuse and Neglect Research: Project and Publications, November 1976, I found 141 descriptions of ongoing projects and a list of 261 published documents. Of the numerous publications listed, only rarely did a study use controls or comparisons. To my mind, the omission of controls in research in this field is a major weakness and requires immediate correction. Should one criterion in this field be to mandate controls in research designs, especially those concerned with prevention?

The tendency to deny that findings in one area are peculiar to that locale is questionable, i.e., findings in Hawaii differ from those on the mainland due to location and population

differences. There may be differences in geographical areas such as Boston or New York on the mainland. We must not lose sight of this when we design prevention programs or any other programs for that matter. In the future, the same research program should be repeated in different regions with definitions, hypotheses, methodology, controls, etc., being the same. A meaningful comparison would then be possible. Certain aspects may be similar, but others must be different. If a difference is demonstrated, other modalities of treatment may be indicated and program development must take this into account. Studies will take longer in some areas where the incidence of NAI and neglect is limited due to population size. However, important findings and better programs may come from these areas.

Klein (1971) points out that the low birth weight infant is high risk for the battered child syndrome. In 1975, while studying the low birth weight infant as a high risk for abuse and neglect, a cursory review of cases hospitalized at Kauikeolani Children's Hospital in Honolulu indicated little if any difference in the incidence of NAI and neglect of low birth weight neonates when compared to that expected in children of normal birth weight (Starbuck). The accepted incidence of NAI and neglect in children of normal birth weight has been about 8 percent. Of particular interest, a recent 1976 controlled study (Starbuck, 1976) of this cursory finding revealed that there appeared to be no significant difference in the distribution of the birth weights between the NAI children and the controls ($X^2 = 3.21100$; df = 4; P = 0.5232). The findings thus fail to show that NAI children begin as high risk neonates. Without controls, the incidence was also about the same for the neglect and NAI/neglect cases.

Controls	35	8.6 percent
NAI	42	7.1 percent
Neglect/NAI-Neglect	31	11.0 percent
KCH Hospital cases	108	

In Klein's study the cases defined as "battered child" included severe neglect while in the Hawaii study the cases were physical NAI but not neglected under four years of age, including "battered children." If the latter study contained a sufficient number of "battered child" cases, using Klein's definition, would his findings be confirmed? Of 525 confirmed cases of NAI and neglect in Hawaii during 1974, 167 were under three years of age and of these, the "battered" were very few. Should each geographical area use the same treatment and prevention measures relating to the NAI but "non-battered" child?

The term "battered-child," in the majority of people's thinking, includes all types of physical abuse, severe or mild. To some, "battered child" means only severely injured children under the age of four; to others, severely abused, usually under the age of three; to others, the seriously injured small child, inferring that they are under one year of age. Others yet include neglect in their definition. Should the definition be standardized? What is the incidence of low birth weight in unhospitalized NAI children?

We also need to study the high risk nonabused child. Initial interest in Accident Prevention was directed toward accidental poisoning, which caused less than 2 percent of all accidental deaths in children under age 14. In 1958, 60 percent of the American Academy of Pediatrics State Accident Prevention Committees were spending 100 percent of their time on poison control exclusively; consequently, study direction had to be changed. Aren't we spending too much of our time on the NAI child? What about the high risk family with numerous children? We say all these children are at risk, but are they abused? Do these children become abusers?

Are we correct in labeling children as "scapegoats?" Lauer's (1974) study does not support this theory. If the term "scapegoat" is to hold up, shouldn't we say that it is the only child being injured at the time? Skeletal surveys of other children in these families often turn up a surprising number of unrecognized bone injuries. Would they be the "scapegoat" at that time? Is it a shifting phenomena dependent upon who is getting the physical NAI? Is it possible for a child to escape neglect or verbal abuse in a multiple child family with these characteristics? There must be some degree of neglect with all these children.

What about the high risk parent who does not currently cause NAI? We can overidentify the high risk and direct our approaches to them. The high risk approach must be modified and studies of this group need to be undertaken.

Identical studies in different geographical locations need to be carried out. Identical services may not be required in every area.

What is the rate of reabuse in the nonseriously injured child, or the neglected child? Are the long term effects the same, better, or worse, than in the seriously injured or neglected child?

What do we do about the male abuser who seems to have different characteristics than the female abuser?

The recent article by Elmer (1977) with a controlled follow-up of traumatized children makes one reflect again on the numerous studies with conclusions not based on controls. While reading her article, one realizes the importance of controlled studies, and the need to sharpen our research by adding them. The findings of "no difference" in incidence of low birth weight children in a control group when compared with the abused group also supports this need. Comparison is impossible without them. However, in a controlled study by Green (1974) entitled "Psychological Sequelae of Child Abuse and Neglect," the impact of chronic physical abuse and neglect on the ego function and behavior of school-aged, inner city children revealed that both the abused and neglected groups were found to be considerably impaired relative to the normal controls along both dimensions. Elmer gives several possible explanations for her findings. Why the opposite findings in these two controlled studies? This is as confusing as the varied definition of the battered child, as well as the opposite finding of Starbuck and Klein regarding low birth weight being high risk for abuse and neglect.

Many accept NAI/neglect as a disease—a disease of society. The epidemiological approach to accident prevention as advocated by McFarland (1962) is echoed in a 1976 article by Justice, which recommends the epidemiological approach for the prevention of NAI and neglect. The first step in the treatment of any disease is prevention.

By definition, to prevent is to avoid NAI, but it is unrealistic to think all NAI will be stopped. What are the early indications that lead to NAI? The predictions we have are weak. Overidentification must be reduced. If 85 percent of all parents identified as high risk for NAI and neglect will never cause NAI (Light, 1973), it is improper to label them in this way.

Advances are being made through education, research, and legislation. Early and correct identification; better reporting; increased sensitization of the professional, nonprofessional and lay population; as well as training programs all result from our preventive assault on this problem. It seems to be inferred that getting the results of current prevention programs quickly will rapidly prevent NAI and neglect in an impressive way. I predict this will not take place, and that any new preventive approach will show its effects slowly and steadily, as did the preventive measures used in accident prevention. NAI prevention may come about sooner, because a lot of knowledge accumulated from accident prevention can be applied to the problem of NAI/neglect. In the early days of accident prevention, we spoke of changing motivations of the family in regard to accidental injury; we used anticipatory guidance; we tried to change child-rearing practices; we increased child guidance and intensified all efforts for better well-baby care. We were thwarted by the crisis-oriented attitudes of people, just as we are now in our efforts to prevent NAI/neglect. How can we get at this mass of people? It is no easier in NAI/neglect than it was in accident prevention.

We must learn more about the stresses associated with raising a child in poverty (Cupoli and Newberger, 1977). We need to spend more time during routine examinations counseling parents about problems and how to cope with them. We need to reach people who do not have private physicians or pediatricians or clinics, and who depend physically as well as mentally on crisis care rather than preventive care.

SECONDARY PREVENTION

In secondary prevention a wider use of the knowledge and skills of the disciplines involved in primary prevention is essential. Certainly, psychological and psychiatric diagnostic evaluations are more necessary. Collaborative team conferences take on increased importance in supporting the caseworker in her formulation of a treatment plan. All NAI/neglect cases do not need the collaborative team conference, but it should be a requirement for cases of repeated NAI. What measures prevent recidivism? A five-year review of cases seen at Children's Protective Services Center in Honolulu showed the rate of recidivism to be three times greater in cases not teamed (Starbuck, n.d.).

PREVENTION PROGRAMS

A number of different prevention programs are active in Hawaii. Some are complete; others are near completion. One 1974 study of relationship of low birth weight and NAI risk began modestly, but rapidly became overpowering. The intervention and observation of this study had three conditions. The experimental group (E) received the entire intervention and observation as

designed. In a second group (C), the parents received contact for data gathering by the researchers, but no therapeutic intervention. The third group (C_2) received no therapeutic intervention and no contact. Some of our problems were:

1. Difficulty in obtaining physicians' reports
2. Difficulty in obtaining parental consent
3. Difficulty in obtaining parental compliance
4. Difficulty in avoiding dropouts
5. Mobility of patients
6. Distances
7. Lack of funds for sufficient manpower
8. Fear by physicians of infringement on their perrogatives
9. Lack of communication with patient (information was given to the primary physician and no response)
10. Informed consent
11. Quality of data
12. Missing data
13. Difficulty in locating controls
14. Contamination of data.

Benefits:

1. Education of delivery room, nursery, and floor nurses (re. claiming period)
2. Indication that low birth weight in neonates was not high risk for abuse
3. Confidence and cooperation of involved physicians spread to their peers and preventive services better accepted
4. Beneficial program to some physicians
5. Problem focused on when we have a right to enter anyone's life
6. Approaches must be entirely through comprehensive supplementary services and not a single reason such as NAI risk
7. Immunizations, nutrition, or life style
8. Importance of controls
9. Importance of evaluation
10. Importance of program design
11. Importance of training personnel
12. Avoid missing data; it is usually impossible to retrieve.

One of the demonstration programs funded by OCD is being carried out by the Hawaii Family Stress Center at the Kauikeolani Children's Hospital. An overview of this program follows:

OVERVIEW OF THE HAWAII FAMILY STRESS CENTER

The Hawaii Family Stress Center has been established under the auspices of Kauikeolani Children's Hospital. The overall goal of the Center is to develop effective, innovative approaches to prevention and treatment of child abuse/neglect, and to facilitate the development of a coordinated system of services in Hawaii. The Children's Protective Services Center, under the joint auspices of the Department of Social Service/Kauikeolani Children's Hospital, is the major affiliate agency with which the Center coordinates.

Core staff of the Family Stress Center include a Project Director, Program Coordinator, Paraprofessional Supervisor/Training Coordinator, Case-coordinator, a half-time Fiscal Officer and two secretaries. Several new services have been developed on a sub-contractual basis. Center staff also provide training in the dynamics of child abuse/neglect and technical assistance in program development. Major components of the system include:

LEGAL CONSULTANT SERVICES: A lawyer experienced in child abuse/neglect serves as a consultant to the Center. His main function is to assist in obtaining court custody where specialized assistance is needed, in the role of guardian ad litum. The legal consultant has developed a training manual to assist social

	workers in preparation for and taking cases to court. He is currently working with the court system to increase effectiveness of court procedures related to child abuse/neglect.
PROFESSIONAL POOL:	A group of paraprofessionals, including community outreach workers, logistic case aides, and homemakers has been established. These workers have been trained in dynamics of child abuse/neglect. They are being deployed to work with child abuse/neglect cases with professional case managers from several agencies, and hopefully will serve as a service integration mechanism through interagency use.
SHELTER CARE PROGRAM:	Kokua Kalihi Valley has established an emergency shelter for spouses and children who have been or are at risk of being abused. It is available for an average stay of six days when it is unsafe for a mother and child to remain at home. It serves approximately 200 families a year.
HALE LOKAHI:	Child and Family Service has established an integrated family service center in Waianae. This center coordinates the activities of services to families under severe stress and at high risk of child abuse. The key to the Center's effectiveness is a relaxed, non-threatening atmosphere.
EARLY IDENTIFICATION PROJECT:	Screening and interviewing procedures have been developed at Kapiolani Hospital Prenatal Clinic to identify highly stressed families who may be at risk of abusing their newborn infant. Families found to be at high risk are defined as in need of extra services and are referred for followup by the Home Visitor Program.
HANA LIKE HOME VISITOR PROGRAM:	Family Service Center has established a Home Visitor service. Paraprofessionals are trained in the dynamics of child abuse/neglect and parent-child interaction techniques. They make home visits to families identified by the Early I.D. project to work with parents in developing a positive relationship with their newborn. The program combines a lay therapy and parent-child interaction approach to prevent incidence of child abuse and neglect.
OTHER SUPPORT SERVICES:	Transportation, emergency financial assistance and babysitting are provided by the Center. The Center makes referrals for day care, medical care, employment assistance, family planning, and marital counseling.

A Sexual Abuse Diagnostic and Treatment Service initially funded by the Center has already become a state-financed program. $200,000 was approved for the Department of Health's budget in order to establish a statewide sexual abuse (including rape) program.

A manual on the dynamics of child abuse has been produced and can be purchased from Kauikeolani Children's Hospital in Honolulu.

A second program—Shelter Care—was obviously needed in the community and through the use of state funds, it can be an ongoing program. Ways to do this are being worked out.

RECOMMENDATIONS

1. Help vulnerable families without special regard to NAI
2. Make helpers (workers) more knowledgeable about the dynamics of abuse and neglect
3. Decrease over-identification
4. Standardize definitions. One makes his own definitions and then proceeds to develop his own program
5. Strenthen our predictors on indices of NAI
6. Conduct and compare identical controlled studies from different geographical areas
7. Increase knowledge of stress associated with child rearing
8. Education of public should keep pace with means to properly screen and handle all reports
9. We need to study:
   a. NAI children not hospitalized
   b. high risk children who have been been injured
   c. children in high risk families who have not been injured
   d. high risk nonabusive parents
   e. rate of repeated NAI in children not seriously injured
   f. female vs. male characteristics of NAI
   g. "scapegoating"
   h. incidence of low birth weight in NAI/neglect children not hospitalized
   i. long term effects of NAI/neglect on the nonserious cases
10. Integrate teaching of NAI/neglect as a routine into all child care education. It should not be treated as an isolated entity.
11. Support the PHN in early identification of families in need of "extra services"
12. Provide additional means for manpower and service to families needing "extra services."

This last recommendation was made at the hearings before the Select Subcommittee on Education of the Committee on Education and Labor, House of Representatives, Friday, October 5, 1973. I pleaded repeatedly, as did others, I am sure, for a substantial increase in the bill for service from the proposed 20 percent to as much as 40 percent or more. I felt that the agencies mandated to give protective services to these cases could not possibly do so without money. I also reported this to our congressman from Hawaii, stating there should be a smaller percentage of funds in the bill for research demonstrations. The appeal was not effective since there was still a 20 percent limit on the amount available for service when the bill was signed into law.

I reaffirm my recommendation as others are doing at this time; namely, that money for the mandated state agency must be increased now for necessary additional manpower and financial support for "extra services." This money must also be used for preventive services, of course. What good does it do if we find a family in need of "extra services" and have none available for them?

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The Future of Training/Education for the Prevention of Child Abuse and Neglect

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I want to focus upon two major areas pertaining to training/education for the prevention of child abuse and neglect.

One relates to strengthening the family as the major preventive strategy, and the other is the central role of the public schools as a vital institution in deterring child abuse and neglect.

I believe a strong, supportive family is the most powerful deterrent, and that other training/education approaches, while valuable, have less chance of meaningfully ameliorating the basic conditions which generate child abuse and neglect.

I contend that the single most effective training/education approach is to create greater public awareness of the profound changes which have occurred in the basic structure of the family which undergirds the development of all children. As a society, I do not believe that we have fully comprehended the significance of crucial trends regarding marriage and the basic organization of the family which currently profoundly influence the lives of millions of children. What are some of these significant changes which have so dramatically changed the definition of the American family? Without understanding these changes, and the powerful social and economic forces which influence parents and in turn their children, we cannot readily understand the underlying causes of child abuse and neglect. Cognizance of the frustrations and powerlessness of parents, in other words, is essential to understanding why child abuse and neglect is escalating. Primary prevention strategies logically must be predicated on understanding the causes of abusive behavior towards children. I argue that escalating child abuse will continue unabated until public policies more realistically begin to reflect basic changes in the way households or families are now formed.

Recently, the family has gained added recognition as perhaps the pivotal societal institution, and yet our citizens are aware of only the tip of the iceberg of profound and rapid change in the basic structure of the American household. These changes, of course, significantly influence the parent-child interaction system that is:

> critical in children's physical, social, emotional, and cognitive development. It is this system that affects parents' abilities to enjoy and guide their children in mutually satisfying ways. It is this system that is being identified as a critical factor in the childrearing process, with special implications for child abuse. Some children are difficult for some adults to "get along" with, some children and parents provoke each other, sometimes there is insufficient bonding and attachment; any or all of these conditions can cause the parent-child interaction system to go awry (Education Commission of the States, 1976, p. 3).

Only in very recent years, indeed months, has the public comprehended the changes in the larger social system which have so dramatically and rapidly altered family units. For example:

> Sixty percent of American families are metropolitan residents;
> Many families move frequently, both short and long distances;
> Families are having fewer children. The average household size in 1974 was 2.97 persons. In 1973 the live birth rate in the United States was the lowest in history;
> The number of single-parent families is increasing, both because of divorce and because the parents never married;
> Over 50 percent of all women are in the labor force; over 30 percent of all women with children under six work out of the home;
> Stable, multi-age communities and the extended family have been replaced by communities linked by interests, age, and income level; and
> Child bearing among adolescents seems to be increasing. In our society these young people have had little or no exposure to young children and even less to how to rear children (Education Commission of the States, p. 4).

Such significant social changes obviously influence and change childrearing patterns in very significant ways.

Many children are cared for out of the home for part of the day. Some are simply left alone. The babysitter and day care center are as much a part of many American families as grandmother and aunt used to be;

Childrearing help and support from a supportive spouse or other family member are not available to many parents. Isolation and frustration may result, with no one to take over and to provide some relief;

Because divorce is usually a transition period between marriages, many children relate to two or more sets of parents, sometimes in quite informal arrangements;

Cultural and religious constraints on behavior, many of which affect child rearing, are looser—for example, what one eats and the manner in which family meals are provided. Physical punishment and control of children is generally sanctioned in our society. The constraints that keep this violent tendency within the bounds of physical safety seem to be less rigid, perhaps reflecting the increase in violence in our total society;

Technological devices for which no norms have been developed have been incorporated into childrearing and family patterns in sometimes deleterious ways. Television is probably the most obvious example of this; and

Men have gradually been excluded from the childrearing process. There is little or no research related to the role of the male in childrearing, yet there is a high involvement rate in child abuse for fathers and stepfathers (Education Commission of the States, p. 5).

An understanding of these social changes is basic to the rationale for and content of any program whose objective is the prevention of child abuse and neglect. The literature on child development compellingly confirms the pervasive influence of the family or home background as a critical variable in determining the educational achievement of young children. Thus, knowledge of changes in family or household formation patterns becomes a *sine qua non* of effective child abuse and neglect prevention efforts.

I want to identify briefly some of the major trends and changes regarding the family which so significantly affect childrearing patterns. At the outset, it may be useful to emphasize that although family formation continues unabated, the structure of the family is changing and becoming more diversified. Indeed, the nuclear family, the traditional cornerstone of our social system, is now in the minority, with less than 40 percent of the nation's households having the typical pattern of father, mother, and children living under one roof. Almost one-third of households now consist of a husband and wife living in a household without children. This demonstrates that attitudes towards having children have changed significantly in recent years, with fertility rates declining among women of all age groups. Current household formation patterns also reflect the increasing tendency for women to postpone marriage, with more highly educated women staying single longer and opting for careers. One-third of today's households are headed by single adults, with dramatic increases in female-headed households as divorce rates escalate and decisions to stay single become more common.

The American family, in fact, is being redefined dramatically, and parents are being influenced and their children affected by social and economic forces over which they have little or no control. These changes have affected not only the poor but increasing numbers of middle-class citizens as inflation, for example, requires double incomes with working mothers helping to maintain standards of living.

If one accepts the family as the key institution in a child's socialization, it is not surprising that children are affected negatively by such rapid change. Many are familiar with the frightening data which indicate, for example: that the rate of infanticide rose more than 50 percent between 1957-70; that parent-perpetrated child abuse is soaring; that the rate of suicides among children aged 10-14 has doubled in two decades; and, that the rate of armed robbery, rape, and murder by juveniles has doubled in the past ten years.

These developments, as well as increases in school drop outs, drug, and alcohol offenses, assaults on teachers, and illegitimate births among teenage mothers have been discussed widely in recent years. The major issue we must address is what we, as a society, do about the problems of raising children in a world in which families undergo such stress and change, and are

influenced so significantly by social forces such as technology, the mass media, and economic and racial discrimination, over which they have little control.

It seems essential that our educational institutions take a greater leadership role in projecting to the public at all age levels the profound social changes which change our lives. Indeed, the general public remains remarkably and dangerously unaware of the impact upon our social structure of forces such as urbanization, the erosion of the extended family, and the influence of television. Too many people still regard the women's movement or ideology as an aberration and not a profoundly pervasive social, economic, and political force which will permanently influence our society in very significant ways. Too few of our citizens, for example, fully comprehend how the dramatic decreases in the number of stable two-parent families undercut the support base for millions of youngsters. Too many of our citizens still regard these problems as being limited only to the poor, and do not realize fully that family disorganization and disintegration affects all communities.

Thus, I argue that the first element of successful child abuse and neglect prevention programs should be massive public information campaigns which will project to a still uncomprehending general citizenry the profound social changes which impact upon families and which unleash the pathologies and frustrations which result in mistreatment of children. The myth that the nuclear family is still the norm must be shattered, and citizens, as well as government policy, must become more attuned to reality. Child abuse and neglect programs must be predicated upon knowledge of these new social realities and appropriate support systems built in terms of these realities.

If greater understanding of the significance and extent of current social change is an essential element of child abuse and prevention programs, how can such understanding be conveyed most effectively? It is here that public schools can become a uniquely effective mechanism for disseminating the new social realities of our time. No other institution has the social penetration and potential grass roots outreach of public education. As adult and continuing education programs grow, the public schools, which now have empty classroom space, are natural vehicles for parent education and related programs in neighborhoods throughout the country. In other words, the public schools are the logical instrument for a dramatic expansion of adult education programs, and these programs should have heavy parenting components. The schools, needless to say, must also provide as a basic element of their regular programs for young people, much more realistic and meaningful offerings in areas such as child development and family life. In fact, schools could become the essential neighborhood or community cornerstone of new family supports and institutions.

It will not be enough, however, to educate parents on nutrition, consumerism, childrearing, and so forth. We must build more comprehensive support systems for families and children. Support systems in all areas, for example: economic, to provide some form of guaranteed income; medical, to provide preventive services such as universal immunization programs; child care, to make available a wide range of day care and home care services for children; and categorical services, to provide assistance to children with special physical and emotional needs.

Indeed, we may have to invent new institutions to accommodate the far-reaching alterations in family life which develop. We need creative thinking and flexibility as men and women cope with a host of new problems concerning child care in our society. For example, the women's movement has precipitated growing concern about the status of women. Can women have status in their jobs and concurrently sustain nuclear families? Schizophrenia can result from this dilemma, and difficult decisions frequently must be made which profoundly affect the lives of the men, women and children involved in such situations where family and work priorities must be sorted out.

Within the immediate future, public policy must reflect more accurately the social realities which we have discussed. The family, traditionally and understandably, has been off limits to outside interference in our society. For the most part the family has remained "private," and many, with ample justification, are apprehensive about the potential intrusiveness of government programs. Indeed, many would subscribe to a policy of guaranteed incomes in which families would be given resources to make their own decisions. In any event, many issues will be decided on political and economic bases, and it behooves researchers and practitioners in the child development and family life fields to build closer ties to policymakers at every governmental level.

If we are to build the supports for families necessary to curb child abuse and neglect, we must influence the creation of enlightened governmental policies. This requires the "children's lobby" to become far more knowledgeable in policy processes if we are to implement programs

that will, for example, redistribute tax revenue, support mothers who opt to stay home with children, provide a range of subsidized services for child care in parental absence, and promote flexible work schedules for men and women.

Many parents need help. They are overwhelmed by a welter of complex social, economic, and political changes and circumstances. If child abuse and neglect is to be prevented, help must be provided to these beleaguered parents. Information about child growth and development must be provided, and better understanding of the dynamics of child-parent relationships inculcated. More intensive efforts must be made to end the social isolation of parents, particularly those with very young children, and parents must share their concerns more openly and frequently with other parents. The social penetration and outreach of the public schools must be capitalized upon more meaningfully as a community base for developing new and more responsive support systems for more diverse family structures.

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Prediction and Prevention of Child Abuse and Neglect

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INTRODUCTION

Child abuse is a major problem affecting many thousands of children from all social strata. Increasing knowledge of the general factors that operate in causing child abuse has resulted in earlier and more accurate diagnosis. Effective therapy is now being instituted at the first indication of injuries in an attempt to break the cycle of parent-induced child abuse and neglect. Although the overall dynamics operating to produce child abuse and neglect are becoming better understood, the specific factors that allow us to predict abnormal childrearing patterns in certain families have not been generally established. The ability to make accurate predictions of abnormal parenting practices will greatly facilitate the initiation of effective intervention before significant damage has been allowed to occur.

This study examines the feasibility of predicting the potential for some abnormal child-rearing practices, of which child abuse and neglect is one extreme example. It concentrates on the perinatal and early neonatal periods, since these offer an excellent opportunity to make assessments of a newborn infant's behavior: to observe the mother's and father's responses to their child, and also provide easy accessibility to individuals as they become a family; permit observations of the mother and child during a critically sensitive time (Klaus, 1972); and allow pediatric intervention to begin early whenever there is indication that potentially harmful child-rearing patterns may occur. Intervention at this time can be aimed at increasing strengths within the family so that the child may have the opportunity to reach his physical, emotional, and intellectual potential.

METHODS

From November 1971 to March 1973, a population sample was drawn from 350 mothers who were having either their first or second child at Colorado General Hospital. Infants with neonatal conditions severe enough to require transfer to the neonatal intensive care unit were excluded from the study.

Some or all of the following screening procedures were carried out to determine which parents were most likely to be predictive of "abnormal parenting practices."

1. Collection of prenatal information: Data were gathered regarding the parents' upbringing, feelings about this pregnancy, expectations for the unborn child, attitudes towards discipline, availability of support systems, and the present living situations. (Appendix 1, a).
2. Administration of a questionnaire: (Schneider et al, 1972) A 74-item questionnaire was administered to the mother during the prenatal or early postnatal period. The questions covered information similar to that obtained in the prenatal interview.
3. Assessment of labor and delivery room information: These data were collected by one or more of the following methods:
   a. Mother-infant interaction forms were completed by the labor and delivery room nurses. The nurses recorded the parents' verbal and nonverbal interactions with their child during their first encounter with him/her (Appendix 1, b). The nurse also added any additional pertinent observations about the parents' behavior.
   b. In a number of instances, with the parents' permission, videotapes were made of mother-infant interaction so as to be able to carry out a more thorough assessment of the quality of this interaction and to check the accuracy of observations made by labor and delivery room nurses and physicians.

c. The delivery room staff was encouraged to provide anecdotal information regarding their observations of the parents and children. This information was also utilized to assess parenting potential (Appendix 1, b).

4. Observations and/or interview during the postpartum period: During the postpartum period, the parents were again interviewed to obtain data or expand upon information gained during the prenatal interview (Appendix 1, c). Information obtained from direct observation of the mother-infant interaction during the postpartum stay in the hospital was also recorded.

From the data gathered in two or more of these areas, parenting potential was assessed. One hundred mothers identified as having psychological, interactional, and life-style dynamics (Steele and Pollock, 1968; Riser, 1974) which might result in "abnormal parenting practices" were randomly assigned to a "High-Risk Intervene" group (N=50) or a "High-Risk Nonintervene" group (N=50). Fifty mothers who also delivered their first or second child at the hospital in the same time period and who were assessed as low-risk in terms of abnormal parenting potential were selected as controls.

"Intervention" in this study meant the provision of pediatric care by one pediatrician at the Medical Center where the child was born. This pediatrician examined the infant during his stay in the newborn nursery, talked with the parents on the postpartum ward, and scheduled the first pediatric clinic visit to take place before the infant was two weeks old. Thereafter, the pediatrician saw the child at scheduled bimonthly visits. Additional pediatric visits took place whenever the doctor or the mother felt that the child should be seen. In addition to seeing the child during visits to the clinic, the pediatrician also contacted the family by telephone two or three days after discharge from the hospital, as well as during the subsequent weeks when a clinic visit was not scheduled. Additional telephone calls were initiated by the pediatrician to ascertain the status of any problems that might have become apparent in previous clinic visits and/or telephone conversations. The physician also contacted the family to provide support to them whenever a medical or other crisis was known to be present. It was not pointed out to the study families that this service was exceptional; it was simply provided as part of the child's well-baby care.

In addition to the contact between the pediatrician and the family, "intervention" also included weekly home visits by public health nurses. The public health nurses had been notified of the pertinent findings obtained in the interview, assessment of the delivery room interaction, and the questionnaires. Whenever necessary, referrals were made to other medical facilities or mental health clinics. Lay health visitors (Kempe, 1976), who visited in the homes to assess the entire family and to provide liaison with the professional health system, were utilized whenever indicated.

"Nonintervention" meant that the investigators did nothing directly for the family after discharge. However, all of the available information was routinely shared with attending hospital staff, community agencies such as visiting nurse service, and the family physician or clinic.

When their child was between the ages of 17 and 35 months (mean age 26.8 months) a home visit was made to 25 randomly-selected families in each of the three categories: "High-Risk Intervene" (HRI), "High-Risk Nonintervene" (HRN), and "Low-Risk (LR). During this home visit, the mother was interviewed and medical and social information involving the entire family was collected. Also, observations of mother-child interaction were made and the Denver Developmental Screening Test (DDST) (Frankenburg, 1970) was administered to the child.

The incidence of various findings was determined for each child during the first 17 months of life (at the time of detailed evaluation, the youngest child was 17 months old). In order to determine whether the measures used had validly predicted a group at risk for deficient parenting, children were assessed for the presence of incidents of "abnormal parenting practices," which included all verified reports of abuse and neglect to the Central Child Abuse Registry, injury secondary to lack of adequate care and supervision, injuries suspicious for inflicted trauma, failure to thrive which was seemingly secondary to deprivation (Schmitt & Kempe, 1975), relinquishments, foster care placements, and parental kidnappings. Children were also assessed as to the number of incidents of trauma thought to be true accidents, reasons why children were no longer in their biologic homes, their immunization status, and their performance on the Denver Developmental Screening Test.

Central Child Abuse Registry reports and indications of "abnormal parenting practices" involving medical concern were categorized for all three study groups as a comparison of the effect of intervention. Data were also compiled to help indicate which of the four screening

procedures (prenatal interview, questionnaires, labor and delivery room observations, or postpartum interviews and observations) resulted in the greatest percentage of correct predictions of "parenting potential".

The three groups were compared by ordinary chi square tests appropriate for 3 by 2 contingency tables. These "total" chi squares were partitioned into single degrees of freedom chi squares appropriate for comparing the two high-risk groups with the low-risk group (HR vs. LR) and the "High-Risk Intervene" group with the "High-Risk Nonintervene" group (HRI vs. HRN), as discussed by Kastenbaum (1960) (See Table 4.).

RESULTS

1. The Ability To Predict

a. Indications of abnormal parenting: By the time of detailed evaluation there were 22 indications of "abnormal parenting practices" in the high-risk groups (25 HRI and 25 HRN) and 2 indications in the control group of 25. The high-risk groups differed significantly from the low-risk group ($p<.01$). In the total population sample (150 children), eight high-risk children and no low-risk children were reported to the Central Child Abuse Registry ($p<.04$).

There were 3 cases of failure to thrive (weight below the third percentile, height and head circumference above the third percentile) thought to be secondary to deprivation in the HRI group. Although children in HRN group were not followed as closely, information was obtained by chart review and contact with the child's physician that two of these children exhibited failure to thrive thought to be secondary to deprivation. There were no such cases in the low-risk group.

b. Accidents: There were 31 children in the high-risk groups and 11 children in the low-risk group who had sustained at least one accident which required medical attention during the time period of the study. During the first 17 months of life, 22 children in the high-risk groups and 4 children in the low-risk group had at least one accident requiring medical attention ($p<.02$).

c. Immunization status: At one year of age, 47 out of the 50 high-risk children (25 HRI and 22 HRN) were up to date with their immunizations. In the low-risk group, 24 of 25 had similar immunization status. The difference is not statistically significant.

d. Denver Developmental Screening Test: DDST assessment of high-risk children revealed that there were 3 whose results were recorded as questionable, 3 children who were untestable, and 44 who were normal. In the low-risk group, all 25 were normal. There is no statistically significant difference between these groups. If the results of the DDST are examined by counting the number of clear failures (test items to the left of the child's chronological age), 10 high-risk children versus no low-risk children had clear failures ($p<.02$).

e. Reasons for no evaluation: There was a significantly increased incidence ($p<.04$) of infants assessed as being at risk for "abnormal parenting practices" not being in their biologic home at the time of the follow-up evaluation. All low-risk children were in their biologic home; but 8 high-risk children were either in foster care, permanently living with relatives, or had been legally relinquished.

Table 1:

Summary of Statistical Analysis

Item	HRI	HRN	LR	Partitioned X^2 results		
				HR-LR	HRI-HRN	Total
Total study population (150): Central Registry reports	6	2	0	p<.04	p<.08	p<.03
Detailed evaluation of population (25 in each category)						
Central Registry reports						
at time of home evaluation (mean 26.8 months)	2	1	0	p<.22	p<.48	p<.36
by 17 months of age	1	1	0	p<.60	p<.99	p<.30
Indications of abnormal parenting practices						
by time of home evaluation	11	11	2	p<.01	p<.99	p<.01
by 17 months of age	10	10	0	p<.01	p<.99	p<.01
Failure to thrive	3	2	0	p<.20	p<.60	p<.30
DDST not normal						
by test manual (see Frankenburg, 1970)	3	3	0	p<.08	p<.99	p<.20
by failed items	7	3	0	p<.02	p<.10	p<.02
Accidents						
by time of home evaluation	16	15	11	p<.14	p<.78	p<.33
by 17 months of age	12	10	4	p<.02	p<.56	p<.05
Not in biologic home	5	3	0	p<.04	p<.36	p<.07
Appropriate immunization status at one year	25	22	24	p<.72	p<.16	p<.16
Inpatient treatment for injury	0	5	0	p<.11	p<.01	p<.01

2. Results of Intervention on the Incidence and Outcome of Abnormal Parenting Practices

a. Incidence: Between the HRI group and the HRN group there were no significant statistical differences on the basis of Central Child Abuse Registry reports, indications of "abnormal parenting practices," accidents, immunizations, or Denver Developmental Screening Test scores.

b. Outcome: Another way to measure the effect of intervention within the high-risk groups is to describe the quality of differences in the types of "abnormal parenting practices" that occurred. No child in the low-risk group or the HRI group suffered an injury thought to be secondary to "abnormal parenting practices" that was serious enough to require hospitalization for treatment. However, five children in the HRN group required inpatient treatment for serious injuries ($p<.01$). These injuries included a fractured femur, a fractured skull, barbiturate ingestion, a subdural hematoma, and third-degree burns. Although these five injuries were treated in local hospitals, only two of them had been reported to the Central Abuse Registry.

3. Screening Procedures

Information from observations of labor and delivery room interactions was analyzed individually and resulted in 76.5% correct predictions of parenting potential. The questionnaire alone resulted in 57.5% correct predictions and the postpartum interview/observations resulted in 54% correct predictions. If all four parameters are used together, they resulted in 79% correct predictions.

During the initial interviews and observations, four factors were considered as possible indicators of high risk: the mother's race, the family's socioeconomic status (as determined by the hospital's financial ratings), the mother's marital status, and the mother's age. In the study population, the mother's race did not prove to be a significant variable. There was a trend toward "financial difficulty" in mothers in the high-risk groups. The mother's marital status and age differed significantly between the high-risk groups and the low-risk group; single and young mothers were considered to be at higher risk for abnormal parenting practices.

DISCUSSION

Child abuse is now being reported approximately 300,000 times each year in our country. The figure rises to 1 million if neglect is included. About 60,000 children have significant injuries; about 2,000 die and 6,000 have permanent brain damage (Kempe, 1976). Multidisciplinary research (social, pediatric, nursing, psychiatric, and legal) has made possible earlier diagnosis and more successful treatment programs. However, as in many other aspects of medicine, prevention is the ultimate goal.

Medical and nursing staff who work in the prenatal and labor and delivery areas and the neonatal nursery are ideally situated to make sensitive observations of a family's interactional behavior. The assessment of attitudes and feelings has been a part of pediatrics for many years. It is now time to formally utilize these assessments in the implementation of supportive intervention for families in need. Systematic use of a prenatal interview, questionnaire, labor and delivery observations, and postpartum interviews/observations can identify a population at risk for "abnormal parenting practices". These data show that accurate prediction of families in need of extra services is possible, as evidenced by the statistical differences between the high-risk groups and the low-risk group in the areas of "abnormal parenting practices", Central Child Abuse Registry reports, the number of accidents (by 17 months of age), children no longer in their biologic homes, and children exhibiting clear failures on the DDST.

Recently there has been an increased awareness of the abnormal behavior characteristics and the developmental lags seen in abused children (Martin, 1975, 1976). This has been observed in the children after documentation of abuse, but with the assumption that the children have been living in an "abusive environment" prior to the physical abuse. In this study, 20% of children thought prospectively to be at risk for abnormal parenting had at least one clear failure on the DDST. These are children thought to be living in an environment deficient in parenting.

It is a belabored point that battering parents tend to lack motivation toward initiating helping services. However, when the health care providers (pediatricians, public health nurses, and lay health visitors) initiate an outreach approach with high-risk families, a comprehensive medical program can be successful.

Now that it is largely possible to identify a population at risk for "abnormal parenting practices," the next step is to determine the success and practicality of initiating early intervention with these families. Although there was no statistically significant difference in the incidence of "abnormal parenting practices" between the HRI and the HRN groups, there was a qualitative difference in the injuries in the study groups. In the HRI and the low-risk groups, no child required hospitalization for treatment of a serious injury thought to be secondary to "abnormal parenting practices". However, in the HRN group five children required treatment for

trauma or poisoning. One of the five serious injuries (the burns) was preceded by relatively minor inflicted trauma, including cigarette burns, scratch marks and strap marks. These all received medical attention but were never reported, nor was an attempt made to involve other helping agencies in an effort to prevent further injuries. There is a possibility that the third-degree burns and the resulting contractures could have been prevented if intervention had been initiated promptly. In another case, a subdural hematoma and its resulting intellectual deficit and neurologic handicap might have been prevented if intervention had been instituted during a "social admission" to a hospital just prior to the injury. If appropriate interventions to alleviate social pressure had been undertaken at that point, there is a possibility that the injury would not have occurred. In the low-risk group, injuries (a minor burn and a metacarpal fracture) thought to have occurred because of negligence both involved children over two years of age. These children were well into the accident-prone toddler years, whereas injuries in the high-risk groups occurred at younger ages.

There was also an increased incidence of failure to thrive in the high-risk groups. Early identification and effective intervention in one case of failure to thrive in the HRI group was therapeutic for that child. This baby was promptly hospitalized at five weeks of age when failure to thrive was discovered. The weight gain was re-established in the hospital and failure to thrive completely resolved by four months of age. On the two-year follow-up, the child had normal growth parameters.

Therefore, in the HRI group, it appears that modest intervention prevented any injuries severe enough to require hospitalization for treatment and any injury that resulted in prolonged disability. The less serious injuries and the failure-to-thrive baby in the HRI group were promptly reported and effective community intervention established, which may have prevented subsequent, more serious, problems.

The concept of early preventive pediatric and community intervention will, it is hoped, lead to progress in prevention of the harmful effects of child abuse and neglect. Families identified as being in need of extra services must have access to intensive, continuous intervention which is both positive and supportive. It makes little sense to provide excellent prenatal, obstetrical, and neonatal pediatric care in our hospitals, only to abandon the most needy young families at the hospital door and leave to chance, or to parent motivation, the needed access to helping professionals.

SUMMARY

In this study, information gained from observers in the delivery room was most accurate in predicting potential for abnormal parenting practices. The questionnaire did not add significantly to the accuracy of prediction. If delivery room observation is not feasible and only one opportunity for evaluation exists, the early postpartum period affords the best opportunity for collection and analysis of prenatal, labor and delivery, and postpartum observations. Such observations are non-invasive and should be part of obstetrical and postpartum routine.

Immediate, effective intervention by physicians, public health nurses, and/or lay health visitors can significantly decrease many "abnormal parenting practices." In this study, such intervention prevented serious injury in a high-risk population.

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Appendix 1: Warning Signs

These are indications of possible problems. A high-risk situation is created by varying combinations of these signs, the family's degree of emphasis upon them, and the family's willingness to change. The interviewer must take into consideration the mother's age, culture, and education, as well as observations of her affect and the significance of her feelings. Many of these signs can be observed throughout the perinatal period; they are listed in this order because they are found most commonly at these times.

1a - Observations during the prenatal period

The mother seems overly concerned with the baby's sex or performance.

The mother exhibits denial of the pregnancy (not willing to gain weight, no plans for the baby, refusal to talk about the situation).
This child could be "one too many."
The mother is extremely depressed over the pregnancy.
The mother is very frightened and alone, especially in anticipation of delivery. Careful explanations do not seem to dissipate the fears.
There is lack of support from husband and/or family.
The mother and/or father formerly wanted an abortion or seriously considered relinquishment and have changed their minds.
The parents come from an abusive/neglectful background.
The parents' living situation is overcrowded, isolated, unstable, or is intolerable to them.
They do not have a telephone.
There are no supportive relatives and/or friends.

1b - Observations during delivery
Written form with baby's chart of parent's reaction at birth.
How does the mother LOOK?
What does the mother SAY?
What does the mother DO?
When the father attends delivery, record his reactions as well.
Passive reaction, either verbal or non-verbal: mother doesn't touch, hold, or examine baby, nor talk in affectionate terms or tones about the baby.
Hostile reaction, either verbal or non-verbal: mother makes inappropriate verbalizations, glances, or disparaging remarks about the physical characteristics of the child.
Disappointment over sex of the baby.
No eye-contact.
Non-supportive interaction between the parents.
If interaction seems dubious, talk to the nurse and doctor involved with delivery for further information.

1c - Observations during the postpartum period
The mother doesn't have fun with the baby.
The mother avoids eye contact with the baby and avoids the direct en face position.
The verbalizations to the infant are negative, demanding, harsh, etc.
Most of the mother's verbalizations to others about the child are negative.
The parents remain disappointed over the sex of the child.
Negative identification of the child: significance of name, who he/she looks like and/or acts like.
The parents have expectations developmentally far beyond the child's capabilities.
The mother is very bothered by crying; it makes her feel hopeless, helpless, or like crying herself.
Feedings: the mother sees the baby as too demanding; she is repulsed by his messiness, or ignores his demands.
Changing diapers is seen as a very negative, repulsive task.
The mother does not comfort the baby when he cries.
The husband's and/or family's reactions to the baby have been negative or non-supportive.
The mother is receiving little or no meaningful support from anyone.
There are sibling rivalry problems or a complete lack of understanding of this possibility.
The husband is very jealous of the baby's drain on mother's time, energy and affection.
The mother lacks control over the situation. She is not involved, nor does she respond to the baby's needs, but relinquishes control to the doctors or nurses.
When attention is focused on the child in her presence, the mother does not see this as something positive for herself.
The mother makes complaints about the baby that cannot be verified.

Appendix 2: Positive Family Circumstances

1. Parents see likable attributes in baby, see baby as separate individual.
2. Baby is healthy and not too disruptive to parents' lifestyle.

3. Either parent can rescue the child or relieve the other in a crisis.
4. Marriage is stable.
5. Parents have a good friend or relative to turn to, a sound "need-meeting" system.
6. Parents exhibit coping abilities; i.e., capacity to plan and understand need for adjustments because of new baby.
7. Mother's intelligence and health are good.
8. Parents had helpful role models when growing up.
9. Parents can have fun together and enjoy personal interests or hobbies.
10. This baby was planned or wanted.
11. Future birth control is planned.
12. Father has stable job.
13. Parents have their own home and stable living conditions.
14. Father is supportive to mother and involved in care of baby.

Appendix 3: Special Well-Child Care For High-Risk Families

1. Promote maternal attachment to the newborn.
2. Contact the mother by telephone on the second day after discharge.
3. Provide more frequent office visits.
4. Give more attention to the mother.
5. Emphasize nutrition.
6. Counsel discipline only around accident prevention.
7. Emphasize accident prevention.
8. Use compliments rather than criticism.
9. Accept phone calls at home.
10. Provide regular home visits by Public Health Nurse or Lay Health Visitor.

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Prevention of Child Abuse and Neglect: Thoughts on a Family Systems Approach

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Currently, the two major models of primary prevention focus on (1) individuals who have a high probability of abuse due to personal characteristics and (2) societal and environmental factors which influence the occurrence of abuse. The first model, which is favored by Kempe and Helfer (1972) as well as others, utilizes questionnaires, hospital observation, etc., and attempts to predict the likelihood of child abuse from criteria largely based on individual characteristics. Health personnel follow and involve themselves with individuals who "score" at risk.

This approach originates from a personality or psychopathological model of child abuse. The most important ingredient in this model is parental character deficiencies and early experiences, which may cause or predispose the parent to abuse his/her child. While many proponents of this model acknowledge that a child (seen as different) plus a form of crisis are requisite before abuse can occur, the child's difference is usually explained as a projection or unrealistic expectation, and the crisis as a precipitator, not a cause, of abuse. Research on the relationship of personality characteristics to actual abuse has frequently been inconsistent and filled with problems; e.g., low agreement of authors, lack of control groups, anecdotal and ex post facto design (Gelles, 1973).

The sociological-environmental model favored by Gil (1970, 1975) and Gelles (1973) states that external environmental stress, cultural values and norms, and societal attitudes are the major determinants of child abuse. Political decisions, such as redistribution of resources, changes of national attitudes toward children, eliminating poverty and unemployment, etc., focus on institutions as well as families. Widespread programs in childrearing are seen as the most important and meaningful measures for prevention of child abuse and neglect.

While there is much merit in both intervening with individuals likely to abuse their children, and dealing with the ills of society as they relate to children and families, there are also enormous logistical and political problems in these approaches. Serious doubt exists that questionnaires (or personality characteristics in general) can predict accurately instances of child abuse. Child abusers vary greatly; many people with "child abuse characteristics" never abuse their children. Labeling of families, whether publicly or not, may cause more harm than good. On the other hand, poverty appears to be a stable element in our society. Likewise, broad changes in national attitudes toward children and violence seem unlikely to occur.

Some of the other problems with these approaches are: (1) greater emphasis is placed on intervention-treatment programs, rather than prevention programs (although both programs now are taking a back seat to research); (2) courses and workshops on parenting (e.g., Parent Effectiveness Training) are not likely to be attended and accepted by the people most in need; and (3) preventive intervention is directed towards parents and environmental situations (Alvy, 1975) while the children are generally ignored.

Considering the state of the art and political realities, the most germane problem is the scatter gun or low specificity approach being used. We must pinpoint more accurately and focus more specifically on those families who will abuse their children. Certainly, helping all families or all poor families is a worthy goal, but whether or not the limited child abuse prevention funds should be used in this way is another question. If families at risk can be pinpointed more accurately and given preventive intervention combined with a program of integrating abusing and nonabusing problem families, then many programmatic and political problems will be solved. The program must focus on both parent and child, and be able to help them with psychopathology and environmental stress when present, as well as with emotional and developmental problems of the child. Such a prevention-intervention program is successfully in operation at the Peanut Butter and Jelly Therapeutic Pre-school, Infant, and Family Center (Albuquerque, New Mexico) in its Family Systems Approach to the prevention and intervention of child abuse and neglect.

The Family Systems Approach (Grodner, 1977) states that child abuse is part of a pattern of relationships and reciprocal transactions between parent and child, as well as other family members, in which all parties play a part. Theoretical influences of this approach include: family therapy, the effects of the child or infant on its caregiver, and research by Chess, Thomas and others on the interplay between child temperament characteristics and parental-childrearing

practices and attitudes (Chess, 1971). Without denying the role of personality deficits or environmental-societal influences on child abuse, the particular relationship and specific transactions of the parent-child dyad are extremely important and generally neglected determinants of child abuse and neglect.

In most models of family therapy, the family is seen as a system, concerned with homeostasis, norms, and communication, rather than individual psychopathology and symptoms (Haley, 1970; Ackerman, 1966). While much specific individual behavior (juvenile car theft, etc.) is viewed from a perspective of the family system, it is interesting that child abuse, which by definition is a family-based relationship behavior, is largely viewed as individual pathology.

Recent research (Lewis and Rosenblum, 1974) regarding the effect of the child or infant on its caregiver shows the great influence children have in shaping the relationship between parents and themselves.

Chess and Thomas (Chess, 1971), in their longitudinal studies on the genesis of behavior disorders, found correlations between behavior problems and the interplay of parenting activity, attitude and child temperament. When emphasis was placed on parents or children alone, no strong relationships were found. In fact, parents of behaviorally disordered children were not markedly different from those parents with "normal children." Many difficult children disrupted the parenting abilities and eventually altered the parenting attitudes of their caregivers. Sameroff (1975) believes that prediction of children's long-range developmental outcome is dependent on an interactional model of individual constitutional makeup and caretaking environment.

It seems reasonable that the interaction of child and parent, and to some extent the child itself, is a greater influence on child abuse and neglect than has generally been acknowledged (Grodner, 1977). For example, child abuse could develop as in the following scenario: A child with a 'difficult temperament' may receive parenting inappropriate for him from 'normal parents' which results in behavior problems for the child. Parents are likely to react with increased discipline and/or tolerance of frustration. Chances are thus increased that the parent will not be able to control impulses or temper, which result in abuse and a reciprocal pattern of child behavior and parental abuse. The observation that many abused children are, were, or have become difficult to handle, hard to tolerate, obnoxious, etc., lends credence to their playing more than the passive role many theorists have given them (Grodner, 1977).

With a family systems orientation, it is possible to look at the parent-child relationship and transactions along a continuum from well-functioning mental health norms to severe child abuse and neglect. Amount and intensity of physical discipline, quality of care and stimulation, and other relevant issues may be ascertained. Families who are having difficulties with these issues, but are not abusing and/or neglecting their children, are the prime candidates for preventive intervention.

The Peanut Butter and Jelly program also deals with families currently abusing and/or neglecting, as well as emotional, developmental, environmental, and/or parenting problems not directly related to abuse or neglect.

It is no longer necessary to focus on criteria such as personality characteristics which are related only indirectly, statistically, or not at all, to actual child abuse/neglect; or focus on environmental issues which affect large groups of people, few of whom will ever abuse or neglect their children.

Intervention, as well as prediction, may be directly related to the interaction of abuse. Many preventive and remedial interventions focus on personal parental problems, such as giving a parent the mothering she never had, while disregarding the problems of the child. This approach is believed both necessary and sufficient to stop child abuse. However, neglect of services to the child is not only unfortunate, since the child plays a part in the abuse cycle, but also precludes preventing or changing the emotional and developmental problems of the child, which Martin and Rodeheffer (1976), as well as others have found to be common. We believe that working with parents and child together can make possible a change in child development and behavior, relationships, attitudes, parenting skills, and stop or prevent abuse and neglect.

The program consists of therapeutic classes, outreach and home programs, with supportive and adjunctive services including psychological, language, speech, training and consultation. Parents interact with, and model interactions between, staff members and their child (Grodner, 1977). Parents also have an opportunity to learn new ways of dealing with their behavior and feelings which formerly resulted, or in the future may result, in an abusive response. Improved behavior and development of the child, and improved parenting, have a reciprocal cumulative effect in the prevention of abuse and neglect. Activities, such as personal therapy and help with

environmental stress, are accomplished as part of the individual family's treatment plan. However, to combat a parent's poor self-concept and sense of isolation, the acquisition of parenting skills and group warmth frequently accomplishes more than individual counseling intervention. A delivery system and environment sufficiently individualized and sensitive to work effectively with the so-called "difficult parent," is one aim of the program.

The integration of abusing and neglecting families with those who have other types of psycho-social-environmental problems, limits program stigma and aids in developing an individual functional approach to viewing families with problems or in high risk situations. In summary, using a family systems approach (which is not mutually exclusive to other approaches) with families at different places on the child abuse and neglect continuum is an innovative, yet practical, approach to the problems of both prevention and intervention in child abuse and neglect.

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Working with Teenage Parents: High School Redirection

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High School Redirection is an alternative high school which has, since its inception in April, 1969, served a "high risk" population of students. They come to us alienated from the traditional educational system, and seeking an alternative way in which to complete their high school education. Our school population comprises potential dropouts; economically, academically, and socially disadvantaged students; some emancipated minors; and young mothers and fathers. They have in common the desire to remain in school and to get a high school diploma. This is evidenced by the fact that they are not mandated to our school but rather apply voluntarily from any city high school within the five boroughs of New York City, and in most cases remain on a waiting list from one to six months.

Our school, which is organized on an alternate week basis, is committed to an approach which, in addition to stressing the improvement of basic academic skills, has also seen a tremendous need for out-of-school learning experiences and ongoing group and individual counseling. Based on this commitment, in 1974 we organized an optional program in early childhood training. This program involves both male and female students in alternate week assignments in a day care center where they work under the supervision of trained day care personnel. On the other weeks, they return to school where they are instructed by our day care coordinator, Ms. Cecelia Barnes, in early childhood methodology and pedagogy. We saw this program, which has been extremely successful, as important both in terms of possible career training in the field of early childhood education and, perhaps more significantly, as a beginning in the field of parent awareness which we felt would do much to decrease the potential for child abuse. We feel strongly that child abuse is often caused by past negative experiences of the abusers, as well as lack of information and preparation for parenthood.

Initially, this program was funded on a very limited basis ($13,000 for teacher salary, $250 for instructional supplies). Additional space is being made available to us for the coming school year and we plan to set up an experimental and pilot day care center in our school. It will be run by our high school students under the supervision of a professional early childhood coordinator. Hopefully, we will include in this day care population some of our students' children, some staff children, and some children from the impoverished, mainly Spanish-speaking community in which our school is physically located. The reason for this mix is an attempt to bring children of different racial and socio-economic backgrounds together in the interest of decreasing the racial polarization which is so evident in our city and our country today.

In addition, in line with our concern about the lack of parent preparation within our educational system, we have instituted a course in parenting. In it, our students receive information regarding pregnancy, abortions, early childhood development and growth, adolescent identity problems, constructive methods in parent-child relationships, and child abuse. The parenting class is taught by Mrs. Barbara Dixon, who is licensed in home economics and biology and is experienced in health-related areas.

The problems in instituting both the day care training program and the parenting class have been financial—we have had to take the staff time out of our regular city tax levy allocation which has, therefore, increased the class size of the rest of our regular offerings. A request from the day care training program for funds for instructional materials was granted, but for only $250. We have no allocation from the central board for our parenting course. During the first two years of our program we were unable to pay for our students' transportation to the day care centers during their alternate week assignments, which produced an unreal and unfair financial burden for our unpaid student participants.

We are deeply concerned that in our society there are more stringent requirements for driving a motor vehicle than there are for becoming a parent. We strongly advocate the introduction of the subject of the understanding and prevention of child abuse into the secondary school curriculum. We feel that child abuse is caused by ignorance of more constructive methods of relating to children and the daily frustrations faced by parents. These frustrations are closely

linked to conditions such as poverty, under-education, and poor housing. There are few resources available to help people to understand and alleviate these stresses. Since children represent a powerless group in our society, they bear the brunt. The discussion and sharing of experiences in high school classes would go a long way toward preparing present and future parents for healthy and constructive ways of dealing with their children.

APPENDIX 1

Parenting Course Description

The course is structured to present the students with various methods of parenting. The students are given the opportunity to recall memories of their childhood, to look at themselves and their values, and to think of different solutions to future problems involving themselves and their children. We cover topics such as conception, pregnancy, abortions, birth control, stages of child development, discipline, and child abuse.

The course is in an experimental stage. This is its first year at High School Redirection. The classes are coed, including both parents and expectant parents. The response has been superb. The students feel it is a valuable contribution to their educational development.

APPENDIX 2

Day Care Aide Training Program

Students are placed in a day care center and come to school on alternate weeks. The emphasis of the program is to give the adolescent some tools, skills, and teaching techniques to use with young children. Trainees are required to cover units which include:

1. Approach
2. Observing - (Anecdotes)
3. Listening skills (crying—a sign of stress)
4. Puppets
5. Fables
6. Language Arts—making books
7. Pre-reading
8. Mathematics
   a. Attribute blocks
   b. Unit blocks
   c. Cuisenaire rods
   d. 1000 beads
   e. 100 cubes
9. Water Play
10. Sand Play
11. Science—plants; small animals.

Socialization of the child is of great importance in the day care program. Students study the society and its effects on the child. Issues discussed include community politics, cultural differences, and family roles. Nutrition is discussed in this course because some children have special diets for religious or health reasons.

On the job, the students serve as teacher aides. They are expected to show good attendance, punctuality, and good service to children. Some students are placed in offices, but most work in classrooms. They assist the teacher with activities for the social, physical, and intellectual development of the children. Typical activities include block building, story telling, table toys, mealtime, naptime, indoor activities, birthday parties, and holiday celebrations.

After graduation some students have been successful in securing full-time positions in the day care center in which they volunteered. Some students have gone on to college to study early childhood education. All have expressed interest in child care careers.

We are planning to open our own child development center in our high school facility. The center will be staffed by students who have all been involved in the day care aides training program, and attended by the children of the high school students, staff, and neighboring community.

Public Awareness

A Public Education Program: The Obligation and the Opportunity

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The focus of this discussion is not just the subject of public awareness in the field of child abuse and neglect but the broader subject of public relations for your organization: public relations for the social service agency, large or small, public, private, or volunteer. Public relations. Do you recoil from the concept? Very possibly and it is understandable. Through misuse, it has come to have most unfavorable connotations. For millions of us it smacks of manipulation, slickness, and at times, flagrant dishonesty. Misuse may be society's greatest single problem. Misuse of inventions, like the gasoline engine, of the products of the pharmaceutical industry, of the arts of printing and movies and television, of plans and programs to help the poor and the disadvantaged, and most important of all, the misuse of human beings. So why should the techniques of public relations be any exception? The point is that these techniques do exist. Sometimes we are aware of them; often we are not. But they are being used and misused all around us every day with varying degrees of success. Used for what? Primarily to persuade: "Registration of hand guns is an infringement of our constitutional rights;" to change attitudes: "Mobiloil is only concerned with keeping America strong;" to change behavior: "You can do it faster and better with a microwave oven." To repeat, public relations techniques are used primarily to persuade: "Try Alcoholics Anonymous;" to change attitudes: "Black men and women are entitled to the same opportunities as everyone else;" to change behavior: "Physical punishment of children produces unfavorable results." The techniques are the same. It is the uses to which they are put that count. But the techniques are available.

Since there are proven techniques that can be used to persuade, change attitudes, and change behavior, do you not have an obligation to make as effective use of them as you can? It seems to me that you do because an important part of the job of every person engaged in any kind of social work is to try to convince others of the importance and the pragmatic value of the work you are doing. In this, you are seeking to enlist their support. You believe that your work is important. That is why you do it and why you stay with it. It is certainly not the prospect of riches that attracts you, nor are you in it because it is easy and pleasant. The satisfaction of knowing that your work is important is not enough, however. You will accomplish far more if the community at large, as well as other groups, also believes it is important. Otherwise your efforts will not get the support they must have if you are to achieve reasonable results. Suppose that the community comes to believe in the importance of the subject with which you are concerned. Excellent; but this is not enough either. If the community is to support your efforts, it must also be convinced that your organization does a good job. You have an obligation to persuade others that this is true. You should do this, of course, only if you can do it in good faith—in other words, only if you are doing a good job.

To summarize thus far, there are proven techniques which can be used to persuade, change attitudes, change behavior. These techniques are available to you, and you have a responsibility, an obligation to make use of them in your work.

As Joseph Califano said the other day, the profession you have chosen is surely the noblest work of man or woman. Look around the society. Can you really think of anything more important than doing what little we can, each in his or her own way, to make things a little better for someone else? Most of you do believe this, of course. Otherwise you would not be here. You would be elsewhere, diligently pursuing the accumulation of capital.

There are two things that impress me about your work. The first is that, basically, what you are trying to do is help the individuals you deal with to be the persons they were meant to be. You are trying to help them realize their potential. In one of Martin Buber's books, Rabbi Zusya is discussing this subject with his followers. He concludes by saying, "And when I die and go to meet my God, he will not ask, 'Why were you not Moses?' He will ask, 'Why were you not Zusya?.'"

The second thing that strikes me about your work is that you are agents of change. Change is what your work is all about. You spend your days and years in trying to change attitudes and behavior so that you can change lives. Now, the more people whose attitudes and behavior you can change, the more people you can help. It now becomes apparent that the term "public relations" is not the one we should be using. Aside from its uncomfortable connotations,

it is too loose for our purposes. I suggest that instead we think about the concept of public education. We are trying, each in our own place in our own way, to educate the public on the subject of child abuse and neglect. If we can do so in good faith, we work to make the public understand that our organization is an effective element in this work.

What are our chances for success? What kind of climate are we working in? Some may be tempted to answer gloomily, "Not very good. Look around you." I admit that when you look around, what you see at first glance is not too encouraging.

One could be forgiven for concluding, at times, that ours is an economy fueled by money and powered by greed. Surveys show that a majority of people are convinced that most businesses (not all, but most) will, if they can get away with it, sell anything to anybody at any price. A company has recently introduced a line of sweet alcoholic beverages designed specifically to attract the young men and women of our country. A headline in the April 1, 1977 issue of the Wall Street Journal reads: "Fearful Firms: Human Rights Stand By Carter Disturbs Companies in the U.S." The subhead reads: "They Fret over Retaliation in Latin America, Russia; But No Business Lost Yet."

Examples of love of money to the exclusion of other considerations abound. As far as government and politics are concerned, it seems that the most important thing President Carter could do before he leaves office would be to restore faith in the leadership and in the institutions of our country. Right now such faith is at a very low ebb.

But there is another side to all this. The very nature of conditions today work to the advantage of all of us. How can this be? Because excesses produce reactions. I believe that increasing numbers of people are becoming convinced that greed may be doing us in, that we could just pollute ourselves off the planet, and that in a society where violence appears to increase with every year that passes, we must be doing something wrong. Therefore, more and more people—old and young, but especially young—may be increasingly willing to listen to the voices of people like you. "That doesn't add up," I can hear someone saying. Because of inflation and economic problems generally, communities everywhere are demanding, for example, that school and welfare budgets be cut. True. It may be, however, that the revolt is not so much against what is being done, but how it is being done. There is a growing demand for evidence that what is being done is having some effect, that money is being spent carefully and not wasted. For vast numbers of people, the revolt is not so much against expenditure, but against waste, slickness, and dishonesty. I would submit that, although we have a lot of things working against us in our efforts to bring about change, we have a lot of things going for us, too.

There is not sufficient space to go into any detail on how to prepare effective public education programs. I used the word "program", not "campaign." "Campaign" implies an effort of limited duration. In public education, we need to think of continuing effort. I would like to offer a few general thoughts, however, and make one specific suggestion: the National Center on Child Abuse and Neglect in Washington has published a rather concise manual that more and more organizations apparently are finding of practical help. It is called "How to Plan and Carry Out a Successful Public Awareness Program on Child Abuse and Neglect." We wrote it for people with little or no experience in public information work. It is designed for organizations that are limited in staff and short on funds. The emphasis has been on being practical. If you are not familiar with it, you can get a copy by writing to the National Center in Washington, Box 1182. You may find it helpful.

Here are a few suggestions on how to approach the problem of conducting a public education program. I am reminded of Yogi Berra. Some years back, he was managing the New York Yankees. They won the pennant that year, and they were expected to "do in" the St. Louis Cardinals in the World Series rather easily. They did not. To the surprise of most, the Cardinals triumphed. A few days later, a newspaper reporter interviewed Yogi to find out why he thought they had lost. "I think we lost," said Yogi after a moment's reflection, "because we made the wrong mistakes." The wrong mistakes. There is a lesson for us here. Mistakes we are bound to make. What we do not want to do is make the wrong ones.

It has been my observation that most public education programs are likely to go wrong at the very beginning, in the planning stage. There are two all-important factors to consider here: what audience do you want to reach and what do you want to accomplish with that audience? It is not possible to exaggerate the importance of carefully thinking through the answers to these questions.

In approaching the problem, it is helpful to examine the word "public" and look at it very carefully. We may mean the community as a whole, but we may not. It is useful to think in terms of many "publics" or target audiences, not just one. Educators are a "public" in this sense;

so are legislators, physicians, law enforcement people, and social workers. You may want to use mass media such as television, radio, and the press to reach the community as a whole. On the other hand, you may want to zero in on the so-called "influentials," such as civic and labor and business leaders. The March 29, 1977 issue of the Wall Street Journal notes that "Toymaker Kenner Products and the New York City schools held a workshop to teach babysitting and child care."

Interesting things are happening outside the United States, too. A recent issue of Advertising Age carries a story about the spectacular rise of the consumer movement in Japan, in the city of Kobe. The Morinaga Company, a large dairy, operates parents' centers to which people can come to get advice on raising children. It also operates a "helpline" or "hotline" that has handled over 100,000 calls in two years. Perhaps there is an idea for us here. Perhaps business leaders are a "public" worth focusing on not just because of their general influence but because of their potential for direct action. In any event, it is vital to define carefully, before doing anything, what audience you want to reach.

Task number two involves defining what it is you want to accomplish with your target audience. The audience you want to reach and your objective in reaching it will determine how you go about the job. It will determine the content of your message and it will determine the means, the media, and the techniques you use to reach them. (The medium is not always the message.)

If you determine that your audience is the general public, perhaps your goal will be to inform or educate. Child abuse and neglect is a serious problem, and it extends across all races and classes. Or, child abusers need help too. Perhaps you want to do more than educate: you want to stimulate action. Do you want to encourage third party reporting, for example, or remind folks that they have an obligation to report suspected cases? Or do you want to limit yourself to encouraging self-referrals?

If your organization is not geared up to deal with broad public response, then you may want to limit your objectives. You may want to confine your objective to one particular aspect of your services: obtaining more foster homes; recruiting volunteers; generating requests for speakers or educational materials; publicizing educational workshops for teachers or other professionals; or publicizing parenting classes for teens.

The subject of public relations for the social work agency and how it can be used to create public awareness of the problems of child abuse and neglect and build support for the work of the agency have been explored in this paper. The following list is a summary that can perhaps serve as a guide for those facing the problems associated with developing public awareness and public education programs.

1. As professionals, you need to gain support in the community for your organization's activities in child abuse and neglect.
2. Therefore, you have an obligation to educate, i.e., persuade, change attitudes, change behavior.
3. There are proven techniques available to you for these purposes.
4. As change agents, you should employ these techniques in your public education efforts—unless, of course, you can develop more effective ways on your own.
5. Before doing anything else, think through the objectives of your program. Define carefully the target audiences or "publics" it is appropriate for you to reach. Then assign priorities.
6. Carefully think through exactly what it is you want to accomplish with your target audience.
7. Remember that if it is appropriate for your organization, a community-wide public education program will provide a backdrop for your efforts with various other target groups, a backdrop that will make these specific efforts more effective.

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The Most Common Misconceptions about Child Abuse

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This paper is presented to examine ten of the most common misconceptions about child abuse, to explain the evolution of these misconceptions, to compare them to the realities, and to emphasize the need for community reeducation. Many misconceptions are related to one's personal feelings, perceptions, and social and cultural norms which consequently support a "comforting" attitude rather than a realistic approach toward abuse.

CHILD ABUSE ONLY OCCURS IN LOWER SOCIO-ECONOMIC FAMILIES

Statistics regarding the socio-economic characteristics of abusers are skewed since most identified cases of child abuse are reported by hospital emergency rooms, clinics, and social service agencies patronized primarily by lower socio-economic families. Cases of abused children seen in private practitioners' offices are frequently from more affluent families and are not reported. In hospitals and social service agencies, professionals are more skilled in the identification of child abuse and are more familiar with abuse laws and reporting techniques than are private practitioners who either fail to recognize abuse, refuse to get involved, or attempt to handle the abuse situation themselves.

Stereotypes of lower socio-economic families and middle and high socio-economic families perpetuate the misconceptions. Lower socio-economic families are thought of as being uneducated, prone to physical violence, problem-oriented and transient while middle or high socio-economic families are perceived to be educated, resourceful and capable of controlling violent impulses. Finally, the majority of middle, upper-middle, and higher class socio-economic families do not want to believe that abuse exists within their communities, much less that it happens to their own children or is perpetuated by adults in financial circumstances like their own. Current literature demonstrates that abuse occurs in all socio-economic levels, races, nationalities, and in all religious groups (*Today's Education*, 1974). Although education is more comprehensive today than at the time abuse laws were first introduced in the early 1960's, extensive education is not only needed for altering the pattern of abuse but also for identifying and treating abuse regardless of socio-economic level. In addition to educating the professional, it is important to educate the general public, emphasizing that services are available to help the abuser and the abused.

ABUSE OCCURS BECAUSE PARENTS MISJUDGE THEIR OWN STRENGTH WHEN PHYSICALLY DISCIPLINING CHILDREN

This attitude presumes that abuse is merely the over-extension of discipline, and focuses only on the physical result rather than on the cause of abuse. For example, bruises on the buttocks are considered the result of a spanking. However, abuse is actually the result of a complex pattern of deviant parenting involving: (1) the parent's potential to abuse; (2) the "special" child (for example, a hyperactive or premature child, a child with a birth defect, a spouse's child by a previous marriage, etc.) for whom the parent has unrealistic expectations; and (3) a personal or family crisis (Helfer and Kempe, 1974). Parents lash out because they have inadequate constraints and are recycling their parents' rearing patterns. It is not how hard a child is struck, but rather where, with what, and under what circumstances, which determines the extent of injury. For example, we saw a child at age three months with black eyes and bruises around the face. The child, according to his 17-year-old mother, would not stop crying although she changed the baby, fed him and played with him. Out of frustration she hit him in the face six times before she reacted to what she was doing and stopped. This mother had multiple scars from being physically abused by her father as early in her life as she can remember. In early adolescence she was raped by her father and finally ran away from home. She perceived her own child's crying as another failure and reacted to her own feelings of inadequacy in the only way she knew, by physically lashing out. Support systems, education, and treatment are just a few

ways of helping a young mother like her perceive herself more appropriately, redirecting her energies toward good parenting while also offering protective services to the child and ultimately preventing the recycling of abuse.

ABUSIVE PARENTS ARE PSYCHOTIC

The idea of an adult victimizing a defenseless child and the horrifying nature of the injuries in some abuse cases makes it easy to believe that an abuser is mentally ill. This is the most comfortable attitude to adopt. Mrs. Jones, the 20-year-old mother of a child seen at Columbus Children's Hospital was, in fact, psychotic. She stabbed her nine-month-old baby twenty-one times and then turned on herself. The mother heard voices saying the child would be killed so she decided she would do the job herself. Fortunately, the child's stab wounds from the initial abuse were superficial. The psychiatrist diagnosed Mrs. Jones as a paranoid schizophrenic, hospitalized her, and treated the event as a single acute episode, although her history indicated the contrary. After receiving what was considered adequate treatment, the child and mother were reunited, the mother presumably being capable of safely caring for the child. The mother, after another psychotic episode, was again hospitalized but this time before injury to the child. The mother's illness is now perceived as chronic, the prognosis guarded, and protection for the child essential. We emphasize that the above case situation is the exception, not the rule. Studies show that less than 10% of abusers exhibit serious psychotic or neurotic behavior; this figure is consistent with the incidence of psychosis or neurosis in the general population (Steele, 1970). Columbus Children's Hospital statistics concur with national statistics. Out of approximately 670 cases of abuse identified at Columbus Children's Hospital in 1975 and 1976, fewer than 5% of the perpetrators of abuse were neurotic or psychotic.

MOST ABUSED CHILDREN ARE THE RESULT OF UNWANTED PREGNANCIES

Many times after a parent has expressed frustration over or inflicted injury upon a child we perceive the parent's actions as a lack of emotional and physical bonding stemming from an unwanted pregnancy. In actuality it may be post-birth frustrations that make the child unwanted. Interviews with abusive parents indicate that in many instances the abused child was a planned pregnancy or, if the pregnancy was unplanned, the infant was accepted at birth. Accepting the established profile involving a potentially abusive personality, a "special" child and a crisis situation, we conclude the circumstances leading to abuse are unrelated to parental expectations during pregnancy. It is not the unwanted child, but the child who cannot meet the adult expectations of parenting and who is unable to assume the role reversal, who is abused. Mrs. K. wanted to become pregnant, and underwent extensive medical treatment, having been married five years before she conceived. When she had her child, she could not tolerate his crying; she would frequently put him in his crib, close the bedroom door and turn up the stereo to drown out the screaming. When examined at the hospital, this five-month-old had radiological evidence of multiple factures at different stages of healing. The mother had grown up harboring the guilt from being repeatedly blamed for her mother's hysterectomy after her birth. She had had an emotionally deprived childhood, developed a passive-aggressive personality, and married a passive, ineffectual man. Emotional abuse had left its scars, but fortunately she and her husband responded to therapeutic intervention.

CHILDREN ARE SEXUALLY ABUSED BY ASSAILANTS UNKNOWN TO THEM

Society would like us to believe that incest is the universal taboo, that intrafamily sexual abuse does not exist, but that in some cultures incest is an acceptable norm. Seventy-five percent of sexually abused children know their assailants. The younger the child, the more likely the abuser is a family member (Fontana, 1973). Over one-third of the 280 abused children reported in 1975 from Columbus Children's Hospital were sexually abused. One-fourth of the 103 sexually abused children were under the age of six, and two-thirds were under 12 years of age. Three-fourths of the perpetrators of these sexual abuses were fathers, stepfathers, grandfathers, mothers' boyfriends, victims' boyfriends, uncles, babysitters, and known neighbors. Statistics in 1976, although not complete, follow the same trend. Out of 93 cases, 82 had previously known their assailant, with 20 of those cases identified as parent incest. Sexual molesting of a child ranks as one of the lowest status crimes, therefore it is difficult to imagine that a parent could "use" his child for sexual gratification. This particular crime tends to evoke social stigma which triggers emotional feelings, therefore hampering effective communication between the professional and lay community. We need to establish programs that will lessen the stigma in order to minimize the trauma to the child. These would include education, identification, and treatment management.

CHILDREN ARE ONLY ABUSED BY PARENTS AND/OR PARENT SUBSTITUTES

This misconception evolves from the belief that parents have the ultimate responsibility for a child and are therefore responsible for the child's well-being. Further, the assumptions are made that children in licensed or regulated institutions are safe from abuse and that individuals who have chosen a profession related to working with children do not abuse those children. Child abuse can occur in any environment where adults possess the potential to abuse and a child cannot meet the adult expectations. Settings in which abuse occurs outside the home include schools, foster homes, day care centers, and schools for the retarded, just to name a few. In Ohio, corporal punishment in the schools is permissable by law, and when this discipline becomes abusive, it is rarely reported. An example of school abuse is John, a 14 year-old-boy who was described by the teacher as one of the "best" children in the classroom. Yet this boy was presented to Columbus Children's Hospital Emergency Room with severely bruised buttocks, the result of a paddling by his teacher. John, interviews showed, was not fulfilling the teacher's expectations for him. Emotional abuse is also frequent in a classroom when a teacher scapegoats a particular child with put-downs, ridicule, or adverse comparisons. There is need to have clearly defined investigatory responsibility for abuse occuring in such institutions. Until there is equity in enforcement of the law, the extent of institutional abuse will increase.

CHILD ABUSE IS A MEDICAL AND SOCIAL PROBLEM RECOGNIZED BY THE COMMUNITY

Many communities are unable to comprehend the complexity of child abuse and are unaware of the extent of this problem. Recently, 25 cases of measles in a nearby community were identified as an epidemic, yet 394 cases of abuse reported by a single hospital are unrecognized for their epidemic proportions. A community's limited awareness is reflected not only in its denial of the existence of child abuse, but also in its lack of social services. Even if services are available, they are limited to working hours or restricted to certain populations or age levels of children. Counties still exist in Ohio which fail to acknowledge even one abuse case in several years. For example, an 18-year-old father brought his three-month-old baby to Columbus Children's Hospital from a neighboring community hospital. The child had burns on all five fingers of one hand and massive subdural hematomas. The father gave the history that he had tripped over an electrical cord while carrying the baby. The child landed on a table top, bounced to a chair and then to the floor, causing the head injury. He claimed that the burns were from boiling milk accidently spilled on the baby's fingers earlier that week. Although this young man never acknowledged that he abused his child, he did recognize his need for help and was willing to become involved in counseling. He was a "loner" and even his 17-year-old wife was running away from him, presumably from fear of injury. Hospitalization for diagnostic evaluation and treatment was recommended, but the county social service agency "sat" on the case. The young man was arrested, and during the first weekend in jail attempted suicide. Six weeks later, having had no legal counsel, no court hearing, and no therapeutic intervention, he escaped from jail, still mistrustful, fearful, without support systems, and with his life in jeopardy. Communities, like abusive individuals, have to be helped to acknowledge that a problem exists before such patterning of mismanagement can be reversed. Education can only be effective if its purpose is realized.

ABUSIVE PARENTS CANNOT CHANGE THEIR BEHAVIOR

This misconception persists because abuse recycles. Violence is thought of as part of a parent's existence, and, as mentioned earlier, the abusive individual is considered psychotic. These are common attitudes of the general public, but the fact is that the majority of families do respond to appropriate intervention. Cohesive relationships between direct service agencies and supportive organizations are essential. Abusive parents are basically mistrustful individuals who will question, "Why would anyone like me? What strengths could anyone possibly see in me?" (Kempe and Helfer, 1972). The Gray family was first seen at Columbus Children's Hospital when their child sustained a superficial hematoma of the skull requiring medical attention. History revealed that abuse had been evidenced before, but the parents had never sought help. Marital discord, an ineffectual parent-child relationship, and the lack of support systems were a few of the identified problem areas. Mr. Gray was reared in an abusive environment where beating was almost a daily ritual from his early years until age 17. He was made to feel inadequate by his parents and consequently developed a poor self-concept which limited his academic learning and reinforced his sense of failure. He did not know how to relate appropriately to his two children in any way and the television became his only escape. His abusive pattern was touched off by any noise interfering with his self-isolation. The mother was somewhat stronger, but also had

weak emotional ties, making identification and alliances difficult. She would support her husband, but then reinforce her parents' negative attitudes toward him. These double messages further intensified his feeling of "I'm no good". Treatment is not short term, but intensive, requiring extensive commitments of many individuals: professionals, nonprofessionals, and extended family members. With recognition of the father's strengths, family supports, and the desire for change, this family was able to develop healthy goals. Individual counseling, family therapy, parent education, and infant stimulation all helped to produce change resulting in improved parenting skills, a compatible marriage, the father maintaining the same employment over an extended period of time and returning to school and learning to read, the mother getting her high school equivalency diploma, and the parents buying a house. These changes helped to effect healthy family interaction. Initially they could perceive nothing positive in things others did, parental expectations were unrealistic, and family dysfunction was raging. They can now reinforce positive behavior and, if a crisis becomes unmanageable, they will seek help before disaster occurs. This family demonstrates the kind of change we see with the majority of families that receive comprehensive services at Columbus Children's Hospital.

CHILD ABUSE OCCURS MOST FREQUENTLY IN SCHOOL-AGE CHILDREN

A variety of reasons can explain this misconception. Babies are viewed as innocent, loveable, cuddly, and warm, incapable of intentionally defying a parent totally, incapable of provoking physical abuse. It is difficult to conceive of the infant, physically helpless, as a victim. As an adjunct to the misconception that abuse is an extension of discipline, the assumption is made that abuse occurs more frequently in older children because parents become more forceful in corporal punishment with the older child. Furthermore, the seemingly logical assumption can be made that older children are better able to verbalize abuse incidents since they routinely come into contact with professionals such as doctors, dentists, school teachers, social and recreational leaders who are trained to identify abuse. In reality, almost half of the children who are abused are under six years of age. At Columbus Children's Hospital in 1975, 47% of abused children were under the age of six, 26% were between the ages of six and twelve, and 27% were over twelve years of age. In 1976, 50% were under age six, 25% between six and twelve, and 25% over twelve years of age. The younger child, because of his physical and emotional growth, has numerous needs to be met by a parent. If this parent is preoccupied with meeting his or her own needs or relies on the child for gratification, physical and/or emotional abuse can occur. Parents who have unrealistic expectations of their child's behavior become frustrated when the child does not perform appropriately.

Close medical follow-up for new-born infants, and observation of the interaction between a parent and the new-born child can help identify abuse potential, and parenting courses at the high school level and elsewhere can teach more appropriate means of managing the child and understanding the child's physical and emotional needs.

CHILD ABUSERS SHOULD BE CRIMINALLY PROSECUTED

Laws of various states are consistent in defining child abuse as a crime. Generally, the community perceives child abusers as "criminals", and therefore feels they should be imprisoned. In practice, however the legal system treats many problems relating to child abuse as civil matters, removing the need to prove who committed the abuse, but clearly providing protection for the abused child. Unlike criminal laws, the civil child abuse laws are used to protect the child and to provide treatment programming for abusive families so that negative parenting behavior patterns can be modified. Less than 5% of perpetrators of child abuse are criminally prosecuted, partly because it is particularly difficult to convict the child abuser. The standard of proof must be beyond a reasonable doubt, and generally no witnesses have observed the occurence of abuse. When there is a witness, a coalition frequently exists between the witness and perpetrator. Failure to convict the abuser in a criminal proceeding often encourages him to continue the abuse. A civil action is generally more effective in protecting the child, and in addition allows therapeutic intervention.

At times, however, because of the nature and seriousness of the abuse (death, irreversible brain damage, etc.) a criminal action is justifiable. Even then we need to direct our education toward enabling the community to empathize with and offer help to an already distraught, emotionally confused individual. If we can perceive the adult not as a violent parent but a person in need, then accepting him in spite of our initial emotional reaction becomes less difficult.

Misconceptions about abuse affect the overall efforts at identification, treatment management, and prevention. Can we appropriately deal with a problem when there is continued

denial? Can we enforce laws differently for parents than we do for teachers, institutions, etc.? Can we humanize an abuser or should criminalize him? These are the "always" questions which need more discussion between professionals and the lay community if we are to succeed in protecting children, in providing services to the abuser, and in preventing the recycling of abuse.

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Designing and Utilizing a Public Awareness Program to Attract Self-Referrals

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INTRODUCTION

The YMCA Family Stress Center, located in Chula Vista, California (South San Diego County), is one of twelve centers funded by the National Center on Child Abuse and Neglect in its first "round" of funding. The National Center was created on January 31, 1974 with the signing (by President Nixon) of the "Child Abuse Prevention and Treatment Act" (Public Law 93-247; commonly referred to as the "Mondale Act").

The Family Stress Center delivers a wide range of services which are specifically designed to prevent and/or treat child abuse and neglect. One of these services is public awareness. The original planners of the Center (a consortium of individuals representing the YMCA, San Diego County Human Resources Agency, Welfare Department, and Board of Supervisors) had such foresight that they included a $5,000 start up budget for a public awareness campaign (funded by San Diego County) to advertise the creation of the Family Stress Center with its services—24 hour emergency intake in particular. I (as the Center's newly-hired director) was extremely pleased with this component since the proposal mentioned the attraction of self referrals as a goal. I had been experimenting with this phenomenon for four years with considerable success, considering the very meager budget with which I had to work.

Mr. Gary Beals of Beals Public Relations was contracted with to produce the materials for and carry out the start up campaign. His work and the responses to it were so positive that I have kept him on a retainer ever since the "start-up" period ended (July 1, 1975).

The most striking (and surprising) result of our public awareness program is that our self referral rate currently constitutes 65% of all referrals. This percentage has been steadily increasing over the two years the Center has been operational. This response has been the most significant reason for our Center's commitment to the belief that every community should spend as much time, energy, and money on attracting self referrals as it expends on getting others to report child abuse/neglect. Both are necessary and both should work together.

This paper presents the how and the why of our Public Awareness Program:

HOW THE PUBLIC AWARENESS PROGRAM WAS AND IS DESIGNED AND OPERATED BY THE YMCA FAMILY STRESS CENTER IN SAN DIEGO COUNTY, CALIFORNIA.

The start-up campaign was designed by the proposal writers, with some later alterations. During the months of April, May, and June of 1975, we produced the materials listed below:

1. 2000 two-color posters;
2. 500 two-color bus posters;
3. Brochures, three-fold, two-color, colored stock, 20,000;
4. Television spot announcements, 30 seconds, with slides. (Production costs only; air time is free).

The following question was kept in mind as we produced the materials: "How do you interest and involve people in child abuse and neglect solutions when the drama and shock value of showing injured children is not only counter-productive, but actually harmful to children in stress-filled homes?" We concluded that the answer was empathy. This could be generated easily enough by a caring staff on a one-to-one basis, but to put that feeling of concern and understanding on paper was not a simple matter. It takes more than a flair for writing or a technical understanding of child abuse. Where were the words going to come from? Possibly right out of the mouths of your staffers and clients. So from the beginning we asked them what they felt about the program (Communications audit). The best copy for brochures and news stories came not from well-polished intellectualizing, but the gut issues.

One immediate example of the ongoing necessity of listening to clients and changing the emphasis as a result was with our brochures. Before the opening of the Center, it was decided that three similar brochures would be the ideal communications forms. Thus 10,000 copies of a brochure titled "Who would hurt a kid? Anyone can. Unfortunately a lot of us do." were

produced. Another 5,000 copies of this brochure were produced in Spanish. These pamphlets were designed to be distributed to the general public. Another brochure, of which 5,000 copies were printed, was headlined "It's not easy to be a parent." These pamphlets were created for abusing or potentially abusing parents. The tone of this piece was caring and empathetic. Within a month of completion, we all realized that this brochure, with its universally recognized headline (to which we found nearly everyone could say "Boy, isn't that the truth!"), was being picked up far more often than the others. That brochure is now in its third printing while the "Who would hurt a kid" version is still in stock.

At present, the concept of "It's not easy to be a parent" either headlines all public awareness advertising that we do, or is incorporated in its text.

The start-up campaign went "public" in July of 1975. Along with the posters, brochures, and radio and TV spots, there were feature stories and news releases in local newspapers. Initially, the meetings between Beals, myself, staff, advisory board and clients were very frequent. Auditing of responses was done continually in order to plan ahead for future public awareness endeavors. Over the last 1½ years, the meetings have been less frequent (but still at least once a month), but they have been with the same people for the same reasons. This has resulted in an ongoing program which has been well planned, executed, and evaluated.

Everything that has been designed, produced, and utilized for our public awareness program has been consistent with the following guidelines:

1. Build the Child Abuse Center's prestige or favorable image.
2. Promote the services provided by the Center.
3. Foster the good will of the community in which the Center operates.
4. Build the good will and confidence of donors.
5. Overcome misconceptions and prejudices about parents who have abused or neglected their children.
6. Prevent or forestall attacks against the Center.
7. Build the good will of government agencies which interface with the Center.
8. Help attract and encourage the best people to staff or volunteer at the Center.
9. Educate the public on the Center as a non-threatening, worthwhile organization.
10. Investigate the attitude of various groups toward the Center.
11. Coordinate in forming new child abuse or neglect policies.
12. Help direct the course of change within the Center.
13. Promote self-referrals.

As the list above indicates, promotion of self-referrals is not the only objective of our public awareness program. However, we have found that those means utilized to meet specific objectives have supported all of the objectives listed, including the attraction of self-referrals. Some of the means utilized principally to meet other objectives have been general news releases; stories about individual staff members (published in papers covering the area where the staff person lives); photographs and quotes of staff members for a "PR Kit"; a PR fact file (including ongoing news stories relating to child abuse/neglect secured through a clipping service); magazine articles, radio and TV shows (monthly ½ hour interview programs); hundreds of presentations to organizations, agencies, and professionals; conferences and workshop training presentations; a newsletter; our logo, buttons, and needlepoint patterns (both the buttons and the needlepoint depict our slogan "It's not easy to be a parent"). A few examples of the numerous materials designed especially to attract self-referrals are: brochures, public service ads, public service announcements (radio and TV), and wall and bus posters. As a result of our ads and announcements, the Center has been given thousands of dollars' worth of free space and time.

WHY AN INTENSIVE EFFORT TO ATTRACT SELF-REFERRALS SHOULD BE A COMPONENT OF EVERY COMMUNITY'S CHILD ABUSE/NEGLECT SYSTEM

The best reason for a public awareness program to attract self-referrals is that it promotes primary prevention. Over half of our self-referred clients call in before any reportable abuse/neglect has taken place. We have labeled these persons as "high-risk", and our clinical observations indicate that these clients exhibit the same psycho-social dynamics and problems as those clients who are referred by the "system" (i.e., Juvenile Court, Probation Department, C.P.S., hospitals, etc.) after abuse/neglect has been substantiated.

Ellen Selfridge, Family Stress Center counselor and Ph.D. candidate, is presently doing her dissertation on "A Comparison of Personality Characteristics of Self-identified Abusive and

Neglecting Parents with those of System-identified Abusive and Neglecting Parents". This research is designed to corroborate our clinical observations. She will compare 20 parents from each group. Each will be administered the Michigan Screening Profile of Parenting (Helfer and Schneider, 1977), the State-Trait Anxiety Inventory "Self Evaluation Questionnaire" (Spielbert, Gorsuch, and Lushene), and the Thematic Apperception Test (TAT). Test results of both groups will be compared with each other and with a normal (control) group.

Ms. Selfridge's hypotheses are as follow:

1. Self-identified parents feel as negative about their own parents as system-identified abusive parents.
2. Self-identified parents have frustration tolerances as low as those of system-identified abusive parents.
3. Self-identified parents are as isolated from other people as are system-identified parents.
4. Self-identified parents have expectations of their children as high as those of the system-identified parents.
5. Self-identified parents are as symbiotic in their relationships with their children as system-identified parents.
6. Self-identified parents are as threatened by other people as are system-identified parents.
7. Self-identified parents are as pathogenic in their relationships with their children as system-identified parents.
8. Self-identified parents are as anxious at the time of testing as are system-identified parents.
9. Self-identified parents are as anxious in general as system-identified parents.

If these high risk parents do have the same problems as substantiated abusers (and we believe they do), then it just makes good sense to place a great deal of time, energy and money into getting them to self-refer. This will prevent a great deal of suffering (by both children and parents), family break-up, out of home placements, and expensive "after the fact" services (i.e., law enforcement, probation, CPS investigations, court costs, hospital costs, etc.).

Attracting self-referrals who have already abused/neglected also makes good sense. The clients who come in on their own are, by this act, showing that they are motivated to seek and use help.

A FINAL NOTE

The public awareness program described in this paper has been very successful in attracting self-referrals. It has been, and is, designed to be of a quality, non-punitive, positive nature. If a similar program is to be utilized elsewhere, the services that back up the advertising must also be of a quality, non-punitive, positive nature (as is the case with the YMCA Family Stress Center). The two components must flow with each other so that clients are not surprised, disappointed and/or angered by the initial and ongoing responses to their appeal for help. The services must also be of sufficient quantity to avoid the same problems.

North Carolina's Statewide Child Abuse and Neglect Public Awareness Campaign (SCANPAC)

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Child abuse and neglect is a community problem that will require the involvement of the community to find its resolution. No matter how many laws we pass, how many services we want to offer, or how much money is provided, it will be the community's attitude that will contribute the most in determining how the child and his family will be helped.

In order to begin, the community must be aware of the problem, that it does exist in their own community. What is child abuse and neglect? Why does it occur? What are the community's responsibilities to the child and his family (not only under the law)? What has it to offer to help? These questions and others need to be answered.

Are public awareness campaigns positive or negative efforts in the areas of child abuse and neglect? It has been shown that public awareness campaigns can in some way affect the community's response to the problem. The fact of the matter is, however, we really do not have enough experience to help us assess accurately what effects awareness campaigns have. We are still experimenting.

Much of the success of a campaign depends on how it is organized, the theme and scope, as well as the type of materials used to get the message across. One also needs to decide on what type of response he is seeking and how to perpetuate the process of the campaign, redirecting or reemphasizing in order to achieve the campaign's goals. It must be well thought out, not only for effectiveness, but to prepare for the impact on service delivery.

Most campaigns seem to be run by the agency having the legal responsibility to respond to the problem. A campaign should involve more than that agency. If abuse and neglect are considered as a community problem, then key elements of that community should be involved in organizing and conducting an awareness campaign within the community, especially relating to the social and cultural complexes of the family in that community. This is not to say that the mandated agency should not take a lead role, but it could enhance its ability to respond to the problem by involving and sharing it with others. This is what North Carolina has attempted to do.

It began when North Carolina was chosen as one of the 20 sites to demonstrate the media materials developed by Joseph Davis Consultants for the National Center on Child Abuse and Neglect, through the efforts of the Protective Services for Children Unit of the State Division of Social Services. The Department of Human Resources sanctioned the development of a campaign and the Protective Services Unit was given overall responsibility for the development and coordination of the campaign.

A group of 24 individuals from various public and private human services agencies and organizations from across the state were asked to help plan and organize the campaign. They developed campaign strategies that included setting target populations, target goals, objectives, evaluation methods and exploring availability of funding. Nearly a year went into planning and organizing the campaign. This group became known as the Statewide Child Abuse and Neglect Public Awareness Campaign (SCANPAC).

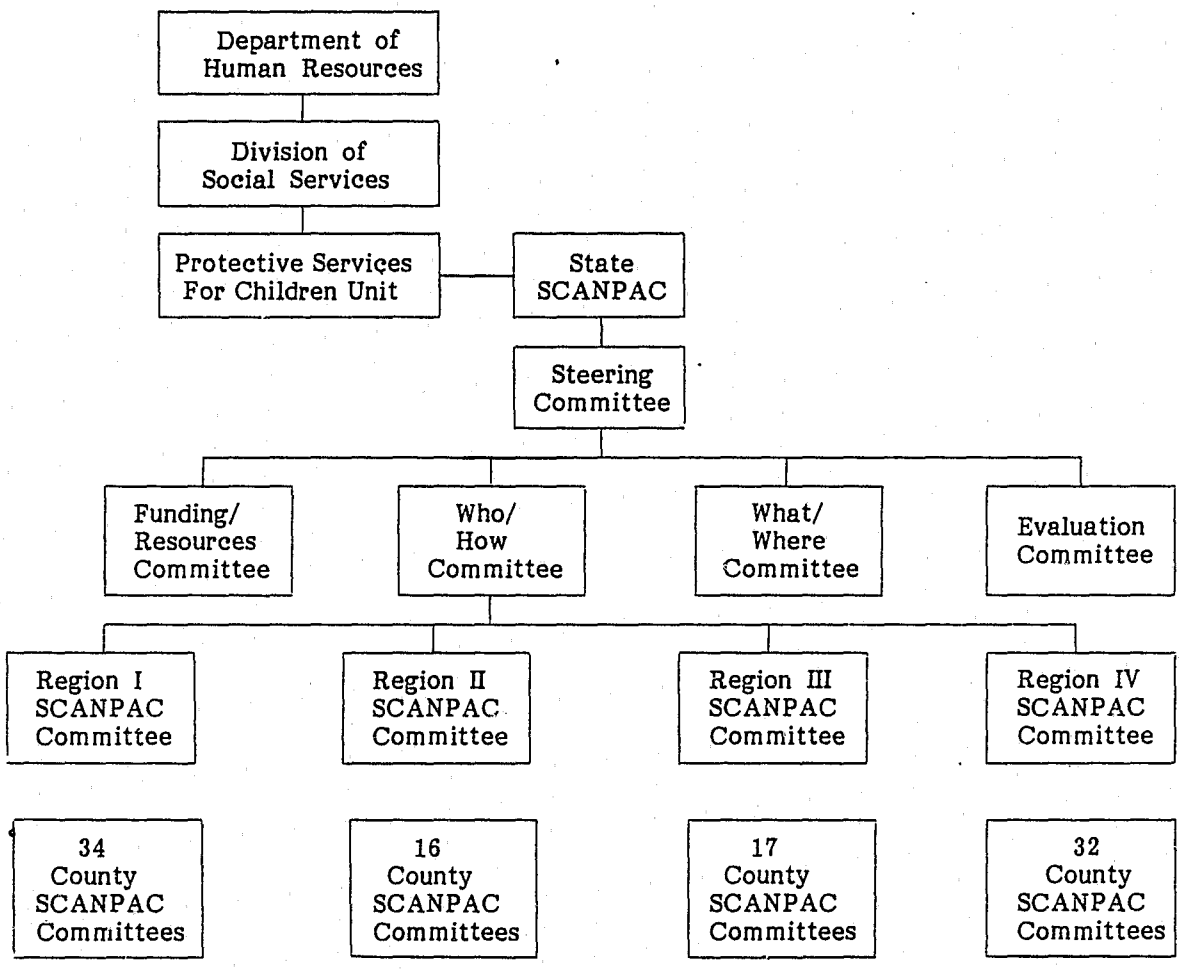
Four regional committees were formed to assist in identifying contact persons in each county and in forming and coordinating county committees. Throughout the organizing of the state, regional, and county committees, the main emphasis has been to invite a variety of people to participate in the campaign program. In this way the major theme of the campaign, that child abuse and neglect are community problems, could be put into practice.

SCANPAC was formed to help plan a way to heighten the public's awareness about the problems of child abuse and neglect. The organizing of the campaign brought it to the county level and got a number of individuals from the community involved in conducting the campaign. It now appears that participation in an awareness campaign not only increases the community's knowledge and sense of responsibility, but can also set up opportunities for the community to work cooperatively, as an agency and nonagency group. Participation permits the community to go beyond just public awareness and take a serious role in problem definition and resolution to protect children and help families. The effects of this are already being seen in North Carolina.

Let us now look at how SCANPAC is structured and examine basic responsibilities and activities that have evolved over the past year. The Protective Services for Children Unit first arranged for North Carolina to be a recipient of the NCCAN materials by recommending the state's participation to the Department of Human Resources through the Division of Social Services. Receiving the sanction and responsibility to demonstrate these media materials, the Unit organized and helped develop SCANPAC as structured on the chart below:

STATEWIDE CHILD ABUSE/NEGLECT
PUBLIC AWARENESS CAMPAIGN
(SCANPAC)

Organizational Chart



The following is an outline of the responsibilities of the various parts of the structure.

I. Protective Services Unit

A. Organize SCANPAC of public and private human services agencies and organizations.

B. Gain approval from the Division of Social Services for—
   1. use of Division of Social Services funds for the campaign;
   2. use of the NCCAN materials; and
   3. participation of Division of Social Services regional and county staff.

C. Provide a staff member to SCANPAC who will—
   1. arrange to produce and distribute state SCANPAC and steering committee minutes and meeting announcements;
   2. coordinate SCANPAC activities; and
   3. make arrangements for state SCANPAC and steering committee meetings.

D. Aid in duplication and distribution of materials.

E. Provide technical assistance and ongoing planning for continuing campaign program.

II. State SCANPAC

A. Approve campaign strategies, goals, and objectives using NCCAN and other materials as proposed by the steering committee.

B. Recommend to and gain approval from Protective Services for Children Unit for use of NCCAN materials and Division of Social Services staff and funds.

C. Organize and coordinate structure to implement campaign.

E. Evaluate effect of campaign.

III. Steering Committee (consists of chairpersons of four committees, Protective Services staff member, state SCANPAC chairperson, vice-chairperson and secretary)

A. Develop specific campaign strategies on a continuing basis.

B. Assign responsibilities to and coordinate committees.

C. Develop a budget.

D. Assist in evaluation of campaign.

IV. What/Where Committee

A. Preview, select, and develop media materials, special events/features, and other interpretive/promotional aspects of the campaign.

B. Put together kits of materials for regional and county SCANPAC committees.

C. Provide training in the utilization of the campaign materials for the regional and county SCANPAC committees. This includes follow-up sessions every three to four months.

D. Assist in evaluation of campaign.

V. Evaluation Committee

Develop, implement, and coordinate evaluation of the campaign. Report the results to aid in determining effectiveness of the strategies, goals, and objectives of the campaign.

VI. Who/How Committee

A. Establish and coordinate four regional SCANPAC committees by identifying and coordinating agency and nonagency resources.

B. Provide a contact person for each regional SCANPAC committee.

C. Aid regional SCANPAC committees in setting up county SCANPAC committees.

D. Collect minutes from the meetings of regional and county SCANPAC committees, forwarding copies to state SCANPAC chairperson, vice-chairperson, secretary, and Protective Services for Children Unit.

E. Provide general review of regional and county SCANPAC committees, campaign plans, progress in utilization of materials and programs, and recommendations.

F. Request additional or new materials, as well as any specific information needed, from the Protective Services for Children Unit.

G. Coordinate with regional chairpersons meetings, places and dates for training and follow-up review sessions.

H. Assist in evaluation of campaign.

VII. Regional SCANPAC Committees

A. Establish and coordinate county SCANPAC committees.

B. Forward to Who/How Committee's regional SCANPAC committee contact person—
   1. county SCANPAC committee's minutes, requests for materials, information or other resources; and
   2. general review of campaign plan, progress in utilization of materials and programs, and recommendations.
C. Assist in evaluation of campaign.
D. Coordinate with Who/How Committee meeting places and dates for training and follow-up review sessions.

VIII. County SCANPAC Committees

A. Establish multidiscipline committee to conduct campaign by—
   1. distributing materials;
   2. doing public speaking; and
   3. giving media presentations on TV and radio and work with newspapers.
B. Raise local funds to help finance county campaign.
C. Assess the county's needs in protective services and assist in developing needed resources.
D. Assist in evaluation of campaign.

As one can note from this outline, the structure permits the breakdown of certain aspects in the development of a campaign, creating a two-way flow of communication and involving a variety of people interested in and willing to work together on the problems of child abuse and neglect.

Having such an organization for the purpose of an awareness campaign provides a vehicle to utilize a variety of materials developed both within the state and nationally. The main concern that a program of this nature has is the implementation of another awareness campaign, particularly a national one, that makes no attempt to coordinate strategies and activities with states having their own campaign programs. There are many of us who are interested in doing something to combat the problems of child abuse and neglect, yet we must make sure that we do not send mixed messages.

National campaign efforts should make every attempt to coordinate with states that have their own campaign programs in order to help supplement and support the states' programs. Established state organizations can be utilized by national programs to distribute national awareness materials. Involvement and coordination of key groups whether national, statewide, or local will be the greatest single factor in the success of any public awareness campaign.

While North Carolina's SCANPAN is coordinated by a statewide committee that develops the basic program and materials, a great amount of flexibility is left to the county SCANPAC committees. In this way they can meet their own specific needs in conducting the campaign. The organization is based on time, volunteered by agencies or private individuals, in order to participate in the campaign. This method appears to be working in North Carolina where an estimated 550 individuals are involved.

How long should a campaign be carried out? As long as it is needed. Much depends on what is to be accomplished. SCANPAC may continue for two more years. The first phase, a general broad audience awareness concentration, is now going on. The second phase will deal with special professional and political groups. A third phase might be the development and formation of programs that would contribute to the prevention of child abuse and neglect, such as parent education courses.

We recognize that a great deal needs to be done in North Carolina to further promote the development of an effective protective and preventive program for children. Providing direction, resources, and materials from the state level down to the county SCANPAC committees, as well as information, recommendations, etc., from these committees will give the program a sense of coordination, support, and commitment towards accomplishing the goals and objectives of the campaign. A similar approach is needed between state and national campaigns.

Child abuse and neglect are community problems. Without community involvement in its own education, as in a media campaign, we cannot really hope to deal effectively with the problems. They cannot be dealt with solely by state and federal governments. North Carolina's SCANPAC shows one way of developing a productive relationship among a group of people where efforts will hopefully develop the opportunity to provide more effective programs for the well-being of the child and the family.

Reporting Systems

Using Report Data in Defining the Community Context of Child Abuse and Neglect

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This paper addresses the complex issue of using report data to analyze the community context of child maltreatment. It attempts to go beyond the many limitations of such data, principally their socioeconomic biases and their unassessed relation to actual incidence. The focus here will be on the practical use of available information, specifically how a local child protective service agency can use its own data to better understand the community it serves. By examining the demographic and socioeconomic correlates of reports, the relation of abuse to neglect cases, differentiations of reports by source, and the geographical pattern of reporting within a given jurisdiction, an agency can develop a community profile that will more accurately portray the "human ecology of child abuse and neglect" and thus enhance intervention through informing policy and directing research.

THE PROBLEM: USING REPORT DATA

An analysis of child maltreatment must begin with the available data on reported abuse and neglect. Systematic reporting is a recent innovation (Gil, 1970; Radbill, 1973). The first nationwide survey of reported cases (Gil, 1970) was only undertaken for the years 1967-1968. New York state, a leader in this endeavor, began its central registry in 1966, but it was not until 1973 that reporting had improved enough to be able to accurately compare child maltreatment patterns across New York's counties (Garbarino, 1976; Gray, 1973). Unfortunately, cross-state and even within-state comparisons are often impractical because of major problems in achieving comparability across reporting units (Garbarino and Crouter, in press). Clearly, to examine child maltreatment reporting it is crucial to choose a setting which contains sufficient cross-unit reliability. This decision can be based on a review of policies and practices as well as on a preliminary empirical test of the direction and magnitude of correlations, as is illustrated below. An agency studying its own area can judge whether or not such comparability exists. It can encourage it by training its field workers to consistently report and describe cases in a useful way, and by encouraging members of the community to report suspected cases.

To date, report data have been used principally to estimate the incidence of child maltreatment. Even a recent analysis by Nagi (1976) does little more than estimate incidence and undertake a limited epidemiological classification of cases (e.g., by sex, race, and age). Such work has been criticized on the grounds that the very processes which generate report data introduce a systematic socioeconomic bias, resulting in the underrepresentation of affluent families. At least three factors contribute to the bias: (a) private physicians account for a very small proportion of the reports (only 3% in Gil's data); (b) agencies are less likely to intervene with affluent families than with poor families; and (c) affluent families are generally more able to maintain the privacy and isolation which permits child maltreatment to occur unreported (Parke and Collmer, 1975). For these reasons, it is assumed that reporting practices tend to underrepresent affluent families, a crucial bias to be kept in mind when attempting to understand the epidemiology of maltreatment. As Light (1973) has pointed out, however, it is possible to use the report data to assess relationships within groups, if not across groups, as will be shown.

THE POTENTIAL USES OF REPORT DATA

Even given their limitations, report data have untapped potential to help researchers better understand child maltreatment in its complexity. Although case reports vary from state to state—and sometimes even from county to county—in the type of information recorded and the depth of detail, the reports contain a promising array of useful information.

Consider the data contained in a typical report based on the National Center on Child Abuse and Neglect form: (1) the address allows the researcher to pinpoint the case by census tract or even street block for later correlational analysis and estimation of rates by sub-unit; (2) information on the children, including victims and non-victims, their ages and sex, can facilitate research on family size and birth order in the abusing and neglectful family; (3) data on the parents' marital status permits one to classify cases by family structure; (4) information about the perpetrator allows study of the characteristics of adults prone to abuse children; and (5) source data permit the researchers to analyze the source of the report (e.g., neighbors vs.

officials) in order to test a variety of hypotheses about the actual reporting process itself (e.g., that the "closer" the reporting source to the family, the better the protection for children).

Given this basic case information, the researcher can supplement report data with other data such as can be obtained from U.S. Census reports: income, housing, characteristics of female-headed households, and other demographic variables. Investigation into community resources may reveal local sources of useful information. For example, the University of Nebraska's Center for Applied Urban Research has conducted survey-based analyses of housing which have proved useful as supplements to an on-going study of "social habitability" in Omaha neighborhoods, of which child maltreatment studies are a part.

TECHNIQUES AND CONCEPTS: A CASE STUDY

Having collected direct and supplemental information, the next stage is systematic analysis of the data. The first step is to determine which phenomena are most strongly related to maltreatment by doing simple correlations of demographic and socioeconomic variables with these rates. Second, partial correlations, controlling for income (two income measures are most useful; the proportion of families with high income, ie., greater than $15,000, and low income, i.e., less than $8,000), allow examination of the same relationships while pulling out the variance accounted for by income differences. At this point research branches out into a variety of directions depending on the interests and goals of the investigators. If a pattern of counter-intuitive results emerges (e.g., a positive relation between high income and maltreatment or between family deprivation and maltreatment) then the validity of the report data may be questioned and explorations to assess cross-setting reporting differences begun (Garbarino and Crouter, in press). If no systematic correlational patterns emerge, the report data may be presumed to be unreliable—i.e., subject to overwhelming random error—given the legitimate assumption that there are "sociological" correlates of child maltreatment (Parke and Collmer, 1975). Following is a description of one procedure which focuses on reports by community sub-areas. It will be described in the next section, using work in Douglas County, Nebraska, as an illustrative case study.

"Screening Neighborhoods for Intervention" is a project which has attempted to pinpoint "high risk" and "low risk" neighborhoods, using actual and predicted rates of child maltreatment. The goal of this series of studies was the development of a multivariate model of the correlates of child maltreatment. The research focuses on sub-areas (N=20) (e.g., planning department program areas) and census tracts (N=93) within a single county, including urban and suburban areas. The data include: (1) child maltreatment rates per 1000 families (reflecting current views of maltreatment as a symptom of family pathology) provided by local and state child protective services; (2) socioeconomic and demographic data from the 1970 census report and 1975 update; and (3) neighborhood and attitudinal items from research by Omaha's Center for Applied Urban Research (CAUR) within twenty community sub-areas. Based on previous analyses (Garbarino, 1976; Garbarino and Crouter, in press; Garbarino, Crouter, and Sherman, in press) and a literature review, five factors were chosen as particularly relevant for inclusion in the analysis:

A. Percent of households with income less than $8,000.
B. Percent of households with income more than $15,000.
C. Percent female-headed households.
D. Percent married women (with children under 6) in the labor force.
E. Percent living in residence less than one year.

Child maltreatment itself was expressed as three variables, all generated by the reports:

A. Overall rate of reported child maltreatment per 1,000 families.
B. Reported child abuse per 1,000 families.
C. Reported child neglect per 1,000 families.

Because previous work (e.g., Banagale and McIntire, 1975; Garbarino, Crouter, and Sherman, in press; Benjamin et al, 1976) suggested that an adequate level of reliability and validity had been obtained in Douglas County's reporting system by 1976 (the period for which the data were collected), and because the analysis introduced statistical controls for possible socioeconomic bias, the data were judged to be adequate for the purpose of the screening procedure.

A series of multiple regression analyses were undertaken. The initial results are encouraging. In the study of 20 sub-areas within Douglas County, the five factors were found to account for a large proportion of the variance: 81% for total maltreatment, 77% for abuse, and 84% for neglect. Even after controlling for economic factors, the demographic factors accounted for a substantial proportion of the variance.

Table 1

Results of Multiple Regression Analysis for 20 Douglas County Sub-areas: Reports per 1000 Families

	Percent of Variance Accounted For		
	Total Maltreatment	Abuse	Neglect
Economic Factors	62%	43%	61%
Demographic Factors (controlling for economic factors)	19%	34%	23%

Data were compiled on the source of the report. These sources were then classified either as "close" to the family (e.g., neighbors and relatives) or as "distant" from the family (e.g., agencies and institutions). These data allow analysis of the percent of reports from each type of source as a function of the socioeconomic and demographic characteristics of the area from which the reports come. The ratio of distant to close sources provides a useful index for this purpose. Moreover, it is possible to examine the correlates of reported maltreatment separately for the rate per 1000 families reported by distant sources and the rate reported by close sources. These analyses can shed light on several important phenomena.

Table 2 presents the results of these analyses for the 20 Douglas County sub-areas. The results for the 93 census tracts parallel these results but are somewhat attenuated due to the small values which result in less reliable indices.

Table 2

The Correlates of Reporting Source for 20 Douglas County Sub-areas

A. Simple Correlations

		Percent of Reports from:*		
		"Close" Sources	"Distant" Sources	Ratio of Distant to Close
1.	Percent with incomes less than $8,000 per year	r = -.60	r = .60	r = .60
2.	Percent with incomes more than $15,000 per year	r = -.55	r = -.54	r = -.51
3.	Percent female-headed households	r = -.58	r = .58	r = .51
4.	Percent married women (with young children) in labor force	r = -.54	r = .58	r = .49
5.	Percent living in residence less than one year	r = -.27	r = .39	r = .43
6.	Overall rate of reported child maltreatment per 1000 families	r = -.52	r = .55	r = .61

B. Multiple Regression

	Percent Variance Accounted For:	
	Rate Based on Close Reports	Rate Based on Distant Reports
Economic Factors	40%	41%
Demographic Factors (controlling economic)	36%	34%

*Note: Some cases are unclassifiable from available records, thus the close and distant percent do not total 100%. Separate, though nearly sign-reversed identical correlations are thus presented.

The data may be usefully addressed to two questions: (1) Does the proportion of the reports from each source vary systematically as a function of socioeconomic and demographic characteristics? (2) Is the multivariate model different for the rates based on close vs. distant sources?

The results presented in Table 2 answer the first question in the affirmative. In general, the proportion of reports coming from close sources varies directly as a function of socioeconomic level. The economically richer the area the more likely it is that a report comes from a neighbor, relative or other source close to the family. In low income areas reports are more likely to come from institutional, "distant" sources. Similarly, the demographic variables which are positively correlated with the overall rate of child maltreatment—stress in the

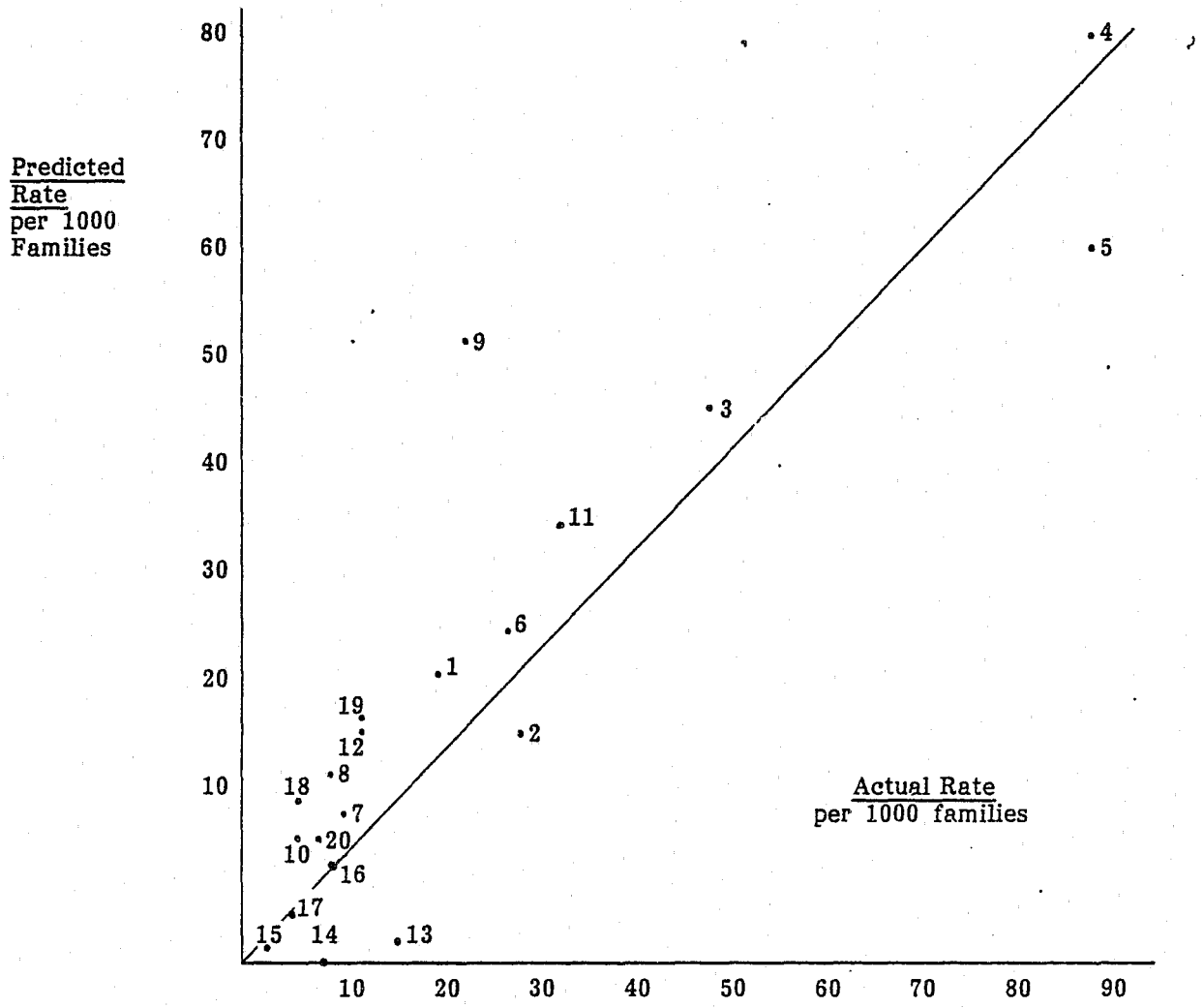
maternal role, transience, etc.—are positively correlated with the likelihood that a report comes from distant sources. Indeed, the correlation between proportion of reports coming from a distant source and the overall reported rate of child maltreatment is high (r=.55).

Addressing the second question, the results of the multivariate analyses reveal very similar correlational models for the rates based on reports from close vs. distant sources. These results, when coupled with the findings presented above, suggest that the rate of socioeconomic bias in reporting may be more complex than previously thought. A simplistic model of socioeconomic bias would suggest that the correlates of maltreatment should be substantially different for rates based on distant vs. close sources since the former is presumably biased while the latter is not. In fact, impressionistic reports from local child protective services and law enforcement personnel stress that persons from the low-income (high rate of maltreatment) areas are less likely to report ("rat on") their neighbors and relatives. This hypothesis is consistent with the data. It sheds a different light on the "bias" in reporting which leads to a greater probability of a person from a low-income, demographically stressful context being reported by an official, distant source. This hypothesis deserves further study since it may provide an important insight into the community context of child maltreatment.

These analyses provide a basis for "screening" the 20 areas. The multiple regressions generate a predicted rate (based on the socioeconomic and demographic factors) which can be compared with the actual rates. Figure 1 shows the actual rates for total maltreatment plotted against their predicted values.

Figure 1:

Actual Rates of Total Child Maltreatment (per 1000 families) Reported: Based on Multiple Regression Equation Containing Socioeconomic and Demographic Factors for 20 Douglas County, Nebraska, Sub-areas (1976 Child Protective Services Report Data)*



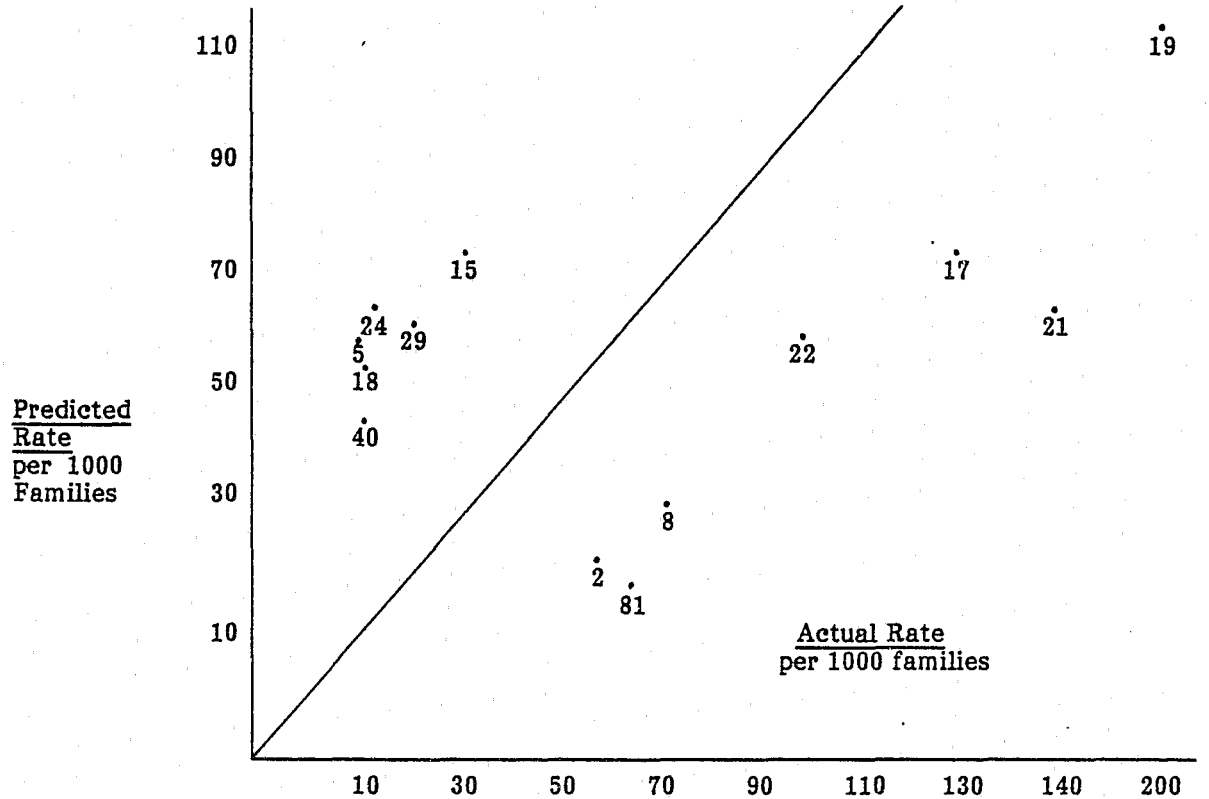
*Numbers indicate sub-area identification codes

As can be seen, most values fall quite near the diagonal line indicating a close correspondence between predicted and actual rates. Several areas, however, are highly discrepant, indicating that, based on socioeconomic and demographic data, they are "high" or "low" risk areas of the county. The policy implications are clear. Once identified, these discrepant areas can be investigated in depth to determine the source of the discrepancy, and, where appropriate, intervention can be undertaken. Investigation in areas with lower than predicted rates may show (a) that reporting is not adequate and/or (b) that particularly effective "family support systems" counteract the influence of socioeconomic and demographic factors. In those cases where the actual rate is far greater than predicted, different hypotheses are generated: (a) there may be particularly stressful circumstances in the area and/or (b) family support systems may be inadequate. The "procedural" hypothesis, that these differences are associated with differential rates of substantiation of reports, must, of course, be tested.

This screening procedure was applied to Douglas County's 93 census tracts as well, and the findings parallel the results for sub-areas, although the correlational relationships are somewhat attenuated due in part to the greater lability of the maltreatment rates for the smaller geographic units. Figure 2 shows the plotted total maltreatment rates against the predicted rates for the census tracts. It is important to remember, however, that sub-areas and census tracts are not neighborhoods in the psychosocial sense and hence our model still lacks an exact ecological framework mirroring the local phenomenology of the community.

Figure 2:

Predicted and Actual Rates of Total Child Maltreatment (per 1000 families) Reported: Based on Multiple Regression Equation Containing Socioeconomic and Demographic Factors for 93 Douglas County, Nebraska, Census Tracts (1976 Child Protective Services Report Data)



The value of the multivariate screening process is that it pinpoints the problematic areas. In other parts of the country, variables other than the five cited here may be found to be more useful in the analysis. Once a "diagnosis" is made, specific intervention programs can be implemented, depending on the area's needs: e.g., a campaign to improve reporting, a human services field office, a job training program, or a community activities center. Researchers may find this approach useful in identifying contrasting settings in which to conduct observational and interview studies of family functioning.

A local agency may find it useful to take action based on the data dealing with the source of the report. Such an approach could identify areas in which reports come largely from institutional sources, such as hospitals and social service organizations ("distant" sources), and those with reports from personal and social sources, such as neighbors and family ("close" sources). Investigation of areas with high and low actual vs. predicted values may be aided by a simultaneous assessment of reporting sources, the strength or inadequacy of local service organizations, and the extent of family support systems.

Report data on child abuse and neglect cases have great potential for the child protective service agency attempting to effectively serve its area of jurisdiction. Given that reporting occurs at a valid and reliable level across sub-units in the area of jurisdiction, the agency can make use of the wealth of information contained in the reports. Moving beyond merely estimating incidence, useful research is needed on "the ecology of child maltreatment"—the complex interplay between individual, social, and institutional dynamics operating in the community. Using report data and supplemental census and local statistics, an agency can perform regression analyses to (a) screen neighborhoods for areas of high or low risk in child maltreatment, (b) explore the sources of reporting, and (c) research the differing ecologies of child abuse and child neglect as they occur in the local area. This approach will allow service and policy groups to work directly with the research community to develop more effective prevention and treatment of child abuse and neglect. As a systematic method of policy-oriented research is applied to different communities, we will begin to piece together a fuller picture of child abuse and neglect, a significant indicator of the quality of life for children and families in contemporary American society.

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Using Needs and Resources Assessment Data to Plan Resource Development and Coordination

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BACKGROUND ON THE PROJECT

The Child Abuse and Neglect Resources Demonstration (CANRED) Project was approved on January 1, 1975, for an initial six-month planning period as a resources demonstration project. Because of the evaluation focus and broad scope of exploratory research, the Project was later recategorized by HEW's Office of Child Development as a research and evaluation project. CANRED is funded by the National Center on Child Abuse and Neglect, and is administered by the Texas Department of Human Resources, Office of Planning and Management Systems, Special Projects Bureau.

The goal of the CANRED Project is to contribute, at both the regional and state office levels, to the Texas Department of Human Resource's ongoing efforts toward identifying, investigating, treating, and preventing child abuse and neglect. The Project's goal is to be achieved through the following objectives: to evaluate the Department's computerized central registry of child abuse and neglect cases; to evaluate the Department's public information campaign on child abuse and neglect; to develop a procedural guide for protective services needs and resources assessment by developing and testing an assessment methodology in six representative counties; and to develop a procedural guide for resource development and coordination by reviewing the literature, other efforts in this area, and the efforts of the local staff in the six representative counties.

Both evaluations, as identified in the first two objectives, have been completed. This workshop focuses on current CANRED developments toward completion of the last two objectives.

PROBLEM CONSTRUCT

The problem upon which the CANRED Project's work in the area of needs and resources is focused can be stated as the lack of an effective and efficient process to identify, address, and meet individual client needs. Specific deliverables of the Project have been produced to address several major inadequacies observed in the operation of the service delivery system in its flow from identified need to met need.

PROBLEM CONSTRUCT

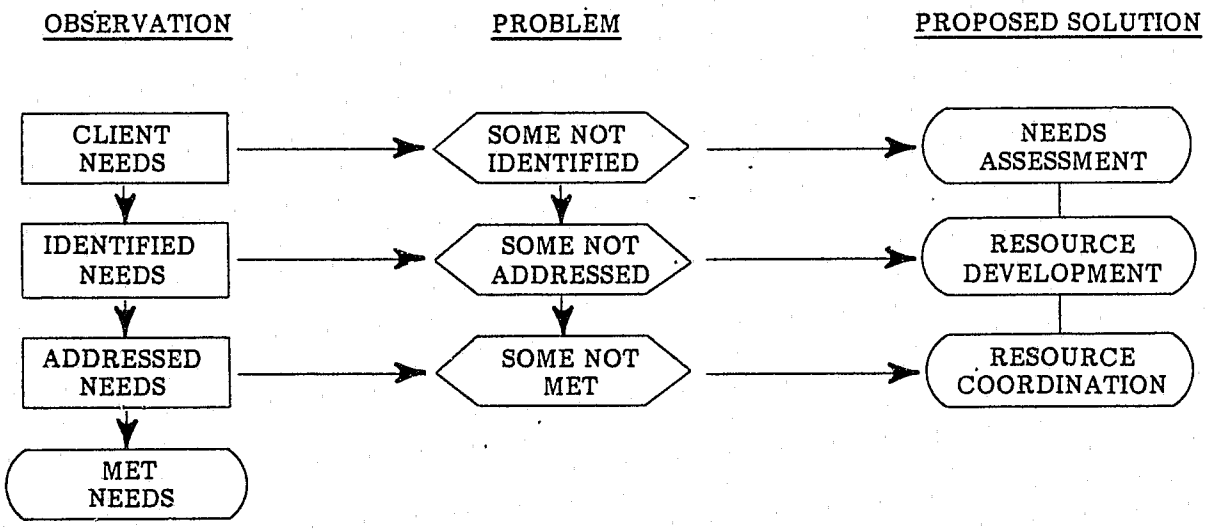

Figure 1. Problem Construct

In the observation of individual client needs, often they are identified by the service delivery system, but in many instances they are not. A methodology for needs assessment has been developed by the Project to more systematically and more accurately identify needs.

However, of all the needs identified, some are addressed and some are not. Since the lack of resources is a major source of this aspect of the problem, resource development is necessary to reduce the instances of needs identified but not addressed by the service delivery system.

Of the needs addressed, some remain unmet. Since much of this aspect of the problem originates in the ineffective interaction among interrelated service providers, more systematic resource coordination is an essential part of any solution.

The concept of this portion of the Project is a systematic approach from the identification of needs and resources through resource development and coordination to an improved delivery system. But this systematic approach is not that simple. What is required is a process that is more specific, more detailed, and more practical than is found in the current literature on needs and resources.

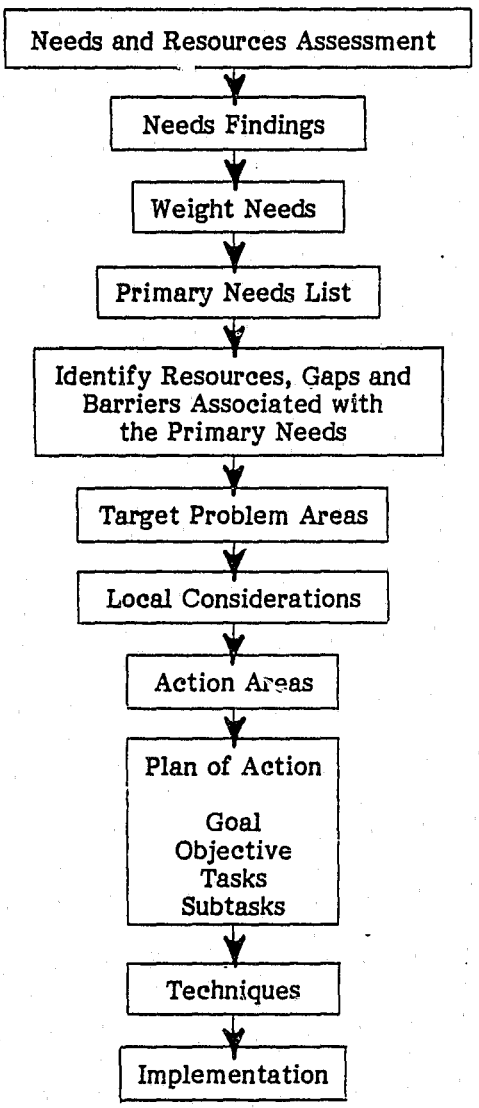

Figure 2. An Overview of a Systematic Approach to Resource Development and Coordination

NEEDS ASSESSMENT

The first step in this systematic approach, as designed by the CANRED Project, is a needs and resources assessment. The purpose of the assessment is to identify the following: the needs of abused and neglected children and their families in the community; the resources available or potentially available to meet those needs; the barriers to the utilization of available resources; and the gaps or service needs for which no resources exist.

In seeking this information, an immediate issue is raised by the question, whom do you ask? It can be assumed that as the experiences and perspectives of different groups of respondents vary, so may their responses. Therefore, to get a comprehensive view of the community's definition of needs, data must be collected from various sources throughout the community. The data sources included in CANRED's methodology are as follows: protective services delivery staff; protective services clients and client groups; delivery staff of other resources; protective services case records; political and community leaders; and leaders of voluntary organizations.

The needs and resources assessment methodology must be designed to allow for the best feasible information from each data source. The data collection techniques included in the CANRED methodology are interviews, self-administered questionnaires, and case reading. For each data source, the choice between the interview and questionnaire is dictated by considerations of staff, time, and other resources available.

Clients	Reflected basic subsistence type services and job related services such as housing
Primary Service Providers	Reflect those services required for documentation of services they provide (Example: court related services.)
Secondary Service Providers	Each resource looked beyond those services provided by their own agency
Leaders of Voluntary Organizations	Service needs indicating those services commonly used by middle-class families (Example: alcohol, drug abuse, marital counseling.)

Figure 3. Needs

When CANRED tested the methodology, the findings from different data sources did in fact reflect their differing perspectives. So whose opinion counts and how much? How do you determine what the "real" needs are if each data source provides a different list? Recommended is a process of aggregating an overall list of needs across data sources. The assignment of weights to each data source is basically a subjective judgment, but it can be systematically applied to reflect a sort of "consensus." In the CANRED application of the methodology, the weights are assigned in proportion to the judged level of knowledge of child abuse and neglect. To obtain the primary needs list, the aggregated listing of the ten most important needs of the community's abused and neglected children and their parents, the following weights are recommended by CANRED: protective services delivery staff - 30; protective services clients and client groups - 25; delivery staff of other resources - 25; protective services case records - 10; political and community leaders - 5; and leaders of voluntary organizations - 5. The top ten needs listed by each source are scored and the scores combined for the primary needs list, with needs in rank order by their aggregate score.

Once the primary needs list is obtained, the needs and resources assessment findings on the resources, barriers, and gaps associated with each primary need are reviewed. With these additional data factors, the primary needs list becomes the list of target problem areas, or the ten top needs, each with its respective available and potential resources, barriers, and gaps.

LOCAL CONSIDERATIONS

The list of target problem areas is the final product of the needs and resources assessment, but it is not sufficient for determining the action areas, or which of the target problem areas should be addressed. The other factors to be taken into account are local considerations. These local considerations are factors which could influence the feasibility or likelihood of success of specific efforts planned. Local considerations, as conceptualized by the Project, fall into the areas of personnel, costs, socio-political environment, and legislative and administrative regulations.

Personnel

A primary consideration in any attempt at resource development or coordination is the agency personnel who will be involved in the effort. For resource development and coordination efforts to be successful, the importance of this area should not be underestimated, as personnel considerations will have a direct influence on outcomes. The specific aspects of personnel considerations for review are job functions, level of staff involvement, staff time, and the locus of decision-making.

Job Functions. The job functions of the personnel charged with responsibility for resource development and coordination will affect the outcome of the effort. In the planning process, the following questions should be addressed:

1. Will resource development and coordination staff perform other job functions? (CANRED found that to combine direct delivery functions with resource development and coordination is difficult because of the priorities of crisis cases. However, on a planned basis, it could also be viewed as a stress relief for direct delivery staff.)
2. Is someone designated with responsibility for insuring that resource development and coordination are carried through and that findings are validated?
3. Are the roles and responsibilities of staff at each level clearly defined and mutually understood and recognized?

Level of Staff Involvement. Since all levels of personnel may be involved in various aspects of the resource development and coordination activities, efforts should be made to engage all agency personnel in a commitment to and consensus on this effort. Agency staff must clearly understand how efforts toward resource development and coordination will be useful to them in performing their jobs. This is particularly important for staff involved with direct service delivery.

Staff Time. Resource development and coordination is not a short term process. Success may be achieved only after many months or sometimes years of planned and consistent effort. Therefore, on a long-term basis, sophisticated service integration will require a considerable investment in staff time. It is imperative that the scope of activities planned be realistically set to allow adequate personnel time to complete the activities.

Focus of Decision Making. The question here is what decision-making authority will those with the resource development and coordination job functions have? The answer to this question has implications in a variety of areas, including the credibility of the effort, the likelihood of success, and the appropriate scope of activities to be selected.

Cost

Cost is another major area of local considerations that should be examined prior to resource development and coordination efforts. Important factors regarding the cost of resource development and coordination include known sources of funding, potential sources, and funding restrictions and limitations.

In reviewing known sources of available funds, considerations should be given to both internal and external sources. It is important to identify which agencies and individuals have access to funds, and also the extent to which funds are fixed or are negotiable. Known sources of funding will constitute a stable base for expenditures to conduct resource development and coordination.

Data collected in the needs and resources assessment on potential levels of service commitment by voluntary organizations partially addresses the topic of potential sources of funds. Potential funds added to known funds defines the upper limit of expenditures that can be planned for resource development and coordination.

A realistic appraisal of funds available for resource development and coordination requires the identification of all restrictions and limitations of fundings. It is important to recognize that the stability and time limitations of funding sources may vary, that some funds will require local matching funds, and that acceptance of funds often mandates compliance with specific regulations and other requirements.

Socio-Political Environment

A third area of local considerations for review is the socio-political environment. Information about three groups within this environment is particularly relevant—the community as a whole, advocates, and political leaders.

In regard to the community, specific information for planning resource development and coordination activities would begin with the extent, origin, and focus of community support for such efforts. Also important to know are the dominant characteristics of the community (i.e., conservative, liberal, socio-economic distribution, ethnic composition), and any currently sensitive or controversial issues. Planning can be improved by a consideration of the success of related past efforts and of specific indications as to the most appropriate timing for attempting the particular project planned. Also, an objective study should be made of the potential benefits to the community and the visible outcomes of the planned efforts.

Advocates as a socio-political group must be analyzed to discover who has a vested interest in a particular resource development and coordination effort and can assist in obtaining support for it. Sources of potential advocates (e.g., parent organizations, civic groups, school officials, boards, as well as previously unknown or unconsidered individuals) can come from any sector of the community.

Political leaders should be examined for extent to which they are the actual leaders of the community. Their power bases and channels of communications also need examination. One should also pay attention to individual perspectives and interests such as political affiliation, pet projects, philosophy toward the poor and government, and possibly relevant campaign promises. In working with these leaders, emphasis can be placed on any of their previously expressed priorities that are supported by findings.

Legislative and Administrative Regulations

Legislative and administrative regulations comprise the fourth area of local considerations which needs to be reviewed to select action areas. All publicly funded resources function under various legislative and administrative regulations that are often very complex and comprehensive. Familiarity with such regulations is important for the continued operation of all affected agencies in the community. One must be aware not only of internal policies, procedures, regulations, and restrictions that could impact upon resource development and coordination efforts, but also relevant federal regulations, regulations of other agencies, and state and local laws and ordinances that are in effect or proposed. To ignore these realities is to risk the success of the effort planned, or, at best, to increase the expenditure of resources required.

DEVELOPING A PLAN OF ACTION

By screening the target problem areas through the review of local considerations, feasible action areas are identified. The next step in the process is to develop goals and objectives for dealing with each action area. Goals should be developed first, and related objectives then delineated for achieving each goal. The objectives should be concise, realistic, and measurable, so that progress in accomplishing them can be easily evaluated. The objectives should focus on the problems in each action area.

As an example of the goals and objectives concepts, if a gap in socialization programs is an action area, then a goal could be "to develop a socialization program for abused and neglected children and their families." An objective to achieve this goal could be "to initiate a Parents Anonymous chapter."

After goals and objectives for a particular action area have been clearly defined, it is important to delineate specific tasks for accomplishing each objective. Tasks should be specific, and personnel responsible for a specific task should be clearly identified. A realistic schedule for completion of each task should also be established. For the objective "to initiate a local Parents Anonymous chapter," a task might be "to identify clients interested in participation," which would be accomplished by a particular unit of the local protective services staff between 10/1/77 and 10/31/77.

To insure that the goals and objectives for the plan of action remain clear and focused, formal tools such as a management by objective form and tracking schedule can be maintained for each action area addressed. In order to monitor progress, the tasks delineated on the tracking schedule should be reviewed and assessed on a regular basis. This periodic review allows for appropriate changes to be made, such as rescheduling, reallocation of staff, or the delineation of additional tasks.

TECHNIQUES FOR RESOURCE DEVELOPMENT AND COORDINATION

There are two basic techniques for resource development and coordination: information sharing and establishing support. Neither of these techniques is new; their planned use in a goal-oriented, systematic approach to resource development and coordination is. These techniques are, in essence, strategies for establishing the environment necessary for effective resource development and coordination.

Information Sharing

Information sharing is the most important component of a resource development and coordination plan. CANRED defines information sharing as an ongoing and established system of communication that involves staff at all organizational levels communicating on all aspects of service delivery. Most techniques used to achieve resource development and coordination include some form of information sharing. Though not a new concept for service delivery organizations, it is seldom formally delineated as a function of staff at any level. In order to be effective, information sharing must be a well-established and ongoing process.

The CANRED Project contends that the primary protective services resource agency in the community should take the initiative and responsibility for both internal and external organization of an information sharing system for protective services. Acceptance of this responsibility involves a strong commitment, both philosophically and in terms of resources. However, the importance of information sharing in achieving resource coordination and development goals cannot be ignored. The following sections will describe the essential elements of an effective information sharing system.

Internal Information Sharing. In the context of a service delivery agency, internal information sharing is the exchange and coordination of information among all areas and levels of staff within the agency, including administrative, support, and service delivery staff. Information on all aspects of operations, including goals, objectives, programs, services, service needs, constraints, and barriers to service delivery should be shared. To be fully effective, internal information sharing should include both informal and formal communication.

Information sharing through informal communications often originates in a social context at coffee or lunch. To the extent to which informal communications enable staff to increase their mutual understanding, respect, and trust, it also improves the possibilities for more effective formal communication. Informal communication is unstructured and may seem superficial, but the resultant improvement in staff relations helps to avoid the misunderstandings and polarizations that often occur in the formal setting.

Formal communication for information sharing can occur internally through contacts specifically arranged for this purpose. Planning for information sharing should include the allocation of adequate staff time and resources. The information sharing system must be designed to integrate administrative, support, and service delivery staff so that all are working toward common goals and objectives.

External Information Sharing. The successful establishment of an information sharing system within an agency will also enhance communication outside the agency. External information sharing, as it applies to a service delivery agency, is the exchange and coordination of information with any extraagency group or individual directly or indirectly related to the service delivery system, including other current and potential service providers, clients, civic organizations, and the community at large. Many of the principles discussed in regard to internal information sharing also apply to external information sharing, including the concepts of formal and informal communication. Effective external information sharing involves all levels of staff and addresses all aspects of service delivery. The most important requirement for external information sharing is the formal establishment of this function with adequate levels of priority and resources.

Strongly emphasized in the literature is the importance of information sharing with clients. Client input to the service delivery system is essential. Title XX requires client participation not only in needs assessment but also in the process of planning programs to meet

identified needs. Clients also have a key perspective for feedback on the effectiveness of past efforts for resource development and coordination. Feedback from clients can be obtained through a formal data gathering process designed to determine clients' needs and problems.

Public Relations. Information sharing is vitally important in the area of public relations. Public relations with the community increases understanding and support of the agency's role and improves its public image. Public relations with community and political leaders is a key factor in achieving goals for resource development and coordination, and informal contacts are very effective in these cases. Building relations and establishing rapport with political and community leaders is a slow and time-consuming process, but one that has many long range benefits. Formal presentations, media materials, talk shows, and public forums can be effectively used to share imformation with the community and thereby improve the agency's public image.

Establishing Support

Internal. Establishing support is the second basic technique for resource development and coordination. It requires considerable investment in resources and staff time. Support for planned resource development and coordination efforts must first be established within one's own agency and its board, if any. This means developing a formal system for achieving consensus, obtaining formal approval, obtaining direction, and providing systematic and continuous feedback on progress and problems. In relation to the board, establishing support consists of obtaining formal approval, defining membership commitment and potential avenues of support, and obtaining feedback on progress and problems. Support from agency staff and the board should be established before soliciting support from outside sources. Once formal approval and active support of the staff and the board have been obtained for a particular resource development and coordination effort, frequent communication is necessary to insure its continuity.

External. Establishing external support for resource development and coordination efforts is equally important to the agency. The contact with clients through service delivery provides the opportunity to involve the clients in planning, evaluating, and hopefully, supporting services. The opportunities for support by clients of resource development and coordination efforts can also be enhanced through communication with and involvement of client advocate groups.

One of the most effective techniques for establishing support and early commitment to specific problems is through individual direct contact. Since this requires a great investment of time, its use should be balanced against the benefits that can potentially be incurred. Individual contact can be effectively utilized to gain support from any segment of the population, but, realistically, the use of this technique will usually be limited to those individuals most directly affecting the planned activities for resource development and coordination, such as political leaders, funding sources, advocate groups, and service providers.

Meetings are one of the most obvious and often used techniques for establishing support for planned resource development and coordination efforts. Meetings allow personal contact, interaction, and availability of first hand knowledge to many people while minimizing time and energy expenditures. Meetings can serve as a mechanism for public information, thereby increasing support of planned efforts. Different philosophical positions, levels of commitment, roles, and expectations can be shared and consensus sought through the group process.

While meetings can establish much of the credibility and support of individual contacts, group communication has its own unique dynamics. Prior plans, goals, or objectives may well be modified through the group process. Meetings involving different interest groups offer opportunities for coalition, but also risks of polarization. Also, it is important to plan followup meetings to identify progress and problems.

The use of media is an excellent method of getting relevant information on current and planned efforts to the general public. However, be aware that this may have either a positive or a negative influence on efforts to establish support. The impact and scope of the media should not be underestimated. Despite the possible negative effects, however, media is valuable because it reaches virtually the entire community with information and solicitations of interest, and thereby promotes active community response.

IMPLEMENTATION

The actual implementation of resource development and coordination plans can take place through a number of alternative arrangements. The determination of which arrangements are used will be a logical consequence of the entire resource development and coordination process that has occurred up to this point. Implementation is a formal process of goal attainment, the actualization of the plan of action. The formal arrangements to be produced include cooperative

interagency agreements, formal contracts, and funding arrangements. These constitute specifically delineated agreements for shared responsibilities for services. As they are tested, strengthened, and proven, these formal arrangements move toward the status of institutionalization; they become an accepted and fully utilized part of the community's ongoing service delivery system. It is the contention of the CANRED Project that the CANRED process for resource development and coordination, with its systematic and objective approach and use of community involvement, will significantly increase the success of resource development and coordination efforts.

Central Registries and Reporting Systems

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The Children's Division of the American Humane Association has, since its inception, provided leadership to the nation in child protective services. One of the services provided by the association has been in the area of research concerning the nature and causes of child neglect and abuse.

Early research by the division indicated that a great need existed in the nation for a national data gathering effort to permit better understanding of the nature, incidence, characteristics, consequences, and related data on this great problem.

Beginning in 1957, the first of the continuing series of state of the art surveys in child protective services in the United States was completed. A follow-up study was made in 1967 to highlight the continuing nature of the problem and to pinpoint needs for the next decade. The third in the series, "Child Protective Services in the United States, 1977," is now in progress.

The 1967 survey indicated that few states had systematic plans for gathering data on the problem. By 1970, only 19 states were required by law to maintain a central registry. In 1972 and early 1973, this number increased to 29. In these, however, the responsibilities were often shared by several agencies. While most states placed the central registries in the state departments of social services, two placed them in the health services department, and two others assigned the registers to law enforcement or justice departments. While today only one or two states do not mandate a central register, this division of responsibility still exists with some reporting still going to the departments of health and some to the justice departments. The increase in state requiring a central register during the last five years has been gratifying; the process of translating a legislative mandate into a well-organized, responsive system has not yet been completed.

At the time of the second survey most states required reporting of abuse only, and in many cases as an extension of criminal law rather than as a process of defining social need. At present, our summary of national reports indicates that only eight states do not include neglect in their reporting requirements.

Legislation concerning children's services reflected a similar wide diversity in the decade of the sixties. A Children's Division survey of legislation in 1964, followed by an update in a 1966 survey, led to the widely accepted report "Child Abuse Legislation in the 1970's." This was revised and reissued in 1974, and a current revision is now being made.

Perhaps the most dramatic study was the publication in 1969 of "Protecting the Child Victims of Sex Crimes Committed by Adults," which dealt with the extent of sexual abuse to children. This report reflects three years of research into the problem. An in-depth examination of records in police administrations, hospitals, social agencies, and juvenile centers revealed that the incidence of sexual abuse in New York City for the study's three-year period exceeded the total number of all cases of child abuse reported to the official system in the state for those years. Unfortunately, the situation today is little better. Sexual exploitation and abuse are still of massive proportions in the nation, and are virtually unreported and unrecognized by the "gatekeepers" of our delivery systems.

These research efforts clearly indicated the need for a central data gathering system based on a common reporting form and using standard definitions. Such a system was proposed to the Office of Child Development, Children's Bureau early in 1972. At that time interest in this project was great but funding was nonexistent. However, as national interest in child protective services increased requests for data became more insistent, and the project was funded on a six-month exploratory study in 1973, the year before the National Center for Child Abuse and Neglect (NCCAN) was established under Public Law 93-247. This initial period was devoted to planning the system and developing the first reporting form, Standard Form 0023. Every state reporting form that existed at the time was studied, and the best features of each selected. A meeting of representatives from all states was held in Denver to resolve details of the program. Forty-four states sent representatives to the planning session. The standard form was printed and issued, and official reporting began in April, 1974. From the initial dozen or so states that participated at the time, the number grew to 23 by the end of the year.

When the results of the first year's operation were reviewed, several problems were isolated. The length and bulk of the original form created problems in filing and handling. An analysis of returns indicated that many questions were redundant. A meeting of the advisory committee to the NCCAN Clearinghouse was held in early 1975 to revise the form, and the present 0024 form was the composite of the suggestions. This form was distributed for use in mid-1975. Minor editorial corrections have been made, but the basic material remains unchanged. At the present time the form is used by 32 states, and five other states submit data in magnetic tape form, based on forms similar to ours.

The national study is deeply involved in the development and refinement of state central register systems. The basic decisions each state faces when entry into the national study system is considered are such questions as:

1. Which individuals or members of classes are mandated to report?
2. What provisions are made to insure confidentiality of data?
3. Is the emphasis to be placed on 24-hour retrieval capability and the tracking aspects, or upon the quality and accuracy of the reporting for management purposes?
4. Is the responsibility for conformity to reporting requirements to be placed in a state central location, or with the supervisors at the district or county level?

Data for the years 1974-1975 have been summarized in two brief reviews, "Highlights of the Data for 1974" and one for 1975. Detailed tables are available for serious researchers.

At this time, we are conducting an intensive systems analysis to determine if response time can be dramatically shortened, and if data files can be restructured to permit almost immediate cross-tabulations by state or county for any variable desired by the research group interested in the data.

The national reporting system today represents notable improvement over the state of affairs in 1972-1973. There remains, however, much to be done to arrive at the established goal of a uniform reporting system based on common definitions of elements and on complete coverage by each state of its counties or districts, and the extension of reporting to include neglect in each state. Goals for the remainder of the grant period, through December 31, 1977, are to encourage remaining states to participate in the program in the form best suited to each state's capabilities, to encourage all participating states to include neglect in the reporting, and to provide technical assistance to states, thereby enabling them to have complete coverage of reporting within the state.

As the concepts of the central register options presented by the National Institute on Community Development become known throughout the nation, the national study staff will be available to provide technical assistance in planning automatic data processing systems (ADP) where needed.

This consultation will include not only our own staff and technical advisors, but will include, through our advisory committee members, assistance from specialists from other state agencies who have met and solved many of the problems that will be faced by states newly considering ADP applications to their central registers.

Our goal of a fully functioning national system by 1980 can be attained. The ideas and concepts developed and defined in this meeting and in the October, 1977 meeting in Washington, D.C., will go a long way in making our goal a reality.

The Central Registry: Help or Hindrance?

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"Where have we been and where are we going," is the theme of the Second National Conference on Child Abuse and Neglect—how appropriate for central registries! We probably should also add, "What have we done to our families and our delivery of services?"

Central registries have been or are being developed in most states partially in response to the requirement for meeting eligibility for state grants from the National Center on Child Abuse and Neglect. In many states, the establishment of a central registry has been accomplished without addressing some very vital questions or anticipating negative consequences.

Probably the most significant question and that which engenders negative reactions is: should names, addresses, and other identifying data be included on a central registry? Before answering that question, it is necessary to define what is a reportable case of child abuse and neglect and to define the function of the central registry. Many state systems currently house several thousand names of abusing and neglecting families. These families' problems may range from a custody battle to the death of a child, but the names are all on the same registry.

How can a name or even a statistic on a central registry have any meaning when there is such confusion as to what constitutes child abuse and neglect? When does discipline become abuse? What is emotional abuse and when does it occur? Do not most of us at some point inadvertently emotionally abuse or maltreat our children? Did we escape the central registry system merely due to circumstances of time and place?

Some states require every complaint of child abuse and neglect be reported to the central registry and an immediate investigation initiated. The initial report would then be followed by an interim or final determination. The worker investigating the case must attempt to fit that family's problem into a specified category of either "founded" or "unfounded" abuse or neglect. If the complaint was based on an isolated incident in which a situation of minor maltreatment actually did occur, it, in all honesty to the system, must be submitted as a founded report. For example: frustrated over a child's lies, a parent strikes the child across the face. In dismay, the parent realizes the blow left a handprint on the child's face. Someone calls in a complaint upon seeing the child's face. The worker investigates—there are indeed physical signs of abuse. The worker has little room for choice—the report relates to the incident, but...It is the "but" that causes such anxiety for workers. Does this isolated incident justify the family's name remaining on the central registry until sometime after the child's eighteenth birthday, as is the case in some states? Whether or not that family's name goes on the central registry depends more on the particular worker's decision whether or not to strictly follow the policy. The family is at the mercy of the worker. In states where an unfounded report goes into the central registry, the length of time before it is purged varies from six months to an indefinite time after the report, depending on the state. Some states enter all reports into the registry but purge a report as soon as it is determined unfounded. It is assumed that if a second report comes in on a family which has an unfounded report on file, doubts will be raised about the first investigation. Or, it is sometimes stated that the unfounded report goes into the central registry for the purpose of establishing whether abuse or neglect actually occurred. The second rationale is the weaker of the two in assuming that the central office could determine whether or not abuse or neglect occurred without ever conducting an investigation.

Many states have procedures through which a family can request an amendment or purging of their central registry record. This, of course, also applies to unfounded cases. I question why a family who has suffered the agency-inflicted trauma of having its name submitted to a central registry as unfounded must endure further trauma of initiating and following through on the purging of the information. The more sophisticated may understand their rights and hope that the purging follows. However, all families falling into the category of "unfounded reports" live with the cloud that any future accident or confrontation with their child will result in a determination of founded abuse. Is it the registry's intent to disrupt the normal functioning of innocent families?

If the worker submits the earlier described example as a founded case, what positive purpose does it serve? It increases the statistics by one more case. That statistic is now in the system alongside the severe and chronic cases. Some systems do distinguish between serious and nonserious cases. The American Humane Association, reporting on its Study for 1975, indicated that 51.3 percent of abuse cases in the study resulted in minor injury or no visible injury, and that 32.8 percent were unspecified. That means only 15.9 percent of the case reports the American Humane Association received represented known severe cases (neglect was not broken down by severity). The 15.9 percent (and possibly some of the unspecified 32.8 percent) represent families who seriously need protective services. However, caseworkers are swamped attempting to provide protective services to the 100 percent that are categorized as abused plus those who are neglected. This results in inadequate service to those in need.

Do we not inflict family crisis on those we categorize and place on central registries as abusing and neglecting families without providing adequate supportive services? It is necessary, therefore, to define what is a reportable case of abuse and neglect and look at it in terms of the purpose of reporting.

The purpose of reporting and the function of the central registry must constantly be addressed and readdressed. It is a mistake to constantly feed information into a central registry without regular reevaluation as to whether the information is necessary, or, more importantly, whether the information has positive or negative effect on delivery of services to abused and neglected children. The various functions of central registries are: (1) "tracking" families; (2) assisting in the diagnosis of cases of abuse and neglect; (3) case management and monitoring; and (4) providing statistics for research and program planning.

The first three functions require inclusion of identifying data such as name and address in the central registry. At this point, we should address the pros and cons of each function.

TRACKING

The earliest stages of the concept of central registries was based on the need for a tracking system. Statistics on which to base the success or failure of such a system have not been documented. However, certain issues must be addressed. First, have not social service agencies for years contacted the agency in a family's prior jurisdiction concerning previous contacts with a family? It is doubtful that the value of having this information on the central registry outweighs its disadvantages. Even if 10 out of 31,000 cases were tracked through the central registry, does that justify the other 30,990 names being maintained? Tracking does not commence until a new incident is reported. Therefore, it has little value in terms of prevention. If previous history is the issue, central registry information is scanty. Good social work investigation should produce more information than would be available through a central registry.

Second, families do not limit their transiency to within state lines. There is not a universal, reciprocal central registry nor do I think there should be (i.e., problems of confidentiality would arise as the network becomes mammoth). Again, there are no statistics on which to base any assumptions. However, reevaluation of the need for tracking should include how many of the cases on record have moved, and of those, how many are now out of state. Of those who have moved within the state, it should be determined how many have required an inquiry to the central registry as sole source for information.

Third, the rationale for tracking often addresses the assurance of continued contact with families who move to avoid agency intervention. This statement reflects an agency's confusion over its identity. Most protective service workers dislike and deny their role identification as being investigative or punitive. They prefer to be considered supportive. If a family moves solely because of agency intervention, then the agency should evaluate what it has done in terms of service and support. However, it is more often the case that a family has moved for economic reasons. The rationale based on moving solely to avoid agency intervention is weak.

ASSIST IN THE DIAGNOSIS OF CHILD ABUSE AND NEGLECT

Another function of a central registry is to assist professionals in diagnosing a case of child abuse and neglect. To use the central registry as a crutch for identification is dangerous. If a name is not on the central registry, a physician or other professional might doubt his or her own suspicions and not report. Conversely, if a prior report is on the registry based on one individual's interpretation, the professional may not investigate other alternatives to abuse and neglect. It is certainly not following the rule of innocent until proven guilty. Case consultation based on the immediate problems would be much more valuable.

CASE MANAGEMENT AND MONITORING

With the massive volume of case reports, case management and monitoring are next to impossible from one centralized location unless the system is computerized. With a computerized system it would be possible to monitor a case until it closes. Such monitoring, however, must be based on regular input from the local agency providing service to the family. In reality, supervisors within an agency should monitor cases in their workers' caseloads. To monitor a case from one central location would require inclusion of several variables such as services needed vs. services available and would require understanding the family in terms of its response to worker effort. It is a valuable program planning tool to be able to assess needed services vs. available services but this hardly requires identifying data in the central registry. It is more valuable to provide training and tools to supervisors so that they can efficiently monitor cases and conduct program needs assessments which then can be forwarded to the state.

STATISTICS

A function of central registries which require no identifying data is that of providing statistics for research and program planning. This function is probably the most justifiable rationale for a central registry. This function is totally unrelated to that of tracking, diagnosis, or case monitoring. With proper data inclusion, valuable demographic and epidemiologic data related to child abuse and neglect can result. Data can be analyzed for research purposes and possible further refinement of the definition and identification of child abuse and neglect.

Program planning can and should be based on the needs of the population served. For example, if data on a central registry could show a correlation between prematurity and abuse, a program could be developed based on that specific problem whether it be related to mother-infant separation or the difficulty of caring for a preemie. Also, if data showed a correlation between the hyperactive or learning-disabled child and abuse, a supportive program could be developed for parents of these children.

In addition, there is little danger in sending statistics on minor injury or neglect if only statistics are submitted. It is valuable to know if there exists a problem defining need for protective services vs. need for other family services.

We must stop the hypocrisy of saying we are protecting children and families. We speak of a nonpunitive approach to child abuse and neglect, yet our central registries with identifying data may put our children and families under greater stress than they were prior to registry. Are we not trying to reduce stress? If so, are we not defeating our purpose? Would not each of us fight a battle if our name was placed on the registry as we faced the daily challenge of raising our children? If the system was developed according to the age-old adage, "Do unto others as you would have them do unto you," I doubt we would need to have names and addresses on a central registry which has become the catchall for most parent-child difficulties.

We should use central registries statistically to assist in defining and designing programs and services to lessen child abuse and neglect.

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The State Central Register: Linchpin of a State's Child Protective Services Program

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The New York State Department of Social Services is responsible for supervising the child protective service program in each of the state's 58 social service districts. The Bureau of Child Protective Services, located in the department's division of services, has ongoing responsibility in this area. Additionally, the bureau maintains and operates the State Central Register for Child Abuse and Maltreatment with its toll-free telephone hotline, which is the linchpin of the state/local child protective service program.

THE ROLE OF THE STATE CENTRAL REGISTER

The National Center on Child Abuse and Neglect has defined seven areas in which a successful state central register operation can become involved. A central register which functions optimally must effectively do the following:

1. Assist diagnosis and evaluation by providing or locating information on prior suspicious occurrences and prior treatment efforts;
2. Improve handling of child abuse and maltreatment situations by providing convenient consultation to workers and potential reporters;
3. Refine diagnosis by providing feedback to those who make reports;
4. Measure the performance of local child protective services by monitoring follow-up reports;
5. Coordinate community-wide treatment efforts by monitoring follow-up reports;
6. Facilitate research, planning, and program development by providing statistical data on the handling of reports; and
7. Encourage reporting of suspected child abuse and maltreatment by providing a focus for public and professional educational campaigns.

A review of the activity of the Bureau of Child Protective Services and the register operation reveals that substantive progress has been made in most of these areas.

With regard to assisting in diagnosis and evaluation, state central register specialists seek maximum information from callers so that all names and information reported can be thoroughly cross-referenced. They immediately notify county child protective service staff if there are opened or closed cases on newly transmitted reports. When a previous report is found, the report is assessed for the purpose of making verbal summaries to local workers. The local child protective service unit is asked to watch closely those cases that show high risk factors in prior reports. The specialist summarizes past cases for initial use by a child protective service unit when a case is transferred from one county to another, since the register has excellent capabilities for facilitating transference of cases. Local workers are encouraged to submit information to the register that is succinct and comprehensive, and to keep in mind the goal of development of useful data. Most importantly, specialists listen and pass on any relevant information besides reportable matters that may help casework diagnosis intervention and treatment (e.g., other service agencies already involved, current family crisis).

Consultation to improve handling of child abuse and maltreatment is an important responsibility. The register is staffed around-the-clock for inquiries and reports, and specialists extend themselves in a friendly and professional way to all callers. They provide quality consultation based on training and past social service experience as well as their continuing, emerging knowledge which comes from the variety of situations to which they are exposed daily. The aim is to provide consultation that is realistic in light of prevailing professional, legal, and policy considerations, a fusion sometimes difficult to obtain. When an immediate answer cannot be given to a problem, the specialist will consult with a knowledgeable person within the bureau in order to gain clarification, and later respond. The specialist may also refer many people daily to other services after it is found that the caller is not seeking help for a child abuse/maltreatment situation, but for another problem that can be aided by other social services. This builds goodwill for the register and reinforces its focus as a helping operation. In all involvement with

local districts, specialists reach for good working relationships with local child protective service workers in order to build mutual understanding in helping children and their families.

Refinement of diagnosis by providing feedback to those who made reports is currently done by referring reporters back to the local districts. A summary of findings is thus provided as required by the child protective services statute. Referral to the local district, though, while satisfactory for meeting this statutory provision, is not likely the best vehicle for refining the relevant diagnosis. Accordingly, new procedures will be explored and developed during the coming year.

Measuring performance of the local child protective service by monitoring follow-up reports is one of the register's most important functions. Specialists review each dispositioned and closed case coming from local districts to evaluate the quality of contacts and the appropriateness of the decision. The local child protective service unit will be contacted if the decisions and actions taken do not seem to be in the best interests of the children reported. Following consultation it may mutually be decided that the determination may stand or that corrective action is required. Local child protective service personnel are aware they must be able to give a reasonable account of what they do in cases. Concomitant with this, register specialists must follow through to get revisions when improper reporting and actions appear. Specialists must keep their program supervisors informed of unresolved individual case situations as well as pointing out discernible trends relative to local reporting and follow-up. Specialists must understand the system under which local child protective service personnel work so that an overall context is established for evaluative purposes. To that end, specialists are given an opportunity to review and comment upon the Annual Plan for the Provision of Child Protective Services for the counties they monitor.

With regard to coordinating community-wide treatment efforts by monitoring follow-up reports, the register does not accommodate this function except as it notes areas of inappropriate or inadequate follow-up, and brings this information to the attention of the local agency.

The register plays an important role in facilitating research, planning, and program development relative to development of statistical data. Specialists code information from dispositioned cases for eventual conversion into nonidentifying statistics. They are available, on a limited basis, to extract necessary information for an occasional research project. Specialists are committed to making accurate transcriptions so that statistical information is enhanced. In response to planning and development, specialists spontaneously make program suggestions and are asked for opinions based on their work experience. Because New York State's central register has one of the greatest storehouses of raw data on child abuse and neglect in the nation, officials hope that ultimately it will be used maximally for bona fide research purposes.

The register provides a focus for public and professional education campaigns and encourages the reporting of suspected child abuse and maltreatment. Specialists are not formally involved in educational campaigns, but they do as much as possible in their phone work to educate the public about the phenomenon of child abuse and maltreatment. Each day they receive many calls concerning the definition of child abuse and treatment activities. Specialists are limited to brief conversation but refer many callers to sources where they may receive more phone information or literature. Often, the register serves the point of introduction to the field. The Bureau of Child Protective Services and the department make available pamphlets on the reporting system and disseminate reporting guidelines and other information to the public. Most local districts in their own public education campaigns have used the register and its toll-free number as the focal point.

The role of the register specialist has expanded. The specialist must make countless professional judgments about many complex situations. The job is far from mechanical in nature, but rather calls for a high degree of resourcefulness and flexibility. The register is young and emerging, with certain areas remaining to be developed. However, it has fulfilled its early promise, and portends more effectiveness in the future.

OPERATION

The New York State Child Abuse and Maltreatment Register receives oral and electronic reports of suspected child abuse or maltreatment and monitors the provision of child protective services 24 hours a day, seven days a week. A statewide toll-free telephone number, 800-342-3700, is available for use by any person wishing to report cases of suspected child abuse and maltreatment. The register is also available through this number for authorized persons to determine the existence of prior reports in order to evaluate the conditions or circumstances of a child.

REPORTING PROCEDURES

All persons required to report and others wishing to report a case of suspected child abuse or maltreatment make initial oral reports to the register through the statewide toll-free phone number (except in those districts which were reauthorized in 1976 to receive reports locally, i.e., New York City, Monroe County, and Onondaga County. Local reports are then transmitted immediately to the state central register).

The specialist receiving the report obtains information from the reporting source, searches the register files for prior reports, and then immediately transmits all information to the appropriate local child protective service for its investigation and follow-up.

Each local department of social services has developed a system whereby reports transmitted by the state register may be received 24 hours a day, seven days a week. A person making an oral report of suspected child abuse or maltreatment must submit a written report on Form DSS-2221 (Report of Suspected Child Abuse and Maltreatment), used statewide, to the local child protective service within 48 hours of oral report. Upon receipt of this written report, the local child protective service must immediately send a copy to the state register.

INQUIRY SYSTEM

During 1976, there were 2,101 requests for information contained in reports maintained in the register. This compares to the 1,560 similar requests received in 1975.

Information in the register and in local child protective services is confidential and only available to:

1. A physician who has a child before him whom he reasonably suspects may be abused or maltreated;
2. A person authorized to place a child in protective custody when he reasonably suspects the child may be abused or maltreated, and requires information in the record to determine placement of the child in protective custody;
3. An authorized agency responsible for the care or supervision of a subject of the report;
4. Any person who is the subject of the report;
5. A court, upon finding the information in the record necessary for determination of an issue before the court;
6. A grand jury, upon finding the information in the record necessary for determination of charges before the grand jury;
7. Any appropriate state legislative committee responsible for child protective legislation; and
8. Any person engaged in bona fide research.

When an authorized person (e.g., physician, subject of a report, etc.) requests information from the register, the person's identity is verified before information is released. Whenever information is released, the status of the report is identified as "indicated" or "under investigation." Any person given access to identifying information from the register or from a local child protective service is informed that he may not make public such identifying information unless he is a district attorney and the purpose is to initiate court action.

AMENDMENT, EXPUNGEMENT, AND SEALING OF CONFIDENTIAL RECORDS, AND FAIR HEARINGS

All information obtained, reports written, or photographs taken concerning reports of suspected child abuse or maltreatment are confidential and can be released only to authorized persons as outlined above.

The local child protective service must notify the register within 90 days of the initial oral report as to whether the report is "indicated" or "unfounded." The register expunges unfounded reports by removing all identifying data from cross-reference files and reports. Written notice of the expungement of an unfounded report is sent to the subjects of the report and to the local child protective service. The copy of this notice is itself expunged after it has been established the subject has received notice.

The record of all other records to the register is kept on file and will be sealed no later than 10 years after the subject child's eighteenth birthday. A sealed record will not be made available unless the State Commissioner of Social Services, upon notice to the subjects of a report, approves.

Upon request the subject of a report is provided, by certified mail, a copy of all information contained in the register, except data which would identify the person who made the report or who cooperated in the investigation of the report if this would be detrimental to the reporter's or investigator's safety or interests.

The subject of a report at any time subsequent to the completion of the investigation may request the state commissioner to amend, seal, or expunge the record of the report.

A request for expungement results in a full-scale review by the department of reports of child abuse or maltreatment contained in the register and the circumstances surrounding these reports. The request is either granted or denied. If denied, the subject of the report, upon request, may have a fair hearing scheduled and conducted, usually in his home district. A fair hearing is an administrative review of the reports which is conducted by the Department of Social Services and is not a court action. State and local child protective services staff are parties to the proceedings and attend all hearings.

During 1976, 685 requests for copies of reports of information from the register relative to requests for expungement or amendment of reports were received in addition to 198 formal requests for expungement, comparable to the 372 requests received the previous year. On behalf of the subject, the bureau seeks clarification of a request for information. This is only done after the subject of the report is notified by letter of his rights under the child protective services statute and that a report of alleged child abuse or neglect has been made. Previously, it was not uncommon for the subject of the report to request, in reaction to the notification letter, copies of information, amendment, expungement, and a fair hearing without regard to the natural sequence of events. The decision to expunge, for example, leads automatically to an action which obviates the need for a fair hearing. States which may be developing registers similar to New York's must work assiduously in this area.

Twenty-two fair hearing decisions were rendered, resulted in confirming the decision made by the department not to expunge the reports as requested. In two of these, it was directed that certain portions of the reporting forms be amended. In six decisions, it was directed that reports be expunged as requested by the subject(s) of the report.

MONITORING LOCAL AGENCY OPERATIONS

The department reviews the operation of child protective services in each local district from several vantage points. Observations and evaluations based upon the department's monitoring of follow-up reports submitted to the register is a viable monitoring mechanism.

Register specialists monitor the daily activity of local agencies in a variety of ways. All unfounded, indicated-closed, and some open cases are regularly reviewed to ensure local case activity meets the requirements of the law. An unfounded case is one in which no credible evidence is found to substantiate the allegation of child abuse or maltreatment, and all identifying data are expunged. An indicated-closed case is one in which there was some credible evidence to substantiate the allegation and the case is being closed because all available services appropriate to the case have been rendered.

Because of this activity, register specialists are in a unique position to spot trends concerning the activity of local districts. A perception is gained from the review of follow-up reports as well as daily telephone contacts with local agencies. When problems are discovered, information to resolve them is routinely passed along to program personnel within the bureau. Experience shows that local districts tend to cooperate when issues of mutual concern are raised with regard to handling of reports of child abuse and neglect made to the register.

GOVERNMENTAL INTERVENTIONS

The necessity of a role for government in the effort to deal with child abuse and neglect was expressed in the FOCUS section. The papers here elaborate on those themes to better define what that role should be and to explore the complex legal issues that must always result from so significant an intrusion as child abuse and neglect intervention makes into the lives of families. The papers in this section do not uniformly advocate governmental intervention. Unfortunately, governmental intervention with a problem does not guarantee its solution, and may result in a spectrum of new problems or even an exacerbation of the original one.

Most of the papers concerned with the *role of governments* seek to delineate distinct federal, state, and local roles for approaching the planning and provision of services for child abuse and neglect. The role of the federal government is seen as a facilitator, offering financial, informational, and organizational resources to states to assist them in program development. The state's role is to create and administer the service delivery programs, as well as to provide technical assistance to the local government. The local level is seen as being where the action is: the level at which services actually reach families in need, and also a source of information which should feed back into the system to assist federal and state governments in planning.

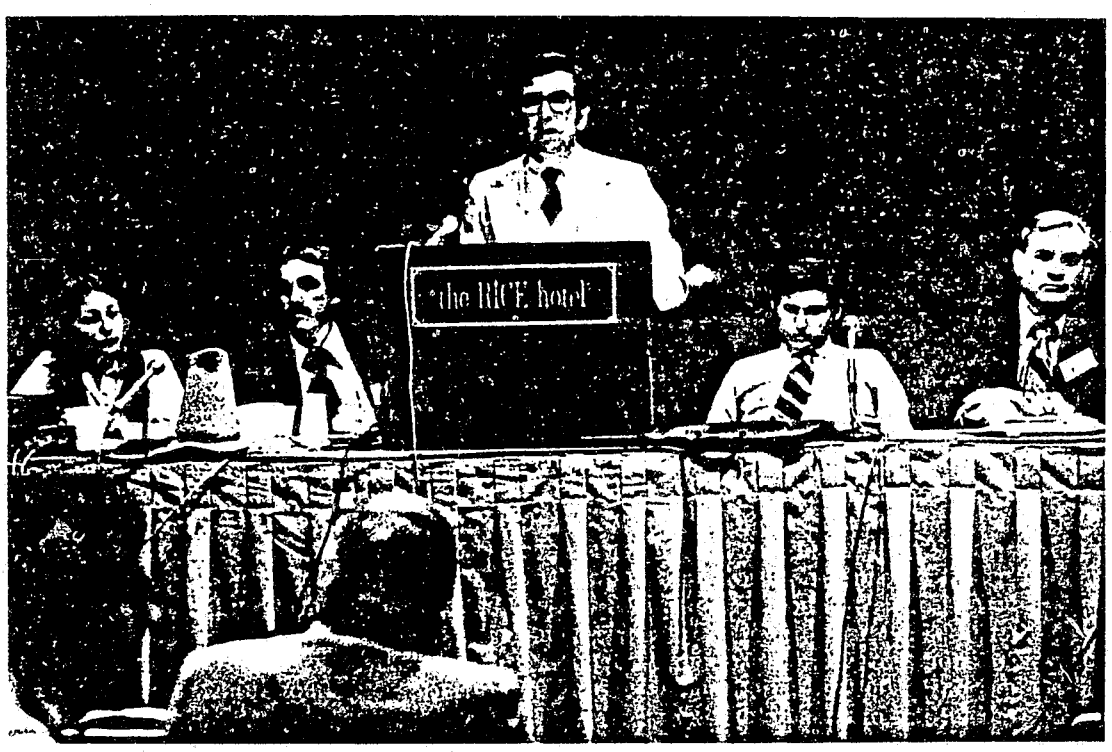
In such a three-tiered system, it is inevitable that there will be conflicts between levels. These conflicts are sometimes seen as evidence of fragmentation, which often has the effect of creating a lack of continuity through the hierarchy. They can, however, be looked upon as creative tensions which, if developed, can lead to better planned and more creatively implemented programs through controlled feedback to guide governments in creating policies that strengthen and support—not stress—families.

The *legislative and legal issues* papers define three main responsibilities of the legislature: creation of an effective reporting act, funding of child protective services, and funding of programs for primary prevention. The legislator can also serve as an educator and as a creator of community consciousness. Special interest groups are urged to initiate legislation and work for its passage. Such activities in the area of creating model legislation should be structured to ensure full participation in planning from all interested parties, e.g., service providers, behavioral scientists, legislators, and juvenile court judges, whose opinion has sometimes been neglected in the past. Major trends in the area of model legislation are identified: definition, mandatory reporting, central registries, and issues concerning parents' and children's rights. In addition, the legal implications of the institutional use of corporal punishment are reviewed, along with comments on limiting it through formal legal action.

In discussing *the state as parent*, authors grapple with the question of how much power the state should have to intervene to disrupt the family unit, and the more difficult question of whether children are even valued in our society. The evidence presented portrays the state as a highly negligent parent, and raises serious questions about the practices of foster care and institutionalization. Certainly there are instances when the state must act as parent; how to fulfill that parental role "in the best interest of the child" has yet to be discovered.

David Slader

S. M. Murphy



The panel on model legislation; left to right: Patricia Connell, Brian Fraser, Sanford Katz, Michael Wald, The Honorable James Lincoln

Nancy Amidei

Kenneth Wooden

Panel on Treatment Issues; left to right: Allene Goldman, James Kent, Julie Levitt, Arthur Green

The Role of Government: Federal, State, and Local

The Role of the (Federal) Community

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As you think about the role of the community in relation to families there is a particular "community" that should be kept in mind. The community that I am going to talk about this morning is, ironically, something that is rarely thought of in those terms: the federal government. Yet it is nonetheless a group of individuals with a vital and immediate involvement in what goes on in the lives of families and children and should not be ignored. As a member of the Family Impact Seminar I am part of an effort that is trying to look at the role of government in relation to families, and attempting to design a process by which the government would pause in its proceedings and consider—before it enacts new policies, adds money to old programs, takes something out of the system, or puts something else in place—the impact of the change on families.

The Family Impact Seminar is made up of people drawn from three different kinds of backgrounds: from public policy, from academic life, and from clinical practice. It includes Salvador Minuchin, a leader of the family therapy movement; Rosabeth Kantor, who studies the ways in which the government as an employer affects families; Urie Bronfenbrenner, who has spent many years studying families and children; and Robert Mnookin, a law professor specializing in family law, as well as the heads of family studies centers, a pediatrician, a home economist, students of the women's movement, and present and former government figures like former HEW Secretary Wilbur Cohen. It is a varied, thoughtful, and distinguished group of individuals.

The idea for the Family Impact Seminar goes back several years to hearings conducted by then Senator Walter Mondale, while he was head of the U.S. Senate Subcommittee on Children and Youth. In the course of a series of hearings on the state of the American family, one witness remarked that it is indeed ironic that the federal government should be required to stop and consider the environmental impact of proposals, but not required to stop and think before taking actions that might impact on families. That was such a reasonable idea that Senator Mondale immediately said he would plan to introduce legislation to establish such a system.

He and his staff quickly realized, however, that this was a much more complicated proposition than it originally seemed. But the idea was a very attractive one, and so a little later the Subcommittee's staff director, Sidney Johnson, left the Senate to set up a private organization that could design a process to assess the impact on families of various public policies. That organization is the Family Impact Seminar of Washington, D.C.

From the very first it was clear that the Family Impact Seminar had to be an independent forum that had no direct involvement with the government itself. Any of you who were involved in the battle to enact the Child and Family Services Act a few short years ago know how sensitive a matter it is to talk of involving government in the lives of families. That bill never became law, in part because of the flood of angry letters, telegrams, and calls from all across the country at the prospect that government might become involved in the ways that American families conduct their lives. The campaign may have been based on a misunderstanding about what the bill would do if enacted into law, but it reflected a genuine concern on the part of many that families are a private matter and not a proper focus of government activity. The experience of that bill was very sobering, and was not lost on Sidney Johnson or the private foundations that provide the Family Impact Seminar with financial support.

Curiously enough, if government is ever required to consider the impact of its policies on families, that requirement will not *put* government into a position of influencing how families live. Every day the people in public life adopt policies that affect families. They may not be labeled "family policies" but they affect families just the same. We are long past the point where the federal government could be put in a position of influencing families; that is happening all the time. What we are asking is that a process that has gone on for as long as we have had government in any form be made more responsible in relation to families. At the very least, we believe, government should not act in ways that add to the stress that modern life puts on families.

If anything, the Family Impact Seminar is in a large and growing company. "Family" has become the new buzz word. Everybody seems to be getting on the "family" bandwagon. Many people who continue to do the things they've always done, now describe them as "family interventions" or "family-related activities." It is as though we have just discovered that people live in families, despite the fact that clinicians working in the area of human services have always been in the business of trying to work with families. It comes as no news to them that four-year-olds do not live an independent life in independent households. Young or old, whether living physically with other people or alone, all of us live our lives in relation to other people who comprise our families. We just pay more attention to that fact these days. But the current popularity that "family" has makes me cautious. It makes me want to pull back a little bit and pay very careful attention to the kinds of things that are being said in the name of the family.

It has also made me aware of the fact that people seem to be lined up on one of two sides. On one side are those who say that the American family is doomed. You can recognize that group by their adjectives. They describe the family in the gloomiest of terms: it is dissolving, disintegrating, disappearing. One well-known sociologist recently wrote that according to his calculations, by 1990 there would not be *one* American family left. I have not had the heart to tell my mother.

I personally find myself lined up with those who are on the other side of this discussion. I would not deny that families are undergoing rapid and dramatic change, or that they are under stress, but I want to go one step further and point out that there has never been a time when that has not been true. Families have always lived through social change. There has been no time in the history of any society in which families have not been under some kind of stress. As recently as fifty years ago a large portion of American families were recent immigrants whose entire way of life had been left behind, or who were facing the prospect of raising children with one or both of the parents dead in early adulthood. Those were terrible strains. But then as now, families somehow try to cope. Those of you who work with troubled families are no doubt frequently struck by how often even the most troubled families are trying desperately to make things work. It is a very interesting phenomenon. Families survive the death of one or several members, they survive separation and deprivation of various kinds, they survive terrible tragedies and devastating problems. It makes me want to cast my vote, if one is asked for, with my mother and father, with my brother and sisters and their children, with my large assortment of Italian relatives, and with all of those who say that the family is probably here to stay. What we ought to be doing is supporting family life, rather than leaping so eagerly into print to write it off.

Some of my feeling on this point grows out of an experience I had some years ago while working with the Senate Nutrition Committee. I learned then the danger of not appreciating that anything can be heard in more than one way. At the risk of a slight digression, I'd like to recount one incident in particular. I became particularly interested in some of the testimony that the Committee heard on the links between malnutrition and mental development. Some of the same witnesses who appeared before the Committee were invited to the White House to meet with a group of scientific advisors. As scientists tend to be, those witnesses were cautious in their description of the evidence, careful to limit it to just what could be proved, and not prepared to draw sweeping conclusions from the facts before them. So when they were asked whether malnutrition and mental development could be related, they said yes, but only under certain very circumscribed conditions. All the caveats were in place. You are telling us then, the White House advisors repeated back to them, that if the malnutrition is serious enough, prolonged enough, and occurs at critical enough points of development, it can result in permanent mental damage. Yes, the scientists said, it can. Then why, one of their questioners wanted to known, are we wasting all the anti-poverty money? If people are irreversibly damaged, he reasoned, why not simply write them off?

That story may not be perfectly accurate, and there is no way of knowing precisely what was said, but it is one of the reasons that I find myself particularly disinclined to say that there is no hope for families. I am worried that someone may decide that if the state of the family is hopeless, we should not bother to "waste" any money or provide any services to them, but instead should simply "write them off." I'm not ready to write them off. I think we ought to do whatever we can to help and support even the most troubled families. The Family Impact Seminar and the task we have set out to accomplish represent one very small way of trying to find ways of doing just that.

One thing we can all do is try to look at families in a less glib and prejudicial way. A sociologist named Robert Hill has noted that there is a tendency to confuse family structure with family functioning. We tend, for example, to equate one-parent families with bad or

dysfunctional families. Just think how often we describe them as "broken" families. By the same token we tend to equate two-parent families with good families, ignoring the abundant evidence that many single-parent families function very well, and many two-parent families do not. Instead, we take note of the structure and immediately make a judgment about how the family behaves. We use divorce statistics to prove the point that the family is an institution in decline, when all they can actually tell us is that legal divorce is easier to obtain and couples whose relationship is no longer sound no longer feel constrained to stay together. Wait, Hill says, and look at how those families function before drawing your conclusions.

If you stop to consider all these things that I have touched on briefly—the fact that government actions already affect families, the realization that everyone seems to want to claim credit for being involved with the family issue, the way our language has led us to glib and often erroneous notions of what is happening to families—you will begin to appreciate something that we at the Family Impact Seminar have learned the hard way: there is no magic formula for putting the idea of family impact analysis into practice. What is such a simple idea on the surface, namely that government should not do things that are going to hurt families, turns out to be a very complicated business indeed.

At the simplest level the idea poses problems. If, for example, all government decisions affect families, and they do, then to what decisions should something like family impact analysis apply? How do you draw the limits to what should be included? Should it apply to decisions like whether we agree to go to war? Certainly that has an immediate and often devastating effect on families. Or should it only apply to decisions like whether or not we put more money into child health services?

There are many very basic questions to be asked. What kinds of families do we want government policies to support? (For some people that raises fears of government support for hippie communes and group marriages.) How do different policies impact on families at different stages of family development? Assume for a moment that pro-family tax policies would include enacting only measures that are supportive of families with young children. You will quickly discover that policies which are supportive of that kind of family may not prove to be good policies from the point of view of families composed entirely of people over 65, or families in which there are adults who are responsible for an elderly parent or a handicapped but grown-up family member. The same policies apply to everyone, so we need to be very clear about the kinds of families we have in mind and the goals we want to achieve before we know what it means to adopt policies that are supportive of families.

Or, looking at families in structural terms, should we try to insist that government policies support extended family networks? We know that such family networks exist in the life styles of many Americans, but particularly among Black, Hispanic, and Southern European families. Can government policy be expected to take into account the fact that grandparents and aunts and uncles and cousins sometimes contribute emotional and financial support within their families and provide social supports that no public institution has managed to achieve? If government wanted to support those family networks, how would it do so?

Which family-related interests should take precedence? We know that unemployment is bad for families. Does that mean we should consciously adopt or reject certain economic policies depending upon whether or not more heads of households are going to be employed? What about teenagers? They are not usually heads of households, but they are members of households, and forming families of their own may be conditional in part on whether or not they are employed.

What happens when the rights of different family members appear to be in conflict? Do the rights of parents automatically take precedence over the rights of children, or the reverse? What about the rights of foster family members, of divorced and separated parents, of grandparents after a divorce has taken place? Should family impact analysis try to take all of them into account? Even if it wanted to, would that be possible?

Finally, we have to ask whose values should apply. That may be the most difficult question of all to resolve. The simple business of only doing things that are good for families, of asking that government only enact policies that support families and do not cause harm, is doubly complicated when values are introduced. What does help or harm a family? Many people would differ on the question of whether freeing families from burdens is not also a way of relieving them of responsibilities that they should carry. For example, is providing day care a way of helping families bear their child-rearing responsibilities, or a way of interjecting government in a function that should be carried out only by families themselves? What about abortion? Or issues like integration and the vigorous prosecution of anti-discrimination efforts? Think for a moment about providing family planning services for teenagers. Whose values are going to be applied

when we try to assess the family impact of that? Do we want to give someone in a government office or in the Congress the power to decide the goodness or badness of a given policy when it is *our* families that will be affected?

All of these are terribly difficult questions. At the Family Impact Seminar we make no claim to having found the answers yet, but we are struggling with the questions and eager to have them considered by as many people as possible. And we are not discouraged. We are convinced of the need for the careful, independent, thoughtful consideration of these issues. We think that it is inevitable that we ask the questions and face up to their implications, and hopeful that our early thinking will help to make the public policy process more ethical and responsible in relation to families. We have begun our task by identifying topics which might be suitable for model legislation that could be ready by the end of 1978. We have begun to look at issues such as the biases toward institutionalization in the various health reimbursement programs like Medicare and Medicaid, at the placement of children outside their homes, at the impact of unemployment on families, and at the government's employment practices in relation to its own employees. We think issues like these may ultimately provide the focus for some model family impact legislation.

There is one point on which we differ among ourselves and would welcome reactions to: how a family impact analysis process can build in feedback from families themselves. Families are not like trees and waterways; they cannot be analyzed in the same way that environmental impact statements can be written about our natural resources. There is probably going to have to be some way to enable families to tell government how its policies affect them. We will need a process that includes comment from communities and the people who work with families, so that we can learn first-hand how families are being affected and whether policies ought to be changed. I find myself thinking in terms of what I call community canaries. You may remember those poor canaries that were sent down into the coal mines to test whether there were poisonous gasses in the air. We need to identify and develop people or institutions around the community who have a sense of when the climate has become harmful to families and who, like the canaries, could warn us that something important to families is changing in helpful or harmful ways. If the people in public life are indeed going to be made to stop and think before enacting new policies, adding money to programs, or ending programs and policies that are already in place, then we will need to involve the families themselves and their communities in the process. If you who work with families have any thoughts on that subject, we at the Family Impact Seminar would be very glad to hear them.

I will make just one last comment, even though it will reveal the fact that I am an unredeemable optimist. I realize that dealing with your subject, child abuse, can be terribly discouraging at times, and that it puts a tremendous strain on the people who try to find new ways of working with these families. I think that is why I want to conclude with something hopeful. When I was new in government I went to a meeting that was supposed to mark the conclusion to about a year and-a-half of work on a new idea. Everything was supposed to fall into place, and in theory there was nothing left to be done but sign the papers. The meeting, however, was a disaster, and eighteen months of planning and meeting and memo-writing, along with all the inevitable calling back and forth among the agencies, suddenly went right down the drain. I was devastated, but the person I had gone into the meeting with said, "Don't be discouraged. If the world had been a demonstration project, it would have never been refunded."

The Role of Governments in Relation to Families—The Federal Perspective

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FROM INADEQUATE EXTREMES

There are two basic extremes in social policy the federal government should avoid: (1) "benevolent paternalism"—the government should be all things to all people; and (2) "benign neglect"—let the social problems resolve themselves, or leave total responsibility and accountability to state and local government or private and nonprofit enterprises.

Both extremes have been pursued during the sixties and seventies. Neither proves effective in reducing family breakdown, strengthening quality of family life, or reducing abuse, neglect, or delinquent behavior. Nor do they develop a truly integrated services approach to family problem-solving, or help a family cope with the stresses and crises of daily living.

"Benevolent paternalism" never provided the resources necessary to match the level of expectation or verbalized commitment to the "Great Society." "Benign neglect" failed to provide national direction or leadership in social policy, and left the responsibilities of advocacy and social planning almost entirely to state and local levels which were frequently ill prepared and often reluctant to carry out these new roles effectively. Resources failed to equal the needs and expectations of the constituency.

The failure of these two extremes, plus the onset of spiraling inflation and increased tensions in today's society, results in more competition among special needs constituent groups for the same level of dollars now funneled through a confusing variety of categorical grants, "special" revenue sharing, general revenue sharing, and research and demonstration programs. The needs of the family most often are lost in the struggle.

TOWARD A NEW STRATEGY

There is currently no comprehensive national public policy on social services. Arabella Martinez, Assistant Secretary of Human Development, Department of Health, Education, and Welfare, has as her major goal the articulation and legislation of a new national policy for social services constructed around four basic concepts: (1) addressing the whole person; (2) focus on strengthening the family as a unit; (3) building supportive community institutions; and (4) developing "livable" communities. The basic thrust would be to support the development of efficient, effective, accountable, and compassionate delivery systems for comprehensive integrated social services for the family.

Secretary of Health, Education, and Welfare Joseph A. Califano, Jr., in his policy paper on the American family written for President Carter during the 1976 presidential campaign, graphically expressed the federal government's proposed role and its challenge in developing a new social policy concerning services to American families and their children:

> The changes, opportunities, and difficulties families are experiencing are the result of a complex set of circumstances and influences. Some reflect personal and interpersonal actions and attitudes. Others are the result of economic, social, religious, or cultural forces. Some are easily understood; others are not.
>
> One set of influences is public policy. Unlike many other countries, America has no official, explicit family policy. But the absence of a formal family policy does not mean we have no family policy at all. What we have, instead, is an inconsistent patchwork of policies affecting families. Some are explicit, direct, and consciously adopted. Others are implicit, indirect, and largely unexamined.
>
> It is precisely those public policy implications that we need to explore.
>
> Clearly, there is no "federal solution" to all the problems our different types of families are experiencing. Any effort to produce one would be inappropriate.
>
> An appropriate government role, instead, is the examination of the way its policies and programs may be contributing to family difficulties, so that policies and programs that hurt families can be ended and policies and programs that help families can be

strengthened. As Dr. Edward Zigler, Professor of Psychology at Yale University and former Director of the Office of Child Development, stated: "We can and should demand the rejection of apathy and negativism and expect a renewed commitment to the proposition that families are indeed important and that it is the Federal Government's role to help reduce the stresses and to help meet the problems confronting families."

We need to understand far better the changes which have occurred in the structures, values, and circumstances of our families and the pressures and problems that they are facing. The task will be extraordinarily complex, and short-term "solutions" to many of the problems will not be found. Values, jobs, lifestyles and needs of families vary widely. To envision a single model family or a single way to raise children would do great damage to the pluralism and diversity that make our country strong; would be beyond the legitimate concerns of government; and could produce at least as serious problems as ignoring altogether the impact of policies on families.

But the challenge must be accepted, for our strength as a nation depends more on the vitality, love, and compassion of our families than any other single policy, program or institution. To address the issue, we must expand considerably the dialogue about families and children, increase the accumulation and dissemination of our knowledge on the subject, and actively solicit the views of concerned parents, youth, experts, and organizations.

While a comprehensive understanding of the problems facing families and children will take time, there are some problems we can and must confront now:

> We must provide jobs for parents and curb inflation. Nothing is more essential to America's families than a strong and healthy economy.
>
> We must restore trust and confidence in our families as the basic institution for meeting human needs.
>
> We must begin to review the impact of Federal programs on families so we can change those which are destructive and strengthen those which are supportive.

Families are the cornerstone of national well-being. There can be no more important task than to strive forcefully and thoughtfully to assure the freedoms and opportunities from which they draw strength (Califano, 1976).

STRENGTHENED FEDERAL, STATE AND LOCAL PARTNERSHIP

Proposed roles of the various levels of government within a new strategy for social services to families should be developed and implemented on a partnership rather than adversary basis as has sometimes (all too often) happened in the past. That partnership must be premised upon: (1) mutual trust; (2) joint commitment to common social goals and objectives; (3) a clear understanding of and agreement to both the distinctiveness and interrelatedness of the roles of each partner; and (4) recognition and acceptance of the legislatively mandated programmatic, regulatory, and fiscal authorities and responsibilities of each level of government unless or until more appropriate legislated roles may be effected more in keeping with joint goals, objectives, and social policy.

Within the partnership concept the following roles seem appropriate:

1. The Federal Role:
   - a. Dynamic leadership and catalytic action by top-flight, highly qualified national and regional staff;
   - b. Formulation, with appropriate state and local inputs, of broad national social policy, goals, and objectives;
   - c. A White House conference on the family in today's world;
   - d. Research, demonstration, and evaluation projects which are national or regional in scope, impact, or potential for replication;
   - e. Quality technical assistance to state and local governments and agencies as well as private agencies and organizations, including consumer groups;
   - f. Development, dissemination, and assistance in using model legislation, standards, programs, and service delivery systems;
   - g. Assure a basic service level for every family in the United States: (1) national legislation; (2) basic funding; (3) minimum standards/regulations; and (4) monitoring/evaluation; and

h. Serve as convener of the federal, state, and local partnership, including support of the basic mechanism for joint policymaking, and setting of priorities, goals, and objectives.

2. The State Role:
   a. Develop and implement statewide social policy, comprehensive family service plan, and priorities, goals, and objectives consistent with national policies and goals, and specific state needs;
   b. Provide leadership and serve as catalyst in encouraging appropriate state legislation, programs, and appropriations to meet state goals and objectives;
   c. Establish viable partnership with communities to assist them in planning for and serving families within their jurisdictions;
   d. Assure minimum standards and levels of service for all families throughout the state;
   e. Establish effective and compassionate delivery systems;
   f. Monitor state/federal funded services, their implementation and impact;
   g. Provide state inputs to federal policies, goals, objectives, legislation, standards, and regulations affecting families and their environment;
   h. Fund and evaluate appropriate state research and demonstration projects; and,
   i. Assure quality training at all levels for staff serving families and children.

3. The Local Role: Where the Action Is!
   a. Assure delivery of services appropriate to priorities of need;
   b. Identify gaps in services;
   c. Develop and implement comprehensive service plans, coordinated delivery systems, and evaluation feedback;
   d. Promote grass roots consumer and citizen participation in formulation of policy, legislation, appropriations, and programs at all three government levels;
   e. Promote maximum use of local resources to supplement state and federal resources;
   f. Implement and evaluate programs, standards, and regulations concerning services to families;
   g. Provide the key to the "livable" community, so necessary to the well-being of families; and,
   h. Promote federal, state, and local partnership but keep partners honest and realistic in identifying and addressing the critical needs of families with appropriate individualization according to geographical, ethnic, socioeconomic, cultural, and structural differences of each family and each member thereof.

Why all this effort? Why the need for renewed joint commitment? Why a new priority on the family as a unit? Why is action demanded now?—because of the plea of a child:

Come, grow up along with me;
The best is yet to be!
Help me become what I was meant to be—
And I will return a thousandfold each precious opportunity!

Yes, Come grow up along with me;
The best, indeed, is yet to be!
A thousand tomorrows are in your hands
Why not invest a few in me?

S. M. (Pat) Murphy

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The Role of State Government

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The history of government intervention goes back as far as Hammurabi, the 18th century B.C. king of Babylon who included the first recorded building regulation in his famous code. It prescribed simply that if a house fell down and killed the occupant, the builder should be put to death. Modern experts consider this a model code because it stresses performance instead of prescribing the details of construction. Thomas Jefferson, in his inaugural address, promised Americans "a wise and frugal government which shall restrain them from injuring one another, which shall leave them otherwise free to regulate their own pursuits of industry and improvement." However, with the increasing size and complexity of our whole economic and social system, it's obvious that a larger, more complex society generates more and tougher problems. As Kenneth Bolding of the University of Colorado has pointed out, an astronaut in a space capsule has to follow a far stricter regime than a cowboy on the prairie. A space age economic and social structure must have rules that a cowboy social structure didn't need.

We have in our country an ingenious balance of powers, a disequalibrium, a creative tension that works two ways. First, our system of government is based on three tiers, three levels of federal, state, and local governments. This system is part and parcel of our political and legal heritage. The Tenth Amendment of the Constitution states, "The powers not delegated to the United States by constitution nor prohibited by it to the states are reserved for the states respectively or to the people." Second, the powers of government are divided among the executive, the legislative, and the judicial branches.

On the wall in my office hangs a quote from Justice Learned Hand which says, "The Spirit of Democracy is a spirit that is never quite sure it is right." At times I indulge myself, as perhaps you do, in damning the federal government or the courts for injecting themselves into the business of state or local government. At times that criticism is no doubt justified, but let's examine the phenomenon for a moment. The field of education is the most familiar to me. In education, the greatest amount of criticism of federal government or court intervention centers around desegregation of schools. People are forever criticizing the feds or the courts for taking over the prerogatives of local boards of education or of the states concerning school districting, assignment of teachers, busing, etc.

Examples: At one time our state legislatures were controlled by a disproportionately large number of legislators from rural districts. Finally the courts were drawn into this issue and ordered reapportionment—the one person-one vote rule. In 1965 Congress passed the Elementary-Secondary Education Act which among other things provided for compensatory education—Title I—providing for additional educational resources to compensate for the education deficits suffered by children from poor families. Last year Congress passed sweeping provisions for the education of handicapped children. These are now causing serious implementation or finance problems in some states.

Why do these stresses—sometimes conflicts—exist? They are the product of our system. The rural-controlled legislature, for example, couldn't really be expected to voluntarily vote itself out of existence—fortunately—in our system. The role of the court was to order it as a right of the people. Obviously, state legislatures could have outlawed segregation—could have provided more adequately for the education of children from poor families or for the education of the handicapped. In fact, some states did in each of these instances, but some states didn't, so there came a time when the courts or the Congress acted to extend these provisions to all people.

Sometimes, I think, the federal government goes too far, by making explicit regulations rather than establishing principles and broad standards and giving state and local government more opportunity for initiatives in implementation. Sometimes I wish advocate groups would work harder and be more successful at the state and local levels instead of looking to Congress to solve all our people problems.

Like it or not, the trend toward more government regulation in both public and private efforts is here to stay. For example, in 1970 the federal government spent 1.6 billion dollars on

economic and social regulatory agencies and produced 54,000 pages of regulations. In 1975 the figures were 4.8 billion dollars and 72,000 pages of regulations.

With this three-tiered system of government and division among the branches, it is inevitable that there will arise tensions among these units of government. The area of child abuse and neglect is certainly no exception. It does seem clear to me, however, that all components of government have a role to play. The local government most vividly experiences the pain and agony of child abuse and neglect. The states have the legal jurisdiction to intervene on behalf of the child in peril. Likewise, the federal government has a leadership role to play in terms of allocating resources and generating new knowledge and approaches that would be useful to states.

Decisions about the role of the federal and state governments should grow out of basic assumptions:

1. Federal actions should be designed to strengthen the state—not weaken it. Incentives, encouragement, supports that will cause the states to face up to their responsibilities are preferable to federal actions that take over state functions or ignore or bypass the states.
2. We need better mechanisms for national planning among states. The federal government performs an essential role in establishing national goals and planning for their achievement.
3. Some activities are bigger than any one state can do. These activities can be done more efficiently or effectively by the federal government. They should be identified and the federal government should do them or provide for their being done by public or private agencies.

With these assumptions in mind:

- Strengthening and working through the states;
- Identifying national goals and planning for their achievement;
- Performing nationally those functions that can be done more efficiently or economically by the federal government,

I think the federal role includes but is not limited to:

- Conferences, seminars, and workshops to train state leadership;
- Preparation of publications on child abuse and neglect;
- National awareness building;
- Providing for and financing research;
- Providing for and financing development of materials:
  - curriculum for youth;
  - parent training;
  - staff training in education, welfare, etc., agencies;
- Funds to states to help finance their work.

The state role <u>includes</u>, but is not limited to:

- Enactment of good state laws;
- Training leaders at state and local levels;
- Coordination of agency services;
- Enforcement;
- Counseling and other family help and supports;
- Development and implementation of curriculum in the schools;
- Development of programs and providing for parent education;
- Supervision and quality control of public and private institutions for children.

I think those of us in education and welfare often underestimate the existence and the subsequent influence of state government. The states support public schools, universities, and prisons, build highways and hospitals, and run public welfare systems, but this is not necessarily the full picture. They require and issue our birth certificates and our burial permits and between the alpha and the omega of our mortal existence they protect our rights in various other ways. If we hunt, fish, drive a car, marry, teach, practice law or medicine, or enter into a wide variety of other professions or callings, we must have a state license. We buy, sell, lease, rent, and inherit property under state law. In short, to the extent that our activities depend upon or are controlled by government, that entity is usually the state.

In closing, it seems there will continue to be conflicts—<u>creative tensions</u>—between state, federal, and local governments. Certainly in this area of child abuse and neglect, emotions run

high. I expect those tensions are and will remain rather intense, but there has been and will continue to be a measured amount of compromise on the part of all entities. This is as it should be. To abandon the states, to seek answers to the problems of child protection without the states, is to misunderstand our system and to undermine it. To build up the states, to involve them to their utmost capacity, is to strengthen our system in all of its endeavors and protections. This may keep the fires of tension burning between the federal government and the states, but it is the energy of this very fire which has propelled our system since the birth of the Nation. Thomas Jefferson wrote that the only way the states can avoid the abuse of national power is to "strengthen the state governments and this cannot be done by any change in the federal constitution. It must be done by the states themselves."

The Role of State and Federal Government in Child Protective Services: Support for a Community Program

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In dealing with child abuse and neglect, state and federal government agencies must, together, assume supportive roles to local communities. The supportive role of the federal government must be one of generalized policy formulation and the financing of services to be offered in local communities, with appropriate guidelines, yet with flexibility which will allow for adequate local variation to meet specific community needs. State government should then assume the role of offering technical assistance to communities in assessment of needs, organization of local coalitions, training of service deliverers, maintenance of appropriate services and continuity of service delivery across community boundaries.

While the federal-state-local megasystem for the delivery of child protective services may boast of widely acknowledged success in the areas of public awareness, expanded knowledge of the maltreated child phenomenon, and treatment innovation on a limited basis, the overall service delivery to abused and neglected children and their families has been largely inefficient and less than effective. Except for a few highly funded pilot and demonstration projects, the child protective services effort may be characterized as having placed Band-Aids on broken arms. This is not so much a reflection on the dedicated individuals at all levels as it is a commentary on our present service megasystem.

Robert Levine in *Public Planning: Failure and Redirection* states:

> Public programs in the United States have not worked well in the past nor do they in the present. The major reason for this outcome is that programs designed to fulfill policy objectives are laid out by planners for operation by administrators, with the administrators fulfilling the plan by following a hierarchy of rules. The planners and administrators at the top lay out the basic rules as general guidelines; the middle-level administrators make them into detailed rules of procedures; the operators at the bottom must apply them by interpretations based on administrative discretion. In this process of interpretation the original policy objectives more often than not get lost or even reversed. Ordinarily they are changed around not by malfeasance but by honest attempts at interpretation with each attempt a little bit off and the cumulated result far from the intended objective of the public program (Levine, 1972).

This generalized bureaucratic problem is exacerbated and compounded by a number of other factors. With all our federal programs directed toward family life and the amelioration of family dysfunction, our nation has no overall family policy. As Joseph Califano wrote to then presidential candidate Carter, "Unlike many other countries, America has no official, explicit family policy. But the absence of a formal family policy does not mean we have no family policy at all. What we have, instead, is an inconsistent patchwork of policies affecting families. Some are explicit, direct and consciously adopted. Others are implicit, indirect and largely unexamined. An appropriate government role is the examination of the way its policies and programs may be contributing to family difficulties, so that policies and programs that hurt families can be ended and policies and programs that help families can be strengthened." Since it is difficult, if not impossible, to separate the various needs of children, an ideal family policy would necessarily include all areas of need which would incorporate and integrate such programs as child protective services, substitute care, adoption, child care and child development.

A second major difficulty is the unclear responsibility and authority for child protective services programs at both federal and state levels. On the federal plane, in the Department of Health, Education and Welfare, child protective services is a service of Title XX and is administered by the Office of Child Development through the Children's Bureau. This relationship was, until very recently, further complicated by the fact that these organizations were second-level agencies operating within separate larger agencies. The merger of the Social and Rehabilitation Service and the Office of Human Development would appear to have had a

positive effect on this problem. At the state level, this role ambiguity of child protective services continues. Often in these cases there is a question of jurisdiction between child protective units of public welfare agencies and law enforcement or various agencies of family or juvenile courts.

One primary problem results from fragmentation of the legislative branch of government. Jurisdiction of program laws affecting children and their families is divided among several committees. These laws generally have been developed over the years with little attention paid to existing statutes or continuity of program philosophy. Further, most child protection and child development legislation is funded on a temporary basis, making long-range planning and the establishment of long-range goals exceedingly difficult.

Another malady of our present megasystem is that ours is a diverse nation with varying local resources, needs, and resource development. It is unrealistic to assume that one federal program with its detailed set of interpretive regulations can meet the specific needs of abused and neglected children in Baltimore, Maryland and Beaufort, South Carolina; Cedar Falls, Iowa and Palo Alto, California. Although the underlying family dysfunction may be manifested similarly in these diverse locales, their unique subcultures, local community attitudes toward the problem, available resources, and the state of those resources must all be considerations in the implementation of a local program.

The National Association of State Directors of Child Development (1976) suggests:

> The deterrent to better services most frequently mentioned is money, and there is no doubt that a greater share of the vast resources of our nation needs to be channeled into services for young children. However, if by some stroke of magic we were suddenly given all the money we think we need, our problems would not disappear. Most of the deterrents we now have would be with us, and many of the needs of children and their families would remain unmet.
>
> The fragmentation of services among the countless federal, state, and local agencies and other service organizations, both public and private, is a prime problem and thus the task of penetrating this maze and obtaining a single desired service is difficult for an informed and experienced professional. It is next to impossible for the average family with a child with multiple needs; and, in far too many cases, the poor and uninformed simply never obtain the services available.
>
> Suffice it to say that services are almost hopelessly fragmented among a multiple of bodies, and ways must be found to gather these services from where they exist and focus them upon the needs of the individual child or family.
>
> Another characteristic of many delivery systems currently being operated or proposed is that they are designed to deliver singular rather than multiple services. Delivery systems set up within single state or local agencies or by narrow-purpose public and private groups, by and large, deliver only those services in which the personnel in the particular agency or group have specialized training or services which fit the comparatively narrow purpose of the group. Ways must be found to develop delivery systems which are designed to provide a broad or comprehensive set of services to meet the multiple needs of young children and their families.
>
> A glaring weakness of our present efforts can be seen in the fact that services are spotty rather than universal. This is occasioned in part, but only in part, by a lack of funds. Other factors contribute to this problem.
>
> Geographic areas or localities with the greatest concentration of resources tend to provide more services for their children while other remote or impoverished localities are neglected.
>
> Categorical programs limit services to certain economic, ethnic or special category groups to the exclusion of others with equally pressing needs. Many needs of children and their families are not related to economics, geography, or ethnic background.
>
> Finally, our delivery systems often fail because they lack stability and continuity. The best delivery system one can conceive is of no value tomorrow if the basis on which it is built disappears today. Delivery systems which depend for their existence on funding which is temporary, short term or unstable cannot assure continuing services. The same can be said for delivery systems which are set up without benefit of supporting legislation or other appropriate sanction to undergird them and provide stability and continuity.

Given our past and present experience with federally initiated programs, it would seem appropriate that the federal government assume three primary roles with regard to child protective services.

The development and maintenance of a comprehensive and long range family policy is the first of these roles. Our nation needs a unified plan: a guide for future decision making; a policy from which social services programs can emanate with consistency to meet the service requirements of today's families and children. A policy must be developed that will take into account varying lifestyles and the constantly changing American family. This policy should recognize the traditional strength of the family and seek to reinforce it as a cornerstone of our society. A family policy must not purport to have all the answers, nor imply that government can meet all the human needs of its people. Where extended families are available, they should be utilized as resources. Where they are not, the community will become a social support network when needed. An overall family policy is very much needed to reflect the present condition of the family. However, great care must be taken to assure that such a policy does not determine family life. One central policy also will enable the fragmented program segments to be pulled together in both the administrative and legislative sectors of the federal government.

Funding, the second major role of the federal government, not only should allow but should actually encourage maximum allocation at the service delivery level. Experience has demonstrated that the various administrative levels of our present megasystem receive disproportionate funding in comparison to the service delivery level, especially viewing the legislative body's intent in earmarking this money. The funding role is more difficult to control, and is inefficient, as a direct result of the disjointed and narrow-focused programming in child protective services and other services for children and their families. One alternate funding method would utilize an allotment system similar to revenue-sharing disbursement. It would not be difficult to establish a monitoring system more accountable to local taxpayers as well as less expensive than layer after layer of administration. This kind of distribution would free middle management, particularly at the state level, to be involved in technical assistance directly to the service delivery level. Another asset of this type of funding is that it allows for the flexibility necessary to implement programs which will meet the need of each unique community.

In order to operate any social service program efficiently, it is necessary to have information to answer a number of questions: What kinds of new intervention and treatment are being tried? Which ones work? Which do not? Which program innovations are being piloted? What are current trends and projections? Answers to these kinds of questions are useful for directing service administrators but are not readily available outside the various regions. Thus, the third primary function of the federal government would be to act as a central clearinghouse for the collection and dissemination of information. To some extent this already is happening. The regional resource centers do a reasonably good job of this. However, at present, there is a long time lag between production of materials and when they reach other areas through the system. It is expensive and inefficient to conduct research in areas where results already may be available but coordinated information is lacking.

Present state-level agencies are as enmeshed in bureaucracy as those at the federal level. If child protective services are to be appropriately and efficiently delivered to children who are at risk, and their families, the primary role of the state level needs to be altered from administration to technical assistance and program development. Certainly, administration should remain as a part of state office overall responsibility. Also, while the argument of diversity of need and resources is applicable within states, a need exists for some continuity throughout a state. This becomes evident when ancillary resources, such as substitute care, are examined and are found to be unavailable to the extent needed in a particular area. Standardization is necessary within states because each locality operates under the same state laws and in the same court systems.

To insure quality service delivery, technical assistance and program development must be coordinated in a number of different areas: needs assessment, community organization, training, and program evaluation. The expertise to perform these functions already exists in most state-level agencies. Too often, under our present system, we opt for outside consultants when the most knowledgeable individuals are already on hand, probably having established a working relationship with those to whom the technical assistance is being offered.

Technical assistance in the area of needs assessment will be important in both initial and ongoing phases of child protective services delivery. State-level personnel will help set up instruments to discover needs, resources, potential community involvement, and existing strengths and weaknesses which will affect programming, then assist in the evaluation of data.

Other evaluation tools could be used on a continuing basis where the technical assistance could be instrument design or outside expert opinion.

The problem of child abuse and neglect is not confined to a single agency, locality, or class of people. It is a community problem, which, to be ameliorated, will require an entire community effort. State office personnel, with expertise in community organization, should work closely with service deliverers to establish local coalitions of professionals and concerned private citizens for child protective services. In this regard, we have had an interesting experience in South Carolina. When we established definitive child-protective services units in thirteen of our most populated counties in 1973, we also assisted those communities in setting up multidisciplinary committees for child protective services.

While we have no abundance of resources in our state, these counties are the best endowed. As a result of these committees, most of the child protective units in these areas have received support from their communities. There are exceptions, of course. It was not until this past year that we discovered that the smaller, more rural areas can make excellent use of resources which are more limited. When coordinated, they not only operate more efficiently but support each other professionally as well.

State-produced training for service providers and supervisors fulfills not only the technical assistance function but it gives continuity to the delivery of child-protective services. Training for new workers in child-protective services should be handled by individuals who have experience in the field and, ideally, who rotate into direct service work on some regular basis. Following this basic but comprehensive initial training, more advanced and specialized training should be offered at set intervals. Again, the real experts are practicing on active caseloads every day in every state. In South Carolina we have decided to use a comprehensive training program which will lead to the certification of all child protective service workers by October, 1977. We plan to implement a prodedure by which no worker will handle an active caseload without first having demonstrated a certain minimum level of competence. We are still in the planning stages. Probably we will use a combination of an examination to evaluate knowledge base and simulated interviews to test interviewing skills, as well as giving feedback to the worker.

Too often, our present system gives service workers and their supervisors the tremendous responsibility of providing child-protective services but it does not give them either the resources or the authority to get the job done.

The commitments from state and federal efforts must manifest themselves in assuring more efficient and effective service delivery if we are to come to the point where we go beyond treating constant crisis to prevention, adequate treatment and maintenance, and strengthening family life.

This can be accomplished through a concentration of our efforts at the service delivery level.

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Enablers or Enforcers: The Role of Governments in Relation to Families—A State's Perspective

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The United States is a "placement of children" nation. Natural families and psychological families are not preserved whenever possible. Archaic state delivery systems for child welfare services are to blame. Federal agencies within the Department of Health, Education, and Welfare and every state agency delivering legally mandated protective and children's services must honestly evaluate its current philosophies and overall goals concerning the child, the family, and the community. Most state agencies' programs and policies do implement: (1) the preservation of natural families whenever possible; (2) the minimizing of placement of children; (3) the recognition of the primary importance of the psychological parent to the child; (4) the ability to keep families in crisis together whenever possible while providing the necessary crisis services; and (5) the inclusion of parent participation in setting and reviewing treatment goals via the use of contracts.

There are many good state social workers across the nation who believe in strengthening, respecting, and rehabilitating natural families whenever possible. But these social workers are too often given unreasonably high caseloads and little quality training, and are asked to work within delivery systems that make placement of children away from home the easier, more expedient treatment choice.

The Children's Bureau's objective must be to facilitate five basic program priorities with states. If states support the five values stated above on the rights, respect, and responsibility due to families, then the following basic statewide resources and programs must be implemented: (1) a 24-hour, seven-day-a-week statewide hotline created by paper or phone to standby emergency protective services workers; (2) trained, live-in emergency homemakers; (3) immediately accessible day-care; (4) public and private agency coordinated comprehensive emergency services; and (5) more continuity of services between protective services and foster care and adoption (usually the same families are involved).

Along with these resources and programs are three basic program goals that state social workers must be trained to carry out:

1. Adequately and permanently safeguard abused/neglected families as opposed to curing such families. (Workers who have such skills would decrease the time the child is placed out of the natural family and would decrease the number of children placed during the treatment period);
2. Focus treatment on the interaction between parent and child (Dr. Alexander Zaphiris stresses this point). Although a parent or a child may need some individual services, to treat the family members separately avoids the real problem. It is in the interaction of child and parent that the conflicts and tensions arise which lead to abuse or neglect; and
3. Recognize early, whenever possible during the assessment of severe cases, the parent(s) who does not want her/his child, or who is hopeless in terms of rehabilitation, or who will take so long to be rehabilitated that her/his child cannot tolerate being placed for that amount of time out of the home in temporary placement without additional extreme trauma. (In such cases, workers must be trained to seek legal action to protect the child and gain for her/him a permanent nurturing placement plan which often means adoption or long-term foster care.

How should the federal government facilitate states achieving these goals and objectives? States now need to ascribe to and implement statewide innovative programs tested in national abuse/neglect demonstration centers. Changing existing state delivery services designs and procedures to take into account such promising recent research takes:

1. A major commitment of administrative and legislative professionals within the state government and

2. A different kind of enabling help from the National Center on Child Abuse and Neglect.

State bureaucracies respond first to two principles: (1) being shown cost-effective designs (unfortunately, professionals wish that human cost-effective values were what really caused change) and (2) federal seed money that would enable the state to do something new, normally not possible to do with state funds.

Prevention, early identification, and crisis services should be less costly in the long run than trying to rehabilitate long-standing family breakdown. Also, the prognosis for rehabilitation worsens the longer the problems persist unaided. The National Center on Abuse and Neglect must encourage states with technical assistance and seed money to try new, direct crisis services that would also be long-term cost-saving. For example, a trained, live-in emergency homemaker who might keep a family in crisis intact, as described in the CES model, is a large, temporary expense. But foster care for the same three children for several years is far more expensive. And once children are separated from their families, they often spend several years in placement. States are reluctant to redirect large amounts of current "board and care" funds from foster care and institutional care payments to "services in the home" payments. The concern is that there then would not be adequate funds for placement of children if the in-home services failed to keep down the number of placement requests.

How can the federal government enable states to change their delivery systems to more cost-effective systems? It takes money to redesign, and money for planning change that states rarely have budgeted. Federal dollars temporarily spent for innovative, direct services could be well-spent here. Once the new design is in place, federal money should be phased out, and then it should be the state's responsibility to meet the ongoing maintenance expense. Also, to enable change, the state's current level of funding commitment must be guaranteed so that no state funding is decreased due to this additional temporary federal funding.

What else do states require from the federal government? They need enabling help via consistent technical assistance consultation. They do not need as many detailed technical model packages into which many states cannot fit themselves.

The process of redesigning a state's philosophy, goals, and delivery system is far more important than immediate adaptation of the "best model;" by working intensively with knowledgeable federal consultants, with public and private sector professionals, and citizens, states can reexamine and redesign (grass roots up) their services. By going through this process grass roots up, many more state people become educated and committed to improving services. Models are most useful to be looked at initially and learned from in order to incorporate key concepts and parts of several good models along with some "down home" ideas to develop into each state's own unique delivery system.

Too few good, innovative concepts are ever implemented in delivery of services to the masses of abused and neglected families. Public Law 93-247 mandates a National Center on Child Abuse and Neglect (NCCAN) to enable states to upgrade their services. NCCAN needs our ongoing support and constructive feedback to plan technical assistance, training, and research relevant to the public and private sectors of our states. To further this goal, I recommend there be state public and private sector representation on its HEW advisory board. The National Center Child Abuse Advisory Board to the Secretary of HEW should do more than insure internal coordination of NCCAN's programs with other HEW programs.

Let us be advocates, planners, and partners with the federal government on behalf of abused and neglected children and their families.

Enablers or Enforcers? Role of Governments in Relation to Family

Eleanor Tinsley, President
Harris County Child Welfare
Houston, Texas

The elementary school nearest our home was going to have a meeting for parents concerning a new school program. The following notice went out:

> Our school's cross-graded multi-ethnic, individualized learning program is designed to enhance the concept of an open-ended learning program with emphasis on a continuum of multi-ethnic, academically enriched learning using the identified intellectually gifted child as the agent or director of his own learning. Major emphasis is on the cross-graded multi-ethnic learning with the main objective being to learn respect for the uniqueness of a person.

This is the reply the principal received from one parent:

> I have a college degree...speak two foreign languages and four Indian dialects...have been to a number of county fairs and three goat-ropings...but I haven't the faintest idea of what you are talking about. Do you?

Each of us has a responsibility to make the federal government responsive to the needs of our communities and specifically to the children this conference is all about. The problems of gobbledegook language, time-consuming detail, and the lack of flexibility could be solved, and to anyone who thinks the Carter Administration, or any other, will move too fast, we remind them of anthropologist Ashley Montagu's comment:

> We should not worry about wrecking the machinery of social organization by exceeding the speed limit of rational inquiry...(we should) expect the inertia of tradition to continue in the great tradition of tradition.

The questions for this conference are, "What is the future of services for the abused child? Is the federal government a help or hindrance? Does the solution rest with dollars and controls coming from Washington or is the answer to be found in individual communities taking action with the financial resources to back their commitments—in effect, putting their money where their mouth is?"

Those of us who are "Johnny-come-latelys" to the field of child abuse should reflect for a few moments on the history of this movement. Early efforts were of a broad social-action nature and were concerned with: promotion of child labor laws, creation of shelter care for children who were separated from their homes, detention facilities to keep children out of jails, abolishment of baby farms, support of special courts for children—a push which led to the formation of the juvenile courts, and promotion of child protective services under aegis of local Humane Societies or Societies for the Prevention of Cruelty to Children. These constituted the only agencies specifically operating to prevent neglect, abuse and cruel treatment of children. These agencies were to be found in almost every state of the Union during the late 1800s and early 1900s. However, most of them went out of existence when the great depression of the 1930s drastically cut down the ability of the private contributor to support these operations. With funding almost impossible to obtain, all but a few hardy Societies for the Prevention of Cruelty to Children folded up or merged with other family and children services, with a loss of the protective function. Among the survivors is the New York Society for the Prevention of Cruelty to Children, the first Child Protective Agency in the world, created as a consequence of the notorious "Mary Ellen Case" in 1874—the first recorded case of child abuse.

Since the Social Security Act of the 1930s, child protective services have become the responsibility of public child welfare. Impetus was given to these programs by the mandate in the Social Security Act which requires child welfare services on behalf of "neglected, dependent children and children in danger of becoming delinquent." The 1962 amendments further stressed

the mandate by defining public child welfare "as services for the purpose of preventing, or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children."

While this mandate is clear, it has not proven specific enough. Nor has it stressed with sufficient force the obligation of each state to implement its responsibility for full services to protect children.

Vincent DeFrancis, Director, Children's Division, American Humane Society, gave the following testimony before Senator Walter Mondale's Committee on Child Abuse in Denver, Colorado:

> Child protection requires a highly skilled, professional social worker—not just the average social worker, but a very highly trained social worker. It requires a large staff with a lot of backup service—backup not only in terms of clerical staff, but in terms of various specialized consultants. There is need for psychiatric and psychological consultants; there is also a great need for legal consultation. All this makes it a very expensive program, one that is not within reach of most private agencies.
>
> Money is a factor which brought about governmental responsibility for child protective services. Only through the tax dollar can communities afford to carry this expensive service.
>
> Legislation can mandate a lot of things, but the implementation of that mandate must come from something other than the compulsion of the law itself. Education is a better answer. This is in tune with the old proverb about taking the horse to water. You can order doctors, you can order teachers, and you can order social workers to report contact with cases of suspected child abuse, but you cannot enforce that order. The surest way to implement the mandate is to create a sense of moral responsibility and obligation to report.
>
> Protecting children is a cooperative process involving the protective service agency, the juvenile courts, and the medical profession.
>
> There is one last member of the team—the broad community. The community serves by providing the sinews for the program—sinews in two ways: (1) the financial resources so the program can be developed in keeping with needs and in keeping with total demand and (2) in terms of identification of children.[1]

A 1957 national survey was the first assessment of what and where child protective services existed, under whose auspices, and an evaluation of capacity to meet need. Findings documented a failure in most communities to implement government obligations for service to abused and neglected children.

A follow-up study 10 years later showed there were more good programs, fewer token ones. Two very glaring weaknesses were documented by the study: (1) every state bemoaned the lack of sufficient funding to expand services in keeping with need and (2) every state voiced a need for specialized training for staff assigned to duty in child protection.

Any current survey documenting the resources providing protective services for children reveals that such services are housed in the public social services programs of every state and community. If the community is to be a real partner in the solution of child abuse, the knowledge many of you as professionals have must be translated and shared at the grass roots level. First, we must try to understand what goes on inside the individual that produces the eventual child abuser. Are there any qualities we can identify? Let me suggest two. Sometimes the authoritarian parent orders a child to obey his commands, but does not communicate the "why." "Do it because I told you to." If the child is a little slow in responding, he/she is apt to be knocked across the room. When this same child misbehaves at school the parent is at a loss to understand why and will tell the teacher, "He always minds at home." Education can help give the tool; the ability to transfer learning—communication is an answer. A second handle to the problem might be learning to control our feelings. Individuals who later become child abusers never learned to postpose the desire for immediate gratification. So when something goes wrong at work or at home, they "take it out" on someone not able to fight back, often a child. The abuse of drugs and alcohol are outward signs of wanting immediate gratification.

Those who have worked directly with delinquent or truant children report that the first answer seems to be to fight force with force; knock them around when they misbehave. But

after this has been done for a while, the desired change in behavior does not result. Knowing the rules and the reason for them are first steps in changing behavior.

Those who have been on the firing line with the worst cases of juvenile delinquency tell us that the way to change behavior is to show concern for the individual, really caring, taking time to talk with and listen to children. My Baptist preacher has a bumper sticker that says, "Have you hugged your kid today?" I grew up with a saying that just has five words and it applies to everyone in this room, at this conference, and even to those child abusers we are trying so hard to understand and change. The five words are, "Everyone wants to be someone." Children need to grow up feeling they are someone and worth something. When adults work with their own children or with those who have been abused, there are five more words that can change lives. They are so simple, no gobbledegook, all one syllable, "I am proud of you."

This sort of information can be taught to parents, but just as important is a fourth tool that we can employ, but it takes money and commitment. Family living concepts must be taught in school—by the seventh and eighth grades. Those who need it most are least likely to be around for a home living course as a senior in high school.

Children from lower socioeconomic backgrounds have several strikes against them in addition to inadequate food and shelter. They are often left alone, neglected because a parent must work and cannot or does not get adequate supervision for small children. Often, the importance of education is not realized in such homes, and when a youngster misses class, the more apt he is to fall behind and become more truant or become one of that growing category of children we call CHINS, children in need of supervision.

A philosophical question that might be discussed is: should there be a national minimum standard of care for all children in the United States? If we answer affirmatively, then we must grapple with whether the standards should be set in the form of guidelines or laws. Guidelines are based on the assumption that communities do care about children and, given the knowledge, will act responsibly.

Laws must reflect community standards or they will not be followed. Laws do not shape community values, but can use dollars and funding as an enforcer. They also make funding available and in turn enable the community to carry out guidelines. Thus, laws have elements of power to enable and/or to enforce.

This is a concrete example of what often bogs down otherwise well-intentioned programs. A close friend lives in River Oaks, one of Houston's most fashionable areas. For the past five years she has driven across town to an elementary school in a lower socioeconomic area where there are many children who need special help. She has a beautiful, brightly painted learning center with lots of resource material, but she is about to ask for a transfer to a school nearer her home where there are fewer children who have special needs. You ask, "Is she burned out?" The answer is "No," but the paper work is crippling her program. Teachers are not willing to fill out all the forms deemed necessary by someone, somewhere. The objective of the forms is good—to protect children's and parents' rights. However, do you really think it is in anyone's best interest for there to be 25 separate forms that must be filled out by either the teacher or the parent or the child before a child is taken from his or her regular classroom and given the special help the teacher feels is needed in reading, math, eye-hand coordination, visual, or other learning disabilities?

Where do we go from here? In Texas we have had the state government's support in an attempt to provide dollars for more and better services for neglected, dependent, and abused children. A law has been passed that makes it a misdemeanor not to report a case of child abuse. The role of government is not an either/or with regard to enabler or enforcer—it is both.

We have the laws and they should be used with federal dollars, but we must renew our commitment to solving the age-old problems of bureaucracy such as: lack of flexibility, the multitude of copies required that we wonder if anyone ever reads, and the language that has made larger agencies come up with a new breed of cat, the proposal writer. I am afraid we are apt to say with Snoopy, "There is no problem so great I can't run away from it."

FOOTNOTES

[1]The American Humane Association, Children's Division, *Speaking Out for Child Protection.* Denver, Colo.: 1973.

Legislative and Legal Issues

Model Child Abuse and Neglect Legislation

Judge James H. Lincoln
Juvenile Court of Wayne County
Detroit, Michigan

One of the great issues of our times is, "What role shall government play in the life of a child?" The problem is as complex and multifaceted as civilization or human nature itself.

Anyone, regardless of credentials, who claims to be an expert on this great issue, will be viewed as a charlatan a century from now. We are all alchemists when it comes to this issue, whether we are professors; psychiatrists; psychologists; social workers; attorneys; administrators; employees of the Department of Health, Education, and Welfare; judges, etc. In light of historical perspective each of us will be considered alchemists. Behavioral sciences are at least 1,000 years behind the exact sciences. I was raised by a kerosene lamp, and the plumbing was behind the lilac bush. In one lifetime I have seen man progress from a kerosene lamp to walking on the moon. That is 1,000 years of progress in the exact sciences in one short lifetime. As far as behavioral sciences are concerned, there has been a great amassing of questionable data and even more questionable theories. Much change but little progress! Of course, human behavior is much more complex than putting a man on the moon. However, those engaged in the exact sciences can disenthrall themselves, and look at their problems objectively. In the behavioral sciences (including the legal profession), we are as conditioned to certain attitudes and reflexes as Pavlov's dog. In other situations those with claimed expertise know so little about the issues that they simply follow some leader who is skilled and articulate in expounding one of the latest popular styles or fads. In the 17 years I have been on the bench, the behavioral sciences have had as many styles as women's clothing. This is also true of the legal profession.

One can classify those in this nation who write model laws, standards etc., for neglected and abused children into three groupings or classifications—right, left, and center. The behavioral and legal scientists that represent the right are largely on the West Coast and the left on the East Coast.

(1) The Right: This group of eminent behavioral scientists is chaired by Michael S. Wald, professor, School of Law, Stanford University, Stanford, California. He, together with more than 50 behavioral scientists, heavily laden with credentials (with a sprinkling of attorneys and a token judge or two), has drafted model neglect and abuse laws and standards for the Institute of Judicial Administration (IJA). The work of this committee will be presented to the American Bar Association (ABA) for approval. It is an outstanding work. The West Coast proponents would severely restrict the role of government in the life of a child even to excluding thousands of neglected children needing help. They are content to help most children in need of help, but whether most means leaving out 49 or 10 percent is debatable.

(2) The Left: One effective and authoritative spokesman for this group is Douglas Besharov, Director, National Center on Child Abuse and Neglect, Department of Health, Education, and Welfare, Washington, D.C. Besharov can back his views and proposals with recognized national authorities. Professors Sanford Fox and Sanford Katz, together with Besharov's committee, have credentials similar to the right or West Coast. There is no way to settle differences by weighing credentials. The East and West Coast are loaded with credentials.

HEW either has or will issue model statutes and standards on every conceivable aspect of neglect and abuse. The East Coast Group would greatly expand the role of government in the life of a child. Of course, this is done under considerable congressional direction. The Mondale Act classifies "mental injury" as child abuse. A mother yelling at her child in the backyard would be registered as a child abuser. If the East Coast (HEW) has its way, by year 2,000 there could be more social workers than any other profession in the nation.

Several examples of East Coast thinking are explained in a letter I directed to Besharov a few months ago. It was printed in the February issue of the National Council of Juvenile Court Judges' newsletter. I explained that in the proposed HEW criteria for foster homes, the children would have concerts, plays, etc. HEW set standards where the majority of parents will need a

court to declare their children neglected in order for youngsters to receive these necessities of life (by HEW standards).[1]

If one could determine how the two philosophies affect specific wording in proposed model statutes or standards, it would be like fighting two tons of feathers. These documents total hundreds and hundreds of pages. I only recently found time to review the Model Act to Free Children for Permanent Placement, with commentary, developed by Professor Katz and his very "credential laden" committee. Of course, termination of parental rights is only a small fraction of the scope of neglect and abuse. However, it is not hard to choose a few parts of this proposed statute that would hardly fit the West Coast philosophy. Example: The grounds for involuntary termination are much broader than West Coast would seriously consider to adopt.

Judge Jean L. Lewis, Circuit Judge, Portland, Oregon, said, "Section 4(a) (3) (iii) indicates that the construction of a parent-child relationship will greatly diminish the child's prospects for early integration into a stable and permanent home. If the goal is to reunite a child and his parents, then it seems that every reasonable safeguard must first be found to get the child back in his home. At what point does continuation of a relationship diminish the child's prospects for early adoption?" This is one of many, many observations that could demonstrate how difference in East and West Coast philosophies would lead to different model acts and standards.

There are many factors in the development of model acts and standards that have little or no relation to philosophy. At this point there is little about which to debate. Both the East and West Coast handle these matters with equal excellence. I refer to such matters as found in section 16 of the Model Termination Act developed by Professor Katz. This requires a report within 90 days after the order of termination by the agency as to long-term placement, etc.

I, of course, highly favor the Model Termination Act drafted by the Neglected Children's Committee of the National Council of Juvenile Courts Judges (NCJCJ). Without trying to balance the merits of these various model acts, note that the NCJCJ Model Termination Act (funded by the Edna McConnell Clark Foundation) is vastly improved over the 50 termination laws now in effect in several states. It is "legal as hell" because it was drafted primarily by juvenile court judges, with heavy reliance on behavioral scientists.

We should consider section 12(b) of the act drafted under Professor Katz's direction for HEW. This proposed model act provides that in cases where the natural father's identity is unknown to the petitioner, the court may ask the mother about the natural father, but "may not compel disclosure by the mother." The juvenile court judges who developed the NCJCJ Model Termination Act would never approve such a provision. The Supreme Court, in the *Stanley* case, provides that the natural father be given notice and certainly, before publication, every effort must be made to give personal notice. Such a statutory provision will result in litigation that should be avoided. I have a petition before me in the Wayne County juvenile court to set aside an adoption. The natural father claims due diligence was not used to locate him before publication was used to give him notice. Regardless of what happens in these cases, it is best to avoid litigation over whether or not service is proper.

I do not say these things critically. I say them analytically. How can two groups of behavioral scientists and representatives of the legal profession develop such opposite views and recommendations? Let us list all possible reasons which, together, exhaust the possibilities. Remember, I have seen no minority reports from either group.

(1) There is careful selection of those serving on each committee concerning their preconceived views;
(2) The impact of leadership in each group determines the broad philosophical approach to the matter under consideration; and
(3) The third possibility is that a combination of the first two account for a result that could not happen once in a billion times.

Suppose we take 70 behavioral scientists, each with impressive credentials. We randomly divide them into two groups. Then, the two groups consider the same subject and arrive at different views and philosophies. The two groups differ as much as heads and tails on a coin.

Such a result does not occur solely by chance. It would be like tossing a coin in the air and correctly predicting the outcome 70 times in a row. That is one chance in a billion. It would not happen by chance in an eternity. Thus one way or the other the conclusions reached by the East and West Coast are determined before any meeting or consultation with behavioral scientists. Why have committees in the first place except for prestige purposes!

The following exhibits[2] are for your consideration.

Exhibit One is a letter to Professor Wald, dated February 24, 1975. The 1975 draft has been changed somewhat but is essentially the same. I prepared a report to the NCJCJ last week recommending that it oppose this committee's report, and I did point out that it was useful as a counter-balance against the equally extreme views of HEW. This report is too lengthy to include here. It has not yet been approved by NCJCJ. It expressed my views, and I will be glad to furnish a copy to anyone on request.[3] Exhibit Two, relating to the East Coast position, was directed to Besharov, dated September 4, 1975.[4] Exhibit Three is a two-page excerpt from the February issue of the NCJCJ newsletter.[5] My correspondence and statement concerning HEW standards and model laws are numerous and lengthy.

We have discussed the left (East Coast) and the right (West Coast). We should clearly indicate another alternative. I labeled this the "Center" only because it is the only ground remaining. All other territory is occupied by either the right or the left.

It is, however, misleading to label this position the Center. The position of this large but ignored group expounds no philosophy that would lead us into either of the other two positions. The group labeled (or mislabeled) the "Center", believes we should rise above principle and be practical. This group is well aware that with perfect logic one can proceed to the grand fallacy.

Thus, in the development of model acts, standards, regulations, etc., there should be a massive injection of the views of several juvenile court judges.

(1) These judges should help draft the project, and should also be present at the discussion stage. It is not worth a damn to be called in after the project has jelled. Having experienced this, I know very well that my presence at one meeting only constitutes "tokenism." It can then be said that NCJCJ was included. Nonsense!

The failure to include a massive injection of the thinking of juvenile court judges is an old and respected abuse. Perhaps the most flagrant example of this occurs in the "Task Force Report on Juvenile Delinquency and Youth Crime" printed in 1967 and issued under the names of Katzenback and Vorenberg. To lend authenticity to the report, five juvenile court judges are listed as advisors. My name is one of those. Four of the five judges listed were never consulted concerning this document. The Supreme Court has quoted this report as the Bible of authority in no less than three decisions. Much of the report is unmitigated nonsense. Much of the task force staff came from HEW.

Vorenberg was the executive director, and if he did not know juvenile court judges were completely excluded from the project, then he did not know what the hell went on in the project. That is what I think happened. His staff wrote and/or assembled the report, and then added names to impress everyone.

I want to clarify that no one has misused judges' names in relation to any neglect and abuse project. The East and West Coast may not desire massive injection of judicial thinking in their projects, but they have not misrepresented or claimed support they did not have. However, I want to strongly stress that the Center has been, with a number of exceptions, either ignored or given only token representation.

(2) How many judges should serve on the committees responsible for drafting model acts, regulations, etc.? When Professor Katz was good enough to invite me to one of his committee meetings in New York, there were several judges and behavioral scientists, etc., present. The same situation existed when I visited Professor Wald's committee in California. I received lengthly material from Mr. Besharov after it was drafted, and I knew by merely thumbing through it that he excluded any extensive judicial input from the draft. Frankly, the situation should be reversed, and all these committees should contain ten judges to every behavioral scientist instead of ten behavioral scientists to every judge.

(3) How should judges be selected to participate in these projects for writing model acts, standards, etc.? The few judges who have been asked to serve on these committees by either the East or West Coast have been well-qualified and experienced. Their views should certainly be heard. However, the judges selected have seldom represented the views of a vast majority of juvenile court judges. This indicates the very skilled way in which these committees are set up and composed. It also may account for the strong division between the East and West Coast.

Ideally, the president of the NCJCJ should nominate five or ten judges for these committees in addition to those selected by the chairman or director of the project. As a matter of fact, the judges who served on these committees for the East and West Coast are as intelligent and well-informed as any of the 3,000 juvenile court judges in the nation. I have had several on the committees I have chaired, and their contributions were second to none. There is no question of the ability of the East and West Coast to select intelligent, experienced, and highly capable judges. However, if the president of the NCJCJ had been permitted to inject the massive thinking of a considerable number of perhaps less gifted judges into the development of these model acts and standards, we might not have such fractured and fragmented recommendations that will surely confuse state legislators and everyone else. HEW and IJA-ABA are a million miles apart, and NCJCJ is somewhere in the middle.

Both the East and West Coast either have or will have a very legitimate complaint should they try to massively infuse judicial thinking into their projects. I do not want to suggest judges are busier than professors or others in the behavioral sciences, but sometimes it is damned hard to get judges to take time from court to work on a project. I know this because I am a former president of the NCJCJ, and have been a member of at least 75-100 judges' committees in the past 16 years. Recruiting judges to work on these projects is frustrating. No committee that I ever served on or chaired worked harder than the NCJCJ Neglected Children Committee. I have chaired this committee for two and one-half years, and we have developed an excellent model terminating act. It has a good chance of being adopted without changes by the Michigan Legislature this year. The Edna McConnell Clark Foundation financed the project. It takes judges only a small fraction of funds to produce excellent model legislation as compared to the East or West Coast projects. A camel is a horse designed by a committee. After reaching a certain point, the larger the committee, the more likely the end product will have several "humps."

The East (HEW) presents the greatest concern. Legislatures and state governments follow the federal dollar like a hound dog follows a rabbit. I personally believe HEW should not issue model legislation and standards. The injection of the federal government in this role is a two-edged sword. Neither IJA-ABA or NCJCJ can use federal grants as bait to impose undesirable uniformity in the 50 states. The federal government should stay out of this business.

Two weeks ago the casework services director of the Wayne County juvenile court came to me with a case where the baby was found dead after being released from a hospital that had a grant to treat drug and alcohol addicts. It is not unusual for heroin-addicted women to be admitted to the hospital, give birth to a child, and both be treated because of heroin addiction. This hospital fears to report abuse cases that Michigan law mandated be reported prior to release of the child. But the experts in Washington decided to delve into the very complex business of confidentiality, and through law and regulation make it a violation for the hospital to report these cases. We are going into federal court hoping to receive a declaratory judgment to have these cases reported. This is not the first child that has died that could have been saved if reported under the state statute, but was not reported because the federal government stuck its nose into something better left to the states.

The state can complicate the very complex problem of confidentiality without receiving any help from Washington. There is no special wisdom in Washington, and all states had laws on this subject. There was no valid reason for the federal government to be involved unless to make more jobs for a larger bureaucracy.

The business of promulgating standards, model acts, etc., by HEW has a far different result than when accomplished by IJA-ABA or NCJCJ. The states can take it or leave it when these organizations get involved. But Congress and HEW have clout. Many states have taken the bait on the Mondale Reporting Act in order to receive federal funds. The states should decide whether "mental injury" or "yelling at a child in the back yard" is a proper act to be subject for a reporting system under child abuse. The end result may be a monolithic system imposed on the 50 states as a result of enforcing uniformity through the bait or requirement of federal grants.

We have not come that far down the road. Much that was good when I went on the bench in 1960, both in behavioral sciences and law, is now considered bad, and much that was considered bad is now viewed as good. We need another two or three decades of variety, experimentation, diversity, and massive noninterference by HEW. After we finish writing all the laws, model statutes, and regulations, the social worker will be the most important factor in handling neglect and abuse cases. I say this in all due respect to the rest of us who work in the system.

When the year 2,000 rolls around some of you here today will still be debating the role government should play in the life of a child. Maybe if you keep a copy of this statement in your files, you will find that much of what I have said will remain relevant in the twenty-first century.

If the East Coast (HEW) has its way, over a period of decades the social worker will present as big a threat to our way of life as the atomic bomb. If the West Coast gets its way, tens of thousands of abused and neglected children will not receive protection. In the meantime, whether you are a caseworker, a judge, or whatever, just keep on handling your caseload. The greatest sense of achievement I have received from hearing a multitude of abuse and neglect cases is that in applying my very best thinking and efforts, I am convinced that life for these children has been improved because I have been allowed to serve in this time and place. A judge must have gray hair to look distinguished, and hemorrhoids to look concerned. But most important, he should realize he is not infallible. I view myself as a concerned, inquisitive, and learning alchemist.

My personal wish for each of you is that when you approach retirement, as I do now, that you will have some measure of my sense of fulfillment that comes from working in one of the most demanding of all professions. I refer to anyone whose work concerns troubled children. Neither you nor I must depend on the East or West Coast, or the Center, in order to make our own unique, exceptional contribution to our time and place.

FOOTNOTES

[1]Louis W. McHardy, "Lincoln Speaks Out On Proposed Standards," *Juvenile Court Newsletter*, 1977, 48 (1), 10.

[2]Exhibits have been omitted here because of space limitations. Interested readers may contact Judge Lincoln directly (ed.).

[3]James H. Lincoln, Letter to Professor Michael S. Wald, (February 24, 1975).

[4]James H. Lincoln, Letter to Douglas Besharov (September 4, 1975).

[5]McHardy, "Lincoln Speaks Out" p. 10.

Child Abuse Legislation

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My paper is divided into three parts: initiation of legislation; introduction of legislation; and, legislative trends in child abuse treatment and prevention statutes.

INITIATING LEGISLATION: ORGANIZATIONS AND THE PUBLIC

The public must become more aware of the growing problem of child abuse, and what legislative action is being taken or can be initiated in this area. There are numerous social legislation advocates competing for attention and dollars at the state and national levels, so it is important to define the problem, and determine how much legislation and/or dollars are needed. Social legislation has a major impact on millions of people, and a steadily growing proportion of state and federal budgets is being devoted to it. Since inflation causes the dollar to be spent at its peak efficiency level, expertise is a necessary element in drafting social legislation—thus, the social legislative advocate.

There are essentially three ways an idea or problem may be brought to the attention of a state legislature: the legislature, or a legislator, may act on its own; the legislature may react to public outcry on a particular issue; or interest groups may bring a problem or an issue to the attention of the legislature. My paper deals with interest groups and their attempts to make legislatures recognize problems in the area of child abuse and neglect.

Social organizations, such as child abuse organizations and agencies, have substantial power because of their knowledge of problems and effects within certain systems. These organizations must learn to use wisely this knowledge and power. One must remember that ideas are more effective if based upon a realistic assessment of what can be achieved. Though initiative is encouraged in developing ideas for child abuse legislation, no idea is viable unless supported by substantial facts and public support.

One of the primary steps to initiate legislation effectively is to form a broad base of supporters. Involve as many diverse groups and individuals as possible. Examples of groups which have been involved in child abuse legislation are: law enforcement groups, attorneys, child abuse agencies and clinics, the League of Women Voters, child protective service organizations, medical groups, education groups, and others. Usually no single group can lobby a package through the state legislature, so coalitions are commonplace in the legislative arena. Coalition groups hit hardest those who urge numerous social changes, and also allow the public to identify with at least one of the groups.

There are several models which reappear in child abuse systems throughout the country. In order to form an effective coalition, the groups working out of these models must first educate each other. The establishment of an open communication network between different organizations and groups concerned with child abuse is essential to the coalition. I feel it worthwhile, for the purpose of illustrating system differences, briefly to outline four models and how they envision child abuse.

The Medical Model. This system usually is composed of physicians, hospital personnel, community health centers, medical schools and related facilities. The system usually proceeds as follows: the battered child is recognized; the child is protected, if necessary, through hospital retention; the medical staff heals any bodily or emotional ills to the extent possible; they report any suspected abuse or neglect; and, on a limited basis, they encourage treatment or rehabilitation of parents or guardians involved.

Due to the separate and diverse factions composing this sytem, it is difficult to establish a well-coordinated and integrated team approach to child abuse. The private physician often plays a much smaller role in the medical model due to time, interpersonal skill, court activity, and nancial limitations.

The Legal Model. The development of more inclusive, mandatory reporting laws allows for development of public awareness, which in turn triggers action. Broadening the base of those mandated to report (expanding from physicians to relatives, neighbors, friends, teachers, school nurses, social workers, and public health nurses) is a current legislative trend. The immunity

clauses in such legislation protect and motivate people to report abuse and neglect. Immunity exists under presumption of good faith. Presently, controversy exists over providing criminal sanctions for the failure to report a case of child abuse, molestation, or neglect.

The Role of the Educational System. The educational system has constant contact with children, placing it in a promising position. Educators must cultivate an increased awareness of the problems of child abuse, promote legislation, and develop prevention/intervention programs.

Since schools can be an important force in combating abuse, the question arises as to why they are not involved more extensively. In some states, they are not acknowledged by reporting laws. These laws do not provide for mandatory reporting by educational officials or immunity for such reporting. This causes school officials to be leery of involving themselves in abuse cases. Also, politics is involved because the parents are voters, and their votes affect the educational system. Finally, schools feel that even if they report abuse, they cannot interfere with parent-child relationships, or offer any treatment. A possible solution to this dilemma might be to enact legislation allowing more freedom for schools in relation to child abuse.

The Social Service Model. Traditionally, child abuse problems have been the responsibility of state protective service agencies or welfare service programs. These agencies are composed largely of caseworkers. Basically, their procedure consists of: the identification of abused and neglected children; the treatment of parents or guardians; placement of children, if necessary; and follow-up programs. The first priority of this model is the protection of children. This system involves medical, legal, psychiatric, and educational aspects of the problem. Many social agencies also try to provide options to the parents or guardians involved. One inherent problem in this system is the high turnover in protective service workers. This may be due to the enormous pressure caseworkers experience, and the fact that it is a 24-hours a day, seven days a week job. Also, increased public awareness compounds these problems by increasing the case loads workers must handle. We must also remember intervention by government in parent-child relationships is an emotionally charged issue, and often the caseworker can provide only a temporary solution.

The child abuse issue is complex and requires the multidisciplinary input from all groups concerned with health, education and welfare of children. Organizations must pool their resources and their contacts. They must educate each other concerning relevant matters. They must establish a network of communication which can effectively organize facts, experience of agencies or groups, comparisons of other state systems, comparisons between agencies, possible alternatives, suggestions and ideas, and present problems in existing systems. Coalitions must recognize the various models of child abuse systems, the ramifications of each, and of each combination of systems. Also, most efficient use of resources must be stressed. This is where expertise is essential in synthesizing systems and ideas.

While groups educate each other, they must reach out to the public. Community awareness of child abuse and neglect did not heighten until the early sixties. This resulted from a lack of medical and technical tools which aid in differentiating accidental and deliberate injury or neglect. Also, before this time adults preoccupied themselves with social, economic, and physical survival, leaving little time for child developmental needs. Finally, there existed almost sacred rights of parents to treat children as they saw fit. Armed with hard scientific data, physicians first highlighted child abuse as a national problem.

Since the sixties, the public has slowly started reacting to the problems of child abuse. Increased awareness provides, at least, support for governmental intervention in crisis situations. However, agencies must still overcome the fear of potential governmental intervention in a nonabusive situation. Many opponents of legislation, in reality, oppose an overreaction and a resulting imbalance of authority to the Orwellian concept of total government control of family life. Therefore, community education and well-planned legislative proposals are keys to a successful effort. Involvement of key community leaders and the general public is essential. Letters and phone calls from constituents capture a legislator's attention, particularly when they come from people who do not directly benefit from the institution of programs as related to jobs and salaries. A ground swell of public opinion is easy for a legislator to spot. Therefore, the public must be educated, involved, and encouraged to accept the proposals. Caution: be prepared for increased reporting as a result of awareness.

Once a coalition is formed and an accurate pool of materials exists, community education has been accomplished, and it is time to meet with legislators if contact has not already been made. A well-informed person from each group, and an overall coordinator should be chosen to present the proposal to a receptive sponsor. Present him with an outline of legislation, keeping in mind past and present law.

Obviously, the use of coercive tactics will be counterproductive under most circumstances. Such attitudes will harden or activate opposition, and will destroy future contact or access to those legislators involved. This should be remembered when selecting group representatives.

Legislative staffs cannot be ignored. They have considerable impact on the legislative process by drawing attention to certain problems and issues, and developing data in support of, or in opposition to, certain legislative proposals. Staffs are also more accessible to group advocates, and can be instrumental in planning legislation, contacting legislators, and arranging testimony.

INTRODUCING LEGISLATION

As a rule of protocol, first contact the committee chairperson, then contact the members. Bring a reasonable number of representatives from your groups. Representatives should be well prepared, organized, and have documented facts to answer a variety of questions. It is always beneficial to have representatives with established credibility, and who have no political ties (a known Democrat may lose Republican votes and vice versa).

When the advocate enters the legislative arena, he must expect compromise. Distinct and conflicting interests are usually encountered. These interests must be reconciled and a temporary coalition formed in order for the legislation to have a chance of passing. Remember, it is easier to kill legislation than pass it. However, beware of overcompromising the substance of the bill.

Select articulate spokesmen who are knowledgeable and confident to present testimony at committee hearings. Administrative staffs of the agencies which will implement the programs are another source of influence. In formulating policy, legislators depend heavily on the technical expertise of legislative liaisons, researchers, and planners. It is unwise to overload testimony. Pick a few persons who represent a variety of groups; refine the testimony; and, hold mock sessions if necessary.

Do not forecast the legislator's position based upon his past actions or voting records. Know what votes are in your favor. If it appears the vote will be in your favor, be relatively quiet. If not, promote your legislation firmly, but be cautious not to close future doors.

If the legislation passes from committee, it goes to the floor for debate. First, approach the leadership because they are usually the power bases. Next, go to the individual legislators. Again, count the votes. A program is not worth the paper it is written on if you do not have the votes.

The same procedures are used should the legislation pass from one house to the other. Stay on top of the legislation all the way to the governor's desk.

LEGISLATIVE TRENDS

Model legislation currently exists in the area of child abuse. Its purpose is to protect the best interests of the child, prevent further abuse, preserve the family unit whenever possible, and encourage cooperation between states in dealing with child abuse and neglect.

Before child abuse can be examined, it first must be defined. Is it a series of physical actions or lack of actions? Is it revealed in the physical evidence of harm done to a child? Does it include sexual molestation which may result in no visible physical injury? Is it evidenced in severe emotional problems? Is it verbal as well as physical abuse? Many states, like Arizona, include "mental injury" in their legislation. Also, the variety of religious and ethnic groups in this country pose a problem because different values and child rearing practices must be preserved as individual rights.

Child abuse cannot be handled effectively if it is not recognized. Arizona has taken steps to conform to the trend of expanding mandatory reporting laws. Also, immunity for those reporting abuse is part of the model legislation. This was discussed in more detail earlier in the paper.

The model legislation provides for mandatory medical examinations or coroner postmortem examinations (should death occur), and includes procedures for such reports. The legislation also authorizes protective custody should there exist a situation in which there appears to be imminent danger to a child's life or health.

An interesting trend in legislation is the belief that since a child has the right not to be abused, he or she also should have access to legal representation. This brings a major issue into light: what are the legal and moral rights of individuals vs. those of institutions? The first step in dealing with this issue is to create an awareness of the current rights and responsibilities of

individuals vs. institutions in each state. The next logical step is to draft legislation so no questions can arise as to who has what rights. If holes exist in the laws, the courts are sure to find them...eventually.

A strongly voiced idea calls for creation of a central receiving agency for data on child abuse and neglect. Such a central agency will serve several functions: (1) it will enable citizens to identify more easily those places where abuse can be reported, and thus increase reports; (2) it will facilitate accurate and complete record keeping; (3) it will provide information concerning statistics, legal intervention, treatment, and allow follow-up studies; (4) it will enable identification of repeated abuse; and, (5) it will formulate a body of data from which research may be initiated and maintained.

The research generated by such a system could be immeasurable. Long range effects of child abuse (retardation, emotional disturbance, or neurological damage) could be examined. Generational cycles of child abuse—abused children becoming abusing parents—could be identified. The effectiveness of various treatment programs also could be compared. These are only a few possible topics which could be researched. However, record centralization is a very controversial issue, and must be approached very carefully.

In order to deal with child abuse, we must ultimately examine and resolve these issues. The legislature is a major component in resolving them.

CONCLUSION

In conclusion, I want to reemphasize the major points in child abuse legislation. First, the public must be sensitized to the problem of child abuse and neglect. Second, no one group or organization can stand alone in advocating legislation or in implementing effective programs. Third, a system concerned with child abuse cannot function without the support of the community or use of its resources. Finally, an open communication network between the organizations, the legislature, and the public is vital to any social program.

The Role of the Legislator in Child Abuse and Neglect

Jan Meyers, State Senator
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During our just-completed session of the Kansas Legislature, I introduced a bill, now passed by both houses and signed into law, which expanded our child abuse and neglect reporting act. The bill calls for:

1. Several professions to be added to those already mandated to report;
2. A peace officer to take a child into protective custody for 48 hours if a judge is not immediately available, and if the child is in imminent danger;
3. The reporting of a death due to suspected child abuse to a coroner;
4. Information programs to be conducted by the secretary of SRS;
5. The safeguarding of one's job, if it is jeopardized because the person followed the law in reporting a case of child abuse and neglect; and
6. The exchange of information concerning child abuse and neglect across state lines if laws of confidentiality are equally strict in both states.

The first changes in the former bill were suggested to me by the Kansas Chapter of the National Committee for Prevention of Child Abuse and Neglect. I then was contacted by nurses, pediatricians, policemen, and teachers. The final bill resulted from working throughout the summer with these groups. When the bill was prefiled in December, it had solid support because it was not my bill, but theirs. They testified at committee hearings and wrote letters.

Regarding the problem of child abuse and neglect, I think state legislators have three major responsibilities. We must first ensure the state has a good child abuse and neglect reporting act, and that it meets the needs of the people and respects their rights. Along with some of our time-honored concepts (that are good and valid) concerning the sanctity of the home, the right of the parent to discipline, and the importance of the confidentiality of records, we must give equal weight to the concept of advocacy for children, who, in some cases, desperately need our help.

In the bill just described, the most controversial portion was the section authorizing a peace officer to take a child into protective custody for 48 hours if the child is in imminent danger, or if a judge is not immediately available. There were numerous questions about this section, and several legislators received petitions which spoke of "the right to discipline," but the bill passed the Senate with 40 yeas and no nays.

Part of the legislator's job is to continue educating people. After all the magazine and newspaper articles, television shows, and meetings, we must continue educating people about the problem of child abuse and neglect. As elected officials we must continue saying we have no desire to interfere in the home or to stop the disciplining of children unless, within that home, and in the name of discipline, a child is being injured or killed. We do not want to replace the family with the government, but we must protect children who are being hurt.

So our first responsibility is to ensure our states have reporting laws that are comprehensive, responsive to the needs of children, and respectful of people's rights.

Our second responsibility as legislators is to provide funding for an adequate number of child protective workers with bearable case loads; provide them with treatment alternatives and resources such as foster homes, emergency shelter, day care, and home visitors; and assist parents in becoming more competent in their parenting role.

Our third responsibility is to provide impetus and funding for prevention of child abuse and neglect. We must:

1. Fund and provide adequate family planning services for those who need and want them;
2. Continue our research in order to determine who our vulnerable families are. We must be willing to try pilot programs, and then follow through and determine what is and is not effective; and.
3. We must provide the impetus, state planning, and funding for parent education. This is complex and difficult. It will be controversial. Those people who worried

about the sanctity of the home and the right to discipline will express concern about education for parenting.

Also, education is complex and difficult to deal with because there are so many different ways to undertake it, and we have no extensive experience with any of them. Do we make education mandatory in high school, junior high, or earlier? If it is not mandatory, will the ones needing it most take it? Should we offer it alongside social studies, biology, and home economics, or in community colleges and churches after people have become parents? If so, how will we attract people to these places? As a Menninger Foundation child psychiatrist suggested, maybe we should give parents a tax deduction if they pass a test covering a televised course on parenting. Not a bad idea! Helping people with parenting calls for a statewide plan with participation from all professions, disciplines and agencies.

However, we sometimes bog down in complexities. What we are really trying to do is help people feel good enough about themselves to nurture another small human being; to understand the scope of responsibilities in maintaining a sound happy family system; and to develop the skills necessary for raising children. That should not be so hard.

Betty Caldwell, my favorite expert on parenting, believes we can start by teaching six basic elements that would fit all subcultures and are not offensive or controversial:

1. The importance of loving your child;
2. The importance of interacting emotionally with your child—talking to, holding, and playing with your child;
3. The developmental milestones: at what age does a baby sit up, walk, and say "daddy;"
4. Basic health care and nutrition;
5. The importance to a child of predictability and stability in his life; and
6. The importance of parenting: how important you are as a parent to that child, especially during the first five years, and how important it is to the parent, child, and society that parenting be done well.

Caldwell also said if objectors say there is no time for parent education in the school system, "Then take out algebra." She does not really mean remove algebra, but that phrase does state what our society considers important. We have given top priority to algebra, and no priority to parenting.

To summarize, this is how I view the role of the legislator as related to child abuse and neglect: to provide a good reporting act; to provide funding for child protection workers and treatment alternatives; and, most importantly, to work for prevention.

Child Abuse: Whose Problem?

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Child abuse is a "hurt" for all communities. Children from all social and economic classes are its victims. Abuse and maltreatment of children transcends class, sex, race, and national origin, and is a frightening problem in a troubled society in which the individual is dehumanized and the family fragmented and torn apart.

In 1975, over 2,800 cases of child abuse were reported in Pennsylvania. In 1976, the last nine months of which saw the operation of the new statewide hotline, more than 6,400 suspected cases were reported. How many go unreported we never really know—until they make the news as a death statistic or an especially offensive case.

In attempting to curb what appears to be an epidemic of child abuse, I introduced Senate Bill 25 at the beginning of the legislative session in January 1975. The bill is a comprehensive proposal, redrafted after the governor's veto of an earlier child abuse bill, Senate Bill 1166, and attempts to present a coordinated attack on the problem. In an effort to satisfy the governor's objections to Senate Bill 1166, Senate Bill 25 underwent five legislative drafts before reaching final form. The bill was unanimously passed by the Senate (45-0), on April 28, 1975, and then overwhelmingly passed by the House (169-22) on October 15, 1975. Finally, on November 26, 1975, the governor signed the bill and Act 124 became law.

Pennsylvania's prior child abuse law was enacted in 1967. This act merely required doctors, school nurses, and teachers to report suspected cases of abuse to county child welfare agencies. Since the prior law was enacted, there have been almost 10,000 cases of child abuse sufficiently serious to be reported in Pennsylvania. During 1968, the first full year of required reporting, there were only 568 cases. And although the number escalated in recent years, most experts feel this is only the "tip of the iceberg."

Though most people are horrified and greatly disturbed when they read about particularly horrible cases in the newspapers, the question remains why only the "tip" of this problem is exposed. There are several answers. They include:

1. Far too many persons seeing suspected cases turn away and deny the existence of abuse or neglect;
2. Many persons are unknowledgeable about the established protective service system, and do not believe that if they report a situation there are adequate services available;
3. They fear retaliation despite the guarantee of the law that they are immune from prosecution for good faith reporting; and
4. Some, most sadly, just do not want to get involved.

In an attempt to modernize and reorient the former law, Act 124 presents a comprehensive vehicle to detect and report child abuse so as to prevent its recurrence. Presently, abused children urgently need an effective child protection service to prevent them from suffering further injury and impairment. Child abuse is a recurring thing. Most child-abusing adults were abused as children. The purpose of this act is to encourage more complete reporting of suspected child abuse cases, and to establish in each county a "child protective service agency" capable of investigating such reports swiftly and completely.

This proposal also provides children protection from further abuse by making rehabilitative services available for children and parents to ensure the child's well-being, and to preserve and stabilize family life wherever possible. A recent survey indicates 85 percent of a sample of juvenile delinquents studied were abused before the age of six.

The prior law was a weak reporting statute with no uniform definition of child abuse, and no safeguards protecting the data now stored in the central register. Presently, 67 different county agencies operate independently and with varying degrees of success. Too often, cases of child abuse are not detected until it is too late, and even then teachers, caseworkers, and judges are frustrated by the technicalities in the law which seem to ignore that children also have rights.

Act 124 provides the following:

1. Defines abused child as "...a child under 18 years of age who exhibits evidence of serious physical or mental injury not explained by the available medical history as being accidental, sexual abuse, or serious physical neglect, if the injury, abuse, or neglect has been caused by the acts or omissions of the child's parents or by a person responsible for the child's welfare provided, however, no child shall be deemed to be physically or mentally abused for the sole reason he is in good faith being furnished treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof or solely on the grounds of environmental factors which are beyond the control of the person responsible for the child's welfare such as inadequate housing, furnishing, income, clothing and medical care;"
2. A statewide toll-free hotline, operating 24 hours a day, seven days a week, to make reporting easier;
3. Expansion of the categories of persons required by law to report cases;
4. Immunity from civil and criminal liability for any person who acts in good faith in reporting suspected child abuse;
5. A modification of the rules of evidence in juvenile court to take into account the realities of child abuse;
6. A temporary protective custody provision to protect children in emergency situations;
7. Mandated rehabilitative services and child protective services in each county;
8. Establishment of a "pending complaint file" of child abuse reports under investigation; and a "statewide central register" which shall consist of founded and indicated reports; and
9. Strict regulations and procedures concerning the confidentiality of records.

The protective custody provision permits a child to be taken into temporary custody only by an examining physician or by a director of a medical facility for a period no longer than 24 hours when necessary to protect the child's life or health. This section also requires that such limited protective custody take place in a medical facility or other appropriate facility approved by the state department of public welfare. In no case may the protective custody be maintained longer than 72 hours without a detention hearing before a juvenile court judge, who decides what the child's welfare requires.

The record-keeping duties of the department play a very vital role in combating the problem of child abuse. If a person suspects a possible case of abuse, he may call a report into the hotline or to the Child's Protective Service (CPS). Thereafter, the initial report will be recorded in a "pending complaint file" and such information will be accessible only for the official duties of the designated employees of the Department of Public Welfare. Then, only upon a follow-up investigation and determination by the CPS that the report is "founded" or "indicated," the report will be entered into the central register. This provision will deter hospital-skipping (frequently used by abusers to avoid detection), aid physicians in identifying prior patterns of abuse, and very importantly, provide monitoring to ensure that the local child protective agency promptly investigates suspected reports and provides necessary services to the child and parents. New York State, which already enacted similar child abuse legislation, has experienced astonishing results since the installation of the central register and hotline system. In 1972, prior to the register's operation in New York, only 3,319 reports of suspected child abuse or maltreatment were received. For the first full calendar year in 1974 an unprecedented total of 29,912 reports involving 59,636 children were received.

Detailed regulations of the statewide register and pending complaint file are aimed at preserving the privacy of the persons involved, while at the same time maximizing its function to determine incidences and patterns of abuse. The following safeguards are built into the bill to protect such confidential information:

1. Access to the central register is limited to the CPS and only upon positive identification by the department;
2. Immediate expungement of all "unfounded" reports;
3. Procedures permitting the subjects of reports to amend, seal, or expunge the records of the report;

4. Initial reports which are not determined to be indicated or founded within 60 days of receipt will be expunged completely; and
5. Restrictive limitations on the information to be contained in the pending complaint file and central register.

A major new emphasis in Act 124 is in rehabilitative services. So often complaints are heard, "Why should we report these cases; nothing happens anyway." Act 124 mandates a child protective service agency in each county which shall provide multidisciplinary teams, counseling, homemaking services, and other supportive services needed by a family with abused or deprived children. Other states have first legislated an improved reporting and detection system and later provided for follow-up social services. In Pennsylvania, Act 124 attemps to do both in one comprehensive piece of legislation.

Some concern has been expressed about the rules of evidence section in Act 124. To those who argue there are constitutional problems, I urge a review of the New York court decisions which uphold the constitutionality of a similar provision in the New York law. The controversial section permits a juvenile court judge to take into account the realities of child abuse in juvenile court proceedings. As you know, the majority of child abuse cases occur within the home. It is very difficult for the prosecutor to sustain the burden of proving nonaccidental injuries to a child as abuse. Because of the lack of witnesses many cases are summarily dismissed in juvenile court only to reappear later at a hospital, all too frequently with greater inflicted harm. Act 124 includes provisions that take into account the secrecy of the infliction of child abuse. When the physical evidence shows that the gross physical neglect or injury is not explained by available medical history as being accidental in nature, the person alleging an accident has the responsibility of satisfying the juvenile court judge that it was an accident rather than abuse. This slight modification would apply only in juvenile court, where the welfare of the child is supposed to be the only issue. It would not apply in any subsequent criminal proceeding, should a district attorney decide the facts warranted criminal prosecution. Many juvenile court judges strongly support this change in the juvenile court proceeding.

It is hoped that with the passage of Act 124 more than just the "tip" of the child abuse problem will be visible, and that more and more persons will become involved and help us deal with this problem. Unless we recognize the need to take compassionate action to improve the plight of these children, we consign them to a life of continuing peril and deprivation. From the most practical and humanitarian point of view, increased protection and rehabilitation of such children certainly is more effective than dealing with the hardened results of frustration and aggression. I hope Act 124, when properly implemented and sensitively applied, will achieve the goals of protection and rehabilitation, responding to the cries of thousands of helpless infant victims.

Adjournment in Contemplation of Dismissal: A Legal Mechanism for Accountability

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In the field of child abuse and neglect juvenile and family court judges have long spoken of and written about their overcrowded courtrooms and court dockets. Some judges have also sought to establish themselves in the role of a facilitator or catalyst with social workers providing assistance to dysfunctional families. They have felt that the law, as interpreted and implemented by the court, should be more of a treatment tool in the social worker's rehabilitation kit than a club to force unwilling parents to change their aberrant behavior. Many practitioners have also felt that existing child abuse and neglect laws have not afforded the abusing or neglectful parent a legal mechanism to hold the authorized social services agency accountable for the lack of mandated services. In other words, there has often been a lack of confidence in the system which is mandated by the law to provide rehabilitative services to the dysfunctional family.

The New York State Assembly, with the urging of that state's Temporary Commission on Child Welfare, has sought to respond to these important issues through the passage of legislation which utilizes the concept of "adjournment in contemplation of dismissal." The purpose of the new law (Section 1039, New York Family Court Act) is to provide "an expeditious means for affording protection to abused or neglected children and their parents under the supervision of the Family Court and a child protective agency without having to resort to a time-consuming and stigmatizing adjudicatory hearing."[1]

Before we examine the specific sections of this law a general overview of the law might prove helpful. The law attempts, through the mechanism of a quasi-contractual arrangement, to bring about a negotiated agreement between the natural parents (and their attorney), the child (and his attorney), the social services agency (and its attorney), and the court, so that all parties become aware of their responsibilities to each other and their rights under the law and are given notice that they will be held accountable if they breach the contract. Upon the breach of the contract the agreement breaks down and the parties face the adjudicatory phase with its often unsuccessful outcome for any of the parties.

Subsection (a) of Section 1039 provides that:

> Prior to or upon a fact-finding hearing the court may upon a motion by the petitioner with the consent of the respondent and the child's attorney or law guardian or upon its own motion with the consent of the petitioner, the respondent and the child's attorney or law guardian, order that the proceeding be adjourned in contemplation of dismissal. The court may make such order only after it has apprised the respondent of the provisions of this section, particularly subdivision (e), and it is satisfied that the respondent understands the effect of such provisions.

This subsection establishes a legal mechanism to temporarily avoid the both stigmatizing and time-consuming adjudicatory phase of child abuse and neglect cases. There must be a motion made by the petitioner (the Department of Social Services) or a motion by the court itself, with consent of all the parties, that the proceeding be adjourned in contemplation of dismissal. Before the court may make such an order, however, the respondent parent and the child's attorney must consent and the court must be satisfied that the respondent parent understands the legal situation. The court must especially be satisfied that the respondent parent understands Subsection (e) which states:

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> Upon application of the petitioner or the child's attorney or law guardian, or upon the court's own motion, made at any time during the duration of the order, the court may restore the matter to the calendar, if the court finds after a hearing that the respondent has failed substantially to observe the terms and conditions of the order or to cooperate with the supervising child protective agency. In such event, circumstances of neglect shall be deemed to exist, and the court may thereupon proceed to a dispositional hearing under this article and may, at the conclusion of such a hearing, enter an order of disposition authorized pursuant to section one thousand fifty-two with the same force and effect as if a fact-finding hearing had been held and the child had been found to be an abused child or a neglected child.

Subsection (e) provides a means for the petitioner or child's attorney or law guardian to hold the respondent parent accountable to substantially observe the terms and conditions of the order as defined in Section (c) and to establish the fact that the respondent parent is expected to cooperate with the supervising child protective agency. If the court finds after a hearing that the respondent has failed substantially to observe the terms and conditions of the order or to cooperate with the supervising child protective agency, the court may decide that circumstances of neglect shall be deemed to exist, and the court may then proceed to a dispositional hearing.

Some critics of the law have objected to this part of Subsection (e) on the grounds that the fact that a parent who has not yet been adjudicated an abusing or neglectful parent should not be foreclosed from the protection of due process for failing to cooperate with the efforts of a supervising child protective agency. Some have also said that, although they support the intent of the legislation, they felt it would have been better for the legislature to have provided for the holding of a fact-finding hearing before adjourning in contemplation of dismissal while witnesses are still present and evidence available.

Although the criticism is correct, in that a serious question of the due process protection due the respondent parent is at risk, the issue must be faced that if a fact-finding hearing were held before adjourning in contemplation of dismissal the whole purpose of the new law would be compromised. As was mentioned earlier, the purpose of the law is to eliminate the time-consuming and stigmatizing effects of an adjudicatory hearing. It must also be remembered that the respondent parent has, in the first instance, the choice of whether to agree to the adjournment process or to proceed to the adjudicatory state (Subsection (a)). Another factor to consider is the risk the petitioner takes in agreeing to an adjournment in terms of the loss of witnesses and other presently available evidence. During an adjournment period the petitioner's witnesses may disappear or have a lapse of memory. Other necessary evidence may become stale.

On a more practical level, it is unlikely that the petitioner would agree to the adjournment route unless it had confidence that the particular respondent parent was a likely candidate for assistance without the necessity of adjudication.

It is also possible for the court to use the occasion of the hearing mentioned in Subsection (e) to give the respondent parent a last warning before ruling that circumstances of neglect exist. The author believes that this could provide an additional opportunity to perhaps avoid the due process question mentioned earlier.

It should be pointed out at this time that that this law has provided a means whereby the child protective services agency is mandated to account for its stewardship. Subsection (d) provides that:

> Upon application of the respondent, or upon the court's own motion, made at any time during the duration of the order, if the child protective agency has failed substantially to provide the respondent with adequate supervision or to observe the terms and conditions of the order, the court may direct the child protective agency to observe such terms and conditions and provide adequate supervision or may make any order authorized pursuant to section two hundred fifty-five this act.

This section provides that if the child protective service agency does not provide the respondent parent with "adequate supervision" or fails substantially to observe the terms and conditions of the order, the respondent or the court itself may initiate a Show Cause proceeding.

One of the important elements in Subsection (d) is the reference to Section 255 of the Family Court Act. That section states:

It is hereby made the duty of, and the family court or a judge thereof may order, any state, county, and municipal officer and employee to render such assistance and cooperation as shall be within his legal authority, as may be required to further the objects of this act. It is hereby made the duty of, and the family court or judge thereof may order, any agency or other institution to render such information, assistance and cooperation as shall be within its legal authority concerning a child who is or shall be under its care, treatment, supervision, or custody as may be required to further the objects of this act. The court is authorized to seek the cooperation of, and may use, within its authorized appropriation therefor, the services of all societies or organizations, public or private, having for their object the protection or aid of children or families, including family counseling services, to the end that the court may be assisted in every reasonable way to give the children and families within its jurisdiction such care, protection and assistance as will best enhance their welfare.

One court that interpreted this section said, after reviewing the legislative history of the law, that Section 255 "was designed as a specific remedy to enable the Court to cut through the bureaucracy, fragmentation and lack of coordination which so inhibits the provision of services for families and children before the Court."[2]

The legislature has shown by its reference to Section 255 that its intention is to provide a means for respondent parents to be provided the kind of services needed to overcome whatever present obstacles they have to proper child rearing.

We have seen that this law provides for an adjournment period during which the parties to the action may attempt to avoid the adjudicatory phase and be given an opportunity to have the petition dismissed. To understand the time frame during which this opportunity is afforded we must examine Subsection (b) which states:

> An adjournment in contemplation of dismissal is an adjournment of the proceeding for a period not to exceed one year with a view to ultimate dismissal of the petition in furtherance of justice. Upon the consent of the petitioner, the respondent and the child's attorney or law guardian, the court may issue an order extending such period for such time and upon such conditions as may be agreeable to the parties.

The next issue to be considered is what the adjournment order entails. Subsection (c) states:

> Such an order may include terms and conditions agreeable to the parties and to the court, provided that such terms and conditions shall include a requirement that the child and the respondent be under the supervision of a child protective agency during the adjournment period. Such agency shall report to the court in such manner at such times as the court may direct.

Under this subsection the parties to the action are given an opportunity to agree on a plan to help the parents and to unite the family. Let us take a moment to discuss this subsection because, in this writer's opinion, it holds the key to the success of an "adjournment in contemplation of dismissal." This author believes that the intention of the legislature is that the adjournment order be, in effect, in the nature of a written contract between all the parties stating very clearly what each party is expected to do to fulfill its obligations towards effecting rehabilitation of the family.

In the case of the social services agency their attorney should consult with them before agreeing to any particular treatment plan. The agency attorney must understand his role in this setting. He serves, in effect, as the spokesman of the agency and should not overstate the ability of the agency to perform the services agreed upon. Because the agency will be held accountable for that which they agree to provide, the nature of services to the family in the agreement should be realistic and should be performed.

In the instance of the attorney for the natural parents, he must make sure that his clients understand their obligations under the agreement and their ability to perform. They must also understand the penalty for nonperformance and the effect it will have on their attempt to keep the child with them. The attorney also must attempt to have the social services agency provide the most useful services to the family, and then he must be prepared to hold the agency accountable under the agreement if they fail substantially to provide the agreed upon services.

In the case of the attorney for the child, this writer finds a real weakness in the law in that Subsection (d) does not have a mechanism for the child's attorney (or law guardian) to hold the social services agency accountable for failure to provide agreed upon services to the respondent (parents). As many of us who have represented children know, oftentimes even when rehabilitative services are not being provided by the social services agency the parents (or their attorney) are reluctant to complain or are not interested enough to complain. In other words, they either are afraid of the system or are willing to leave well enough alone. The child's attorney must be an advocate who serves as the fulcrum of the agreement between all the parties. He must, in effect, keep both the social services agency and the parents honest by insisting that the agency actually provide the agreed upon services and that the parents avail themselves of these services so as to bring about, as quickly as possible, a situation which will allow the petition to be dismissed.

The court, of course, has its role to play in the treatment plan. The court must insist upon strict accountability on the part of all parties. It must not lend its imprimatur to an unrealistic treatment plan nor to a plan that will result in no appreciable change in the family circumstances even if successful.

The New York law providing for a legal mechanism in attempting to bring accountability into the child welfare law is a step in the right direction and should be enacted by state legislatures in the same way and with the same speed as the model child abuse reporting laws were enacted in the 1960s.

FOOTNOTES

[1]*The Children of the State I: A Time for Change in Child Care* (Preliminary Report of the Temporary State Commission on Child Welfare, May 1975): 58.

[2]76 Misc. 2d at 785, 351 N.Y.S. 2d at 606.

Corporal Punishment in the Schools

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This paper deals with some of the legal implications of the use of corporal punishment in our schools. In it I will outline some of the theories and methods of limiting corporal punishment through formal legal action. A review of the common constitutional claims advanced in federal court litigation will be made with a summary of recent court decisions indicating the state of the law today. The possibility of using state court tort remedies against individual teachers, as has been suggested by the U.S. Supreme court Justice Lewis Powell, will be explored.[1] Statutory and agency regulation of the practice will also be discussed. Finally, my own comments on alternatives to attempted legal control of the problem will be offered.

Federal court litigation seeking to end the use of corporal punishment in the schools is usually based on one or more of three basic claims. The first and primary basis is that corporal punishment violates a child's right to be free from cruel and unusual punishment as guaranteed by the Eighth Amendment to the U.S. Constitution. It is this theory upon which claims by adult members of the armed forces,[2] adults in penal institutions,[3] and juveniles in correctional facilities[4] have succeeded in eliminating the use of corporal punishment against themselves.

In the educational context, this claim has been advanced in an increasing number of law suits. Most recently, a group of students from Dade County, Florida, relied upon this claim in *Ingraham* v. *Wright*, a case decided by the U.S. Supreme Court.[5] The plaintiffs in this action did not advance the broad proposition that all corporal punishment was cruel and unusual, but only that the particularly harsh punishment which they had received fell within the protection of the Eighth Amendment. In its decision, a sharply divided Court ruled that the U.S. Constitution offers no basis for granting relief to the children. Dealing with the Eighth Amendment claim, the Court reasoned that the prohibition against cruel and unusual punishment was originally included in the Bill of Rights to protect those convicted of a crime. Consequently, students could not assert the protection to shield themselves in an educational setting.[6] This decision runs counter to a number of earlier lower federal court decisions which, without discussing the issue, had just assumed that the Eighth Amendment claim would apply.[7]

A second line of attack which has been used in many cases is the assertion that a child cannot be physically punished without consent of the child's parents. This claim is grounded in the theory that since parents possess a superior right to the care, custody, and control of their children, this control should extend to the decision whether or not to corporally punish their children.

This issue received limited Supreme Court review in the recent case of *Baker* v. *Owen* in which a federal district court in North Carolina ruled that parental consent was not necessary prior to physical punishment.[8] The Supreme Court, without an opinion, summarily affirmed this decision in May, 1975. That decision runs counter to several federal district court opinions including a case in the Western District of Pennsylvania, *Glaser* v. *Marietta*.[9]

A third basis of attack on the use of corporal punishment in educational settings is grounded in the due process clause of the Fourteenth Amendment. This theory would require that physical punishment only be administered after the imposition of certain protections such as prior notice that an offense may occasion the use of corporal punishment, notice of the offense for which one is being punished, and some chance to defend oneself against the claim that an offense has been committed.

The lower court opinion in *Baker* v. *Owen* specifically addressed this issue and required the safeguards mentioned and the administration of punishment in the presence of a second school official, and upon request of the parent a written explanation of the punishment and reasons for its imposition.[10] Since the Supreme Court never ruled on this issue in *Baker* as it was not appealed to the higher Court, it was a case of first impression when presented in *Ingraham* v. *Wright*. After conceding that freedom from bodily punishment was a liberty protected by due process, the Court concluded that imposition of administrative safeguards, while intruding significantly on the educational process, would add little to the child's protection. This fact, coupled with a belief that the "openness of the school environment" and the availability of civil and criminal remedies against teachers adequately protect children, was sufficient justification for the ruling that due process

procedures were not necessary prior to the imposition of corporal punishment on students in the schools.[11]

From a litigation standpoint, then, it seems the federal constitution does not protect the child from imposition of physical punishment. It is interesting to note that both the lower court opinion and the opinion of the Supreme Court in *Ingraham* addressed this problem. Deploring the use of gross physical abuse that had been alleged in the case, the court directed the plaintiffs that they might turn to state court tort and criminal remedies to redress their grievances.[12] In dispensing with the due process issue the Court specifically relied on the existence of these alternative remedies as justification for disallowing the constitutional claim.

Although this is a tactic which has always been available to the individual, as an attorney who deals daily with the rights of juveniles, I see many problems with this approach. A primary problem with the case-by-case method of dealing with individual abusive teachers is that it only deals with the extreme forms of physical abuse. In *Ingraham* the student needed hospital treatment and missed 10 days of school as a result of punishment. Surely we wish to limit physical violence long before it occasions the need for medical treatment.

We have now started to articulate standards of emotional abuse against parents. Are not some of the methods employed against school children likely to be as damaging as anything done by parents? It is inconceivable to me that any of this type of activity might be limited through private damage actions.

A second problem is that children in general, and especially those children against whom physical punishment is most likely to be inflicted, are largely underrepresented in the legal system. Even the attorney who may consider taking such a case on a contingent fee basis, which is the norm in damage actions, will attempt to assess the likelihood of recovering a monetary judgment against a school teacher. Since the chances are slim in most communities, the lawyer, unless motivated by some altruistic reasons, is unlikely to take the case. The state court remedy then will only be available to that small percentage of families who can afford to employ an attorney and pay for the representation prior to commencement of the action.

If, indeed, state court actions become successful on a large-scale basis, I see a third hurdle to the effective limitation of corporal punishment through the courts. This hurdle is the use of liability insurance to protect teachers against claims of physical assault. As has happened in the case of police and fire employees, it would not be unlikely to see provision of such coverage as a major contract demand by teachers' unions when negotiating with their school boards.

Whether or not any of these problems present insurmountable difficulties to individual recoveries, there exists today a fourth factor which I believe makes state court remedies totally ineffective. In most of these actions the teacher will likely demand a jury as the decision-maker. Dr. Gertrude Williams, a child psychologist instrumental in the formation of the American Psychological Association's Task Force on Corporal Punishment, related her experience when she appeared as an expert witness in a damage suit against a teacher. An 11 year old girl had been beaten on the hands and buttocks by her over six foot tall male teacher for refusing to leave the cloakroom.

> After deliberating for 45 minutes, the jury decided in favor of the teacher who had testified on the need to maintain order in the classroom. During a recess, I heard someone say, "A kid suing a teacher? What'll they think of next?" And as we filed out of court: "A teacher shouldn't have to worry about getting sued for doing his job!" and "That'll teach her to get out of line. Can you imagine what would have happened if the kid had won the case!"[13]

It is this attitude which is found in most of our communities that, in my opinion, is the major obstacle to limiting the use of physical force in the classroom.

If litigation, either through federal constitutional or state court damage actions, ineffectively limits corporal punishment, are there other legal methods that can be employed? One possible method is the enactment of state court statutes forbidding corporal punishment. New Jersey has had for some time a statute forbidding the use of corporal punishment.[14] A few other states, such as Massachusetts, Maine, and Maryland, have more recently placed some legislative limitations on the use of physical punishment in their schools.[15, 16, 17]

Even in these states, however, the problem has not been totally solved. The last Massachusetts legislative session considered a proposal seeking to repeal the ban on corporal

punishment. And in sharp contrast to the few states which have limited its application, 21 states have statutes specifically authorizing its use.[18]

Another method of limiting or eliminating corporal punishment that has been attempted in some areas is agency regulation. In areas with sympathetic administrators this can be a particularly valuable tool, especially since an agency head may feel immunized from public opinion favoring corporal punishment.

In Pennsylvania, the Commonwealth's Department of Education establishes regulations and guidelines which are to be followed by the state's public schools. Their guidelines, which were approved in September 1974, while not eliminating corporal punishment, required that it only be administered with parental approval.[19] A few months ago, Commonwealth Court invalidated the department's authority to impose such regulations on its member schools in the case of *Girard School District* v. *Pittenger*.[20] It would seem then, at least in some states, that agency regulation may not effectively limit corporal punishment.

How then are we to approach the problem of attempting to eliminate the use of physical force in the classroom? To answer this question it is first necessary to consider some of the common justifications for its continued use and look for alternative solutions to the difficulties suggested.

With more and more incidents of violence and disruptive behavior in schools today, parents, educators, students, and communities have become increasingly alarmed. These occurrences are seen by many as a primary reason for sanctioning corporal punishment in schools.

Unfortunately, there are few programs available to schools and communities dealing with the reduction of violence and disruption. One helpful step toward dealing with this problem is to offer coordinated training and technical assistance to teams of local school personnel and community representatives interested in planning interventions tailored to their specific needs and resources.

The U.S. Office of Education and the Law Enforcement Assistance Administration are cooperating to apply the school team approach to the prevention and reduction of school crime and disruption. The Alcohol and Drug Abuse Education Program, which currently operates a system of Regional Training and Technical Assistance Centers, will be expanded to train pilot demonstration teams.

Approximately 80 teams will be trained, representing a cross section of schools serving grades 5 through 12, which evidence a history of school crime or disruptive problems or which have experienced the consequences of these offenses in terms of fear, discord, and interference with the educational process. Each team will consist of seven members including an administrator, classroom teacher, guidance counselor, school security officer or disciplinarian, representative of the local juvenile justice system, community representative, and a student or other young person. One team member will also serve as coordinator responsible for coordinating team activities and maintaining a liaison between the school and the center.

Each team will survey the school and community to assess their own problems and then formulate a set of goals to be met within a given time period. The resources of faculty, students, parents, and others in the community will be drawn upon with the experiences of existing programs and additional suggested approaches being supplied by the centers. By encouraging students to participate more fully in school activities, including such programs as peer counseling, the teams hope to produce added pride and interest in the schools. Parents and the community may be involved in programs like cafeteria monitoring as efforts are made to establish an environment more conducive to learning in which students are free of the fear of violence.

Through an interagency funding agreement, a grant of $1,233,000 will be used to fund this project. Three of the regional centers in midwestern and western states have been awarded the contracts to provide assistance to the local schools. The program is funded until September 30, 1977, and an ongoing evaluation process will be used until September 30, 1978, to assess the impact of the interdisciplinary team approach upon crime and fear of crime in the schools.

Whether plans such as this will decrease violence in schools remains to be seen. The answer, however, may be intimately tied to a second argument for corporal punishment: such conduct is necessary in order that teachers can protect themselves from violent youth. This objection is a false issue since even in states where physical punishment is forbidden, there exist exceptions for this situation in which the teacher is defending herself/himself against a physical attack. Further evidence of the dishonesty involved in this approach is offered by the statistical data which indicate that corporal punishment is most likely to be used against the younger and smaller child.[21]

A final problem often cited as an excuse for hitting students is its efficacy as a classroom control mechanism. Teachers indicate that it is the swiftest, surest method of dealing with disruptions, takes little time to administer, and causes immediate behavior change. While these results certainly make life easier for the teacher, one wonders what effect they have on the child who is taught that the use of physical force against children is acceptable behavior.

I have already stated that I do not believe litigation offers the promise of eliminating the physical abuse of our children in schoolrooms. I leave to you the question of whether state or federal legislatures are likely to act by way of statutory revision, realizing of course that children do not possess a potent political voice.

What is certainly necessary, and what might have some effect, is to begin to deal with attitudes. The American public must be taught to view corporal punishment for what it is, an officially sanctioned form of violence having effects upon the student which last long after the sting or bruises disappear. Teachers must be offered alternative methods of classroom control. Teachers' unions and school boards must likewise be reeducated to take formal positions opposed to the use of physical punishment. Finally, parents must be encouraged to demand that the physical abuse of their children in our nations' schools cease.

FOOTNOTES

[1]Ingraham v. Wright, 45 U.S.L.W. 4364, 4371 (1977).

[2]10 U.S.C. Sec. 855 (1975).

[3]Jackson v. Bishop, 404 F.2d 571 (8th Cir. 1968), and the cases cited therein.

[4]Nelson v. Heyne, 491 F.2d 352 (7th Cir.), cert. denied, 417 U.S. 976 (1974).

[5]Ingraham v. Wright.

[6]Ibid., 4369.

[7]Baker v. Owen, 395 F.Supp. 294 (M.D.N.C.), aff'd, 423 U.S. 907 (1975); Glaser v. Mariettal, 351 F.Supp. 555 (W.D.Pa. 1972); Ware v. Estes, 328 F.Suppl. 657 (N.D. Tex. 1971), aff'd per curiam, 458 F.2d 1360 (5th Cir.), cert. denied, 409 U.S. 1027 (1972); Whatley v. Pike County Board of Education, Civil Action No. 977 (N.D. Ga. 1971) (three-judge court); Sims v. Board of Education, 329 F.Supp. 678 (D.N.M. 1971).

The Eighth Circuit specifically considered physical punishment in the schools and found that excessive punishment could be prohibited as cruel and unusual. Bramlet v. Wilson, 495 F.2d 714 (8th Cir. 1974).

[8]395F.Supp. 294 (M.D.N.C.), aff'd 423 U.S. 907 (1975).

[9]351 F.Supp. 555 (W.D.Pa. 1972).

[10]Baker v. Owen, 302-303.

[11]Ingraham v. Wright, 4372.

[12]Ibid., 4369, and Ingraham v. Wright, 525 F.2d 909 at 915 (5th Cir. 1976).

[13]G. J. Williams, "An Editor's Reflections on Pain," *Journal of Clinical Child Psychology*, 1975, 56.

[14]N.J. Stat. Ann. 18A: 6-1 (West) 1968.

[15]Mass. Ann. Laws Ch. 71 Sec. 37G (1972).

[16]Me. Rev. Stat. Tit. 17-A, Sec. 106(2) (1976).

[17]Md. Ann. Code Art. 77Sec. 98B (1975).

[18]Cal. Education Code. Sec. 49000-49001 (1976); Del. Code Ann. Title. 14 Sec. 701 (1976 Supp.); Fla. Stat. Ann. Sec. 232.27 (1977); Geo. Code Ann. Sec. 32-835, 32-836 (1976); Haw. Rev. Stat. Sec. 298-16 (1975 suppl.), 703-309 (2) (1975); Ill. Ann. Stat., c. 122 Sec. 24-24, 34-84a (1977 Supp.); Ind. Code Ann. Sec. 20-8.1-5-2 (1975); Md. Educ. Code Ann., Art 77, Sec. 98B (1975) (in specified counties); Mich. Comp. Laws Ann., Sec. 340.756 (1976); Mont-Rev. Codes Ann. Sec. 75-6109 (1947); Nev. Rev. Stat. Sec. 392-465 (1973); N.C. Gen. Stat. Sec. 115-146 (1975); Ohio Rev. Code Ann. Sec. 3319.41 (1972); Okla. Stat. Ann. Tit. 70 Sec. 6-114 (1972); Penn. Cons. Stat. Ann., Tit. 24, Sec. 13-1317 (1976-1977 Supp.); S.C. Code Sec. 21-776 (1975 Supp.); S.D. Comp. Laws Ann., Sec. 13-32-2 (1975); Vt. Stat. Ann., Tit. 15, Sec. 1161 (1974); Va. Code Ann., Sec. 22-231.1 (1950); W. Va. Code, Sec. 18A-5-1 (1977); Wyo. Stat. Sec. 21.1-64 (1975 Supp.).

[19]22 Pa. Code Sec. 12.5(c).

[20]370A.2d 420 (Pa. Commw. Ct. 1977).

[21]S. M. Shaffer, *Corporal Punishment Survey* Pittsburgh, Pennsylvania, Board of Education, Office of Research (June 13, 1968).

The State as Parent: Solutions and Problems

Weeping in the Playtime of Others: An Update

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Last year I wrote a book called *Weeping in the Playtime of Others.* The basic premise of this book is that the incarceration of children (dependent-neglected to delinquent) within our country is a multi-billion dollar industry perpetuated by the politics of jobs, corruption, professional power, and public misinformation, while the very children we are mandated by law to protect are forgotten and destroyed.

Now, a year later, I find that although there are signs of change and some grass-roots activities directed at juvenile justice reform, the premise of *Weeping in the Playtime of Others* remains tragically intact.

When Dr. Jerome Miller closed the juvenile institutions in Massachusetts, not one person lost his or her job. Fully confident that their unions and their politicians would protect them, the employees reported to empty buildings each day for three years and wiled away their time playing pinochle tournaments, at a cost of $1.6 million to the Baystate taxpayers.

An update: In summer, 1976, George Phyfer, director of the Alabama Department of Youth Services, decided to close Roebuck Campus. Formerly known as the Alabama Boys Industrial School, the 260 acre facility was a factory of failure. Each year, taxpayers were spending $16,000 per youngster, compared to only $7,000 to place the same child in a more human group home. The facility suffered bad publicity when a police officer found two iron cages where children repeatedly had been placed in solitary confinement over the past sixteen years. Roebuck Campus was also a fire trap: It would cost $340,000 to bring the school facilities up to minimum fire safety requirements.

Reaction to George Phyfer's decision to close the school was spontaneous and diffuse. A group of employees known as "SAVE OUR SCHOOLS," P.O. Box 9719, rallied support in the Birmingham area with a flyer directed at the business community: "SAVE THE CHILDREN: Loss of a one million dollar payroll plus the $500,000 spent locally is of concern to Birmingham Businessmen!"

The political community also responded. Last September 4th, twenty-seven elected officials, including four state senators, fifteen state representatives, the county commission, the mayor, the district attorney and one lone guardian of a youth committed to the old reform school, filed suit to keep the school open. Circuit Judge Willim Barber quickly heard the case. He not only agreed to keep the school open, but ordered Roebuck Campus to be taken away from the Department of Youth Services and turned over to the First National Bank of Birmingham, which would act as trustee.

Victorious in court, the politicians, known locally as "the Sunset Committee," vowed to remove Director George Phyfer and destroy the Alabama Department of Youth Services. Currently, both the department and George Phyfer are fighting not only for the kids, but their "lives", as the Sunset Committee sinks lower and lower in the darkness of their own political intrigue.

Closely related to the politics of jobs is the politics of professional power. I found it strange during my three years of investigating that the well-trained professionals within our juvenile justice industry never once collectively decried the practice of locking up noncriminal children—status offenders (truants, runaways, etc.) and dependent and neglected—with criminal children and adults. Nor did I hear their educated voices anguish over the desolation of children locked away in solitary confinement. Nor did I hear the rage of the medical profession match the rage of children who were driven to suicide. In fact, the National Association for Mental Health, Inc., responded to inquiry on its opinion of extended isolation as follows: "The...Association...has taken no formal position on solitary confinement of children or any other penal practice, nor do we have any data on the effect of solitary confinement on the growth and development of children or such confinement leading to suicide or on suicides within juvenile penal facilities."

With the help of U.S. Justice Department files, including FBI reports, I documented that within the facilities of the $52 million publicly supported Texas Youth Council, children were gassed while in solitary confinement and pregnant girls were forced to take abortion-inducing pills, among various other inhuman punitive measures. Conditions were so cruel that Federal District Court Judge Wayne Justice ruled that Texas was in direct violation of the Eighth

Amendment (Cruel and Unusual Punishment) as well as other articles of constitutional faith. Never before in the history of American juvenile justice was a case so thoroughly investigated, documented and validated as Morales v. Turman.

An update: The state of Texas appealed the court-ordered human reforms and Judge Justice's decision to close down some of the youth facilities. In the spring of 1976 a three-judge Federal Circuit Court of Appeals in New Orleans heard the case. The higher court threw the case out on a point of procedure: the original case should have been heard by a three-judge court. Therefore, the Morales case had to be retried. The outcome is dubious. Cost and time required for a retrial are probably prohibitive. But however it ends, what can never be thrown out on "a point of legal procedure" is the massive evidence of horrors which the trial recorded in the journal of the times in which we live.

Another entry in that journal is the death of Donna Hvolboll at Artesia Hall, another Texas facility. Donna's "accidental" death was later proven to be murder at the hands of the owner of Artesia Hall. The convicted man was later freed, however, because of inadequate Texas licensing laws..."The legislature did not prescribe a statutory code for operators of child care institutions to provide care for its residents."

An update: the unremitting stream of horror stories persuaded the Texas State Legislature to pass a new licensing act in 1975. But there are two yawning gaps in it: (1) It does not cover state-operated facilities; and, (2) "The department may, in specific instances, waive the compliance with a minimum standard on a determination that the economic impact is sufficiently great to make such compliance impractical."

State licensing and inspection laws are supposed to be "the policemen on the beat," protecting incarcerated children, especially in private facilities. Yet, the sad truth is that most state licensing laws are ineffectual and/or ignored. Why? Who takes that cop off the beat? Who ensures that he isn't checking the doors against the prey of night? Could it be the private associations of child care owners with well-financed lobbies in state capitals? Could it be misinformed state legislators? Could it be an uninformed public? I say "yes" to all of them.

Even though the American Bar Association recommends the removal of status offenders from the courts and Congress, in 1974, passed the Juvenile Delinquency Prevention Act which calls for the removal of noncriminal children from penal institutions, the National Council of Juvenile Court Judges stands adamantly against such obvious reform. As recently as November 16, 1976, at the First National Conference on Issues in Juvenile Justice and Child Development, Judge Margaret C. Driscoll, their president, took a strong stand against the ABA new standards: "The Juvenile Court Judges of this nation cannot stand idly by and watch the destruction of the juvenile court system."

Judge Driscoll also stated that "youngsters who are status offenders are often more emotionally disturbed than children who commit criminal acts." My question to the judge is: When are the status offenders more emotionally disturbed—before they are locked away with serious offenders or after they have had the experience of lock-up, institutional drugs, legalized child abuse, etc.?

An update: Recently the Pennsylvania House of Representatives voted overwhelmingly to comply with the new federal law dealing with juvenile delinquency prevention. This would change the status of offenders from "delinquent" to "deprived." It also provided an enlightened clause to end the depressing practice of placing thousands of Pennsylvania youths in adult, county jails.

Pennsylvania Juvenile Court Judges publicly opposed the measure because they claimed to have no alternatives to county jails, and effectively teamed up with two state senators to kill the reform measure—Senate Bill 748. How can one gauge the personal interests of judges? Do they truly desire alternatives before supporting the removal of status offenders from jails or do they fear a loss of their professional power? I have my own opinion, but I leave the answer to you, the taxpayer, the concerned child worker, the humanist, to decide.

The third politics at work is the politics of corruption. I'm not just talking about stealing monies by fraud or whatever. I mean the corruption of P.Y.A.—Protect Your Ass—as practiced by most sister agencies within state government.

An update: In September, 1976, a CBS "Sixty Minutes" program—Interstate Commerce of Kids—showed that the state of New Jersey was sending kids hundreds of miles away from their homes and families for questionable treatment in a private, profit-making facility in Florida. A public-interest lawyer found enough evidence during a visit to the center to ask a Newark judge to reconsider before returning two boys who were home for Christmas vacation.

While one state was investigating the facility for consumer fraud, the New Jersey Attorney General's Office was defending the practice of shipping kids out of state as well as defending its sister agency—the Department of Youth and Family Services (DYFS)—responsible for the placements. New Jersey taxpayers unwittingly provided travel expenses for officials of the profit-making school who flew from Florida to defend themselves. It is ironic that U.S. District Judge Alvin B. Rubin, in his precedential ruling (*Gary W. v. Louisiana*), ordered mentally retarded Louisiana children, being warehoused in Texas, to be returned home, yet the New Jersey State Attorney General's Office acted as the private law firm for a facility that earned a million dollars in profit last year for warehousing hapless out-of-state youngsters.

Of all the things that I personally uncovered, nothing disturbed me more than the loosely operated $90 million National Health Care program for the Uniformed Military Services (CHAMPUS) (Department of Defense) in Washington, D.C. Incompetent administration and corruption were the breeding grounds for mushrooming "child care" units. Sixty percent of these units did not exist prior to Congressional funding of this program (in 1966) for emotionally disturbed children. Abuse was (and still is) widespread, including exorbitant fees and poorly defined medical services.

In July, 1974, nationally televised hearings on abuses of the CHAMPUS program were conducted by Senators Henry Jackson and Charles Percy. After months of intensive investigations, the Senate Subcommittee on Permanent Investigations released its findings on two facilities: University Center in Ann Arbor, Michigan; and, Green Valley in Orange, Florida.

It was Green Valley and its controversial director, Reverend George von Holsheimer, that drew national attention from Time, the Washington Post, the N.Y. Times and the major TV networks. The charges were bizarre but true: urine injections to cure allergies; supplying children who threatened suicide with a loaded gun and telling them to use it (one did); chains and electrical cattle prods, etc., etc.

Senator Jackson called it worse than the German concentration camps and questioned how such conduct could go on in America. The Comptroller General of the United States wondered aloud about $184,000 in questionable billings by the Green Valley School. On national television, the interest of Washington politicians equalled the brilliant TV lighting.

An update: June 9, 1976.

> SEN. PERCY: On July 24, 1974, GAO (General Accounting Office) appeared before this Subcommittee and testified regarding an audit questioning a payment of $184,000 by CHAMPUS to the Green Valley School. On May 24, 1975, CHAMPUS referred this to the General Counsel, Department of Defense, and on March 26, 1976, Defense referred the matter to the Justice Department for investigation. I have since learned from the staff that the FBI, which is currently investigating the questionable billings, has been unable to locate the records of the Green Valley School. Why did it take CHAMPUS a year to turn the matter over to the Justice Department?... You did not have a hearsay piece of evidence. You had the Comptroller General of the United States testifying that there was $184,000 of payments that they couldn't account for. What is so complicated about turning this over to the law enforcement agency of the government and having them do it? What did your delay accomplish?
>
> COL. PENNER: I hope a document that would ultimately lead to some decisive judicial action.
>
> SEN. PERCY: In the meantime, the records are gone.
>
> COL. PENNER: I am at a disadvantage in that I wasn't personally involved. The work on assembling the documents was done by our legal staff in Denver.
>
> SEN. PERCY: You simply cannot justify the delay?
>
> COL. PENNER: I personally can't. No.

And on February 14, 1977, Reverend von Hilsheimer wrote a Ms. Ruth Rice, "Green Valley was closed for economic reasons a year after I left it and has yet to have a single charge against it substantiated by any sworn witness at all. Not a single one."

Let me now address myself to the problem of labeling children "mentally retarded" to insure incarceration and out-of-state placement for the sake of securing federal and state monies. In the words of one "mentally retarded" child from Kansas:

"From the cities Dark and Gray
They send their children far away"

It is these children who suffer most from the neglect of their distant states and parents, for they are truly forgotten and rarely checked by the sending states. A recent report by the General Accounting Office in Washington, D.C. concluded that millions of dollars have been paid by HEW to ineligible institutions where children sometimes languish in dirty, crowded and crumbling conditions while bureaucratic administrators fight over who siphons off the most money. Almost half the institutions visited were either unlicensed or had serious physical deficiencies. Three of the largest exporters of children are state departments of education in New York, New Jersey, and Virginia, yet not one single person is assigned to leave those states to observe the conditions of the receiving facilities or the progress of a single child. Nothing can equal the hell that we, as a society, place on these sadly forgotten youngsters conveniently tucked away from our consciences for years.

The litany of abuse, government mismanagement and incompetence and corruption goes on crushing life's flowers in the garden of youth. How can we protect and defend the children? I have some ideas based on my collective experiences as an educator, a professional political consultant, a writer, and now a national investigative reporter for both TV and the writing press. Basically, these suggestions fall into two categories of accountability: human and financial. I would like to see all of them become policy and law on national and state levels: (1) consolidate existing federal, state, county, and local programs which are designed to help troubled children, while coordinating efforts to help the entire troubled family. Family counseling and crisis intervention would be far more effective than the "therapy in a vacuum" we now practice by placing a deprived child in a cold cell or isolation room; (2) when the family is beyond help or, in fact, no longer exists, local community based programs (group homes, runaway shelters) should be provided to assist the victimized children in their own communities rather than shipping them to facilities in distant states which, at best, are difficult to evaluate and are immensely costly to the taxpayers; (3) if a child needs to be placed in "need of supervision," we should also consider placing his parents, and in some instances, his school, in "need of supervision" if they are not living up to their responsibilities; (4) citizen groups without vested self interests should be supported by government agencies, on a rotating basis, supplying monitoring training for child care programs. This would insure personal accountability and prevent legalized child abuse; (5) initiate (for the first time in child care history) public financial accountability. Profit-making businessmen, caring for troubled children with public monies, should be required to submit full audits of their total operations. Nonprofit juvenile treatment facilities should do likewise, as well as being required to file IRS Form 990 which shows annual and total financial worth within the state. This would allow review by the press and certified public accountants for the public interest; (6) divert present state funds that traditionally go to "Youth Corrections and Public Welfare" line item budgets to new community-based family service programs; (7) prohibit elected officials (who are lawyers) from representing child-caring clients before public agencies that serve as guardians to state wards or dispense public monies; (8) establish a division within the United States Justice Department to protect the constitutional rights of children. For the first time we would take criminal action against adults who fraudulently lock away children (by false-labeling them) for expensive treatment in nonprofit and profit-making residential centers; and (9) create a National Child Health Care Enforcement Agency which would set up strike force teams to make unannounced visits to child care centers, group homes, private and public residential treatment centers, state training schools, etc. It would be comprised of experts and professionals as follows:

(1)	Medical Doctor	Basically a general practitioner with training in possible drug assaults and abuses to children;
(2)	Psychiatrist	To evaluate psychiatric and psychological treatment and drug dosages and administration;
(3)	Psychologist	
(4)	Psychiatric Social Worker	To evaluate semiprofessional treatment and staff;
(5)	Registered Nurse	To evaluate the general nursing care and drug usage;
(6)	Lawyers (2)	One lawyer with experience in criminal prosecution, particularly in crimes of fraud and embezzlement. One lawyer with expertise in civil rights;
(7)	Certified Accountant	To examine financial records and books;
(8)	Dietitian	To evaluate the quality and quantity of food;

(9)	Public Health Officer	To examine basic health facilities;
(10)	Educator	To evaluate the educational programs;
(11)	Correctional Officer	Someone with experience in penal work who will know if an institution is really a "jail;"
(12)	Investigative Reporter	To research and track down former patients, parents, staff, etc., and to expose abuses.

The ultimate value of such a strike force is in the shock waves that would spread in that loose but interlocking network of communications which connects the owners of "human warehouses" and professionals who have become affluent at the expense of the countless taxpayers and children. Programs and concepts that are found to be exceptional could be widely communicated and shared. Programs that are operating merely for financial profit could be brought to the attention of local district attorneys and the U.S. attorneys.

I leave you with this thought: The children within the American justice system are like the character in Joseph K. Kafka's play, "The Trial." He is blindly and determinedly struggling to get before the right judge. At the play's end, Kafka wrote, "Where was the Judge whom he had never seen? Where was the High Court which he had never penetrated?"

I submit to you, that judge, whether good or evil, comes not from the political system. He comes from our own values as a people, and the High Court which Joseph never penetrated is deep within our humanity and our hearts.

The State as Parent: Institutional Abuse

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INTRODUCTION

Institutional abuse of children is a more difficult problem than institutional abuse of adults. Adults, even in institutions, have certain rights of citizenship that children do not have. This is, perhaps, as it should be in certain respects. Parents must have certain rights over their children. Parents determine much of their children's life direction, and I, for one, would be afraid to tamper too much with parent's rights.

It is a different situation when the state makes decisions. The state cannot replace the parent. The best state institution cannot provide parental love. The state must act with due process with regard to all of its people, including children.

With regard to civil rights and the state, children are our last minority. Women, Blacks, Chicanos, Indians, all minority groups other than children have one distinct advantage--they are majors. They were able to get the power of the vote. With a voting bloc behind them, they were able to organize, develop leaders, and demand attention.

Children will not be able to do this. They will not get the vote or become organized. It is our duty as a society to do this for them. The most important role of any society is to raise its children. The way a society raises its children determines the future of that society. Recently, we have not done a very good job.

I believe parental child abuse is a secondary issue. As a society, we are not even doing a good job of teaching our kids how to read. As a society, we should be ashamed of how we treat children when we take them away from neglectful or abusive parents. Our track record is dismal. We must set a better example. When we can offer abused and neglected children a better alternative, then we will have a right to judge individual parental abuse and neglect.

There are many things that can be done. The courts and legislatures can open the door, but it is the public that must be informed and educated. An informed and educated public will force the proper change.

THE CASE OF *GARY W.* v. *LOUISIANA*

Five years ago I met Ken Wooden who was doing research for his book, *Weeping In The Playtime Of Others, America's Incarcerated Children*, McGraw Hill, 1976. Ken told me that Louisiana had sent thousands of children to out-of-state, profit-making "warehouses," and that thousands of lives were being crushed. I, the young "juvenile rights lawyer" did not know what my own state was doing. I later found out the interstate commerce of children is a big business involving many states, not just Louisiana and Texas. After being informed, prodded, and helped by this Irish Yankee, my regional pride took over and with more help from Edith Back and the Children's Defense Fund, I filed suit in September, 1974.

We sued on behalf of all Louisiana children in Texas. This meant suing 44 private child care institutions in Texas and several responsible Louisiana officials. Perhaps a hundred lawyers worked on different sides of the case. The Civil Rights Division of the U.S. Justice Department joined our side and the Federal Bureau of Investigation provided a lot of help.

Gary W. v. *Louisiana* went to trial in March, 1976. I could tell you many horror stories we proved at the trial. I would rather tell of one of the few cases that has a happy ending.

When Joey was two and one-half years old his father left home and Joey's mother applied for welfare. She was turned down because welfare required that her husband be gone for six months. The state said it would care for her children while she got on her feet. After a year, Joey had been to three foster care homes. His mother got back her other children, but was told she could not have Joey because he was emotionally disturbed. His file showed the evidence of his emotional disturbance was that every time his mother visited him he threw a tantrum and said, "I want to go home with my mommy."

Because of this serious emotional problem, Joey was sent to New York for six years and then an institution in Tyler, Texas, for three years. Then, we got a court order releasing Joey as part of the *Gary W.* v. *Louisiana* case.

During this time, Joey's mom contacted welfare officials monthly asking for Joey's return to her home. At the trial, Joey's mom remembered the names of each of the many caseworkers assigned to her case. Joey is now home, attending public school, and doing fine. Joey was labeled neglected by the state—Joey was neglected by the state.

When Joey was released, we were told he must be kept on medication. Our doctors took him off medication and he did fine.

When Joey was released, we were told he was retarded. He is not retarded. His last caseworker told me the state did everything they could for Joey. I wish they had done less.

The case was not about how bad some of the 44 institutions were; some were pretty good. The case was one of state abuse and neglect. Louisiana did not know much about any of these institutions. Louisiana children had literally been banished from their homes. Louisiana was spending seven and one-half million dollars for child care in Texas, but denied even knowing how many children they were paying for in Texas or what happened to them when they grew up.

In July 1976, Judge Alvin Rubin issued an order giving children certain constitutional rights for the first time. The order was 42 pages in length and with later supplemental orders grew much longer. Part of the order states:

> Involuntary institutional confinement of any person, adult, or child, entails a "massive curtailment of liberty." Such institutionalization stigmatizes those confined and may at times exceed even criminal incarceration in its destructive impact on an individual's personal freedoms...In return for this curtailment of liberty the state must consider means that are capable of achieving its purposes in ways that are least stifling to personal liberty, and it must offer a therapeutic consideration to the needs of the individual, treating him constructively and in accordance with his own situation rather than automatically placing in institutions perhaps far from home and perhaps forever, all for whom families cannot care and all who are rejected by family or society.

Judge Rubin did not say we could not send children across state lines. But he did say that each child must be diagnosed and treated according to an individualized treatment plan. That individualized treatment plan must consider the child's need to be near his family and community. The court order also provides minimum constitutional standards for institutionalization.

Gary W. v. *Louisiana* will not close our large institutions any more than *Brown* v. *Board of Education* integrated schools in 1954. We won a battle but still have a long war.

AN ALTERNATIVE TO INSTITUTIONALIZATION: DEINSTITUTIONALIZATION

It is impossible to provide real love to a child in an institution. Institutions separate persons from the real world, making it difficult for them to reenter. Children in institutions adjust to being taken care of and do not learn to be responsible for their own actions.

Children raised without love are scarred for life.

Institutionalization of children guarantees only one thing—that they will grow up to be institutionalized adults.

Two classic cases of institutionalization are Charles Manson and Gary Gilmore. Both spent more than half their lives locked up before we heard of them. Every time they were let out they would do something to get locked up again. I do not know the full biography of Gilmore, but Ken Wooden's book has a chapter on Charles Manson everyone should read. Charles Manson began living his life in institutions as a status offender, for the crime of poorly choosing his parents. As we know, the state did not do a good job of nurturing him.

I believe the state could do better, and it is not a problem of lack of money. The majority of children in institutions could be served better and more cheaply outside of institutions. Neglecting parents who are neglectful because of poverty and ignorance could be helped through education and services such as day-care and crisis care centers. Group home, foster care, and community-based residential centers all cost less than institutions.

When I tried *Gary W.* v. *Louisiana* in federal court in New Orleans, the state attempted to argue that institutions are required because foster care has a high failure rate. This is true, especially when the foster care program is designed to fail.

If you pay foster parents an amount which is less than it takes to care for the child, you are setting up a program which will fail. If you do not provide foster parents with the support services they need, you are setting up a system that will fail.

If the right way does not cost more, if the courts are convinced, why does it not change faster? Change is slow because of politics and the economics of bureaucracy and instititions. Institutions are made by architects and cement mixers who have friends in politics. Institutions provide political patronage jobs. The state bureaucracy is rewarded for failure, not success. If we deinstitutionalize, the bureaucratic empires of state departments are threatened. Their budgets grow by getting more warm bodies, not by sending them back to the community.

As a society we must learn to reward success, not failure. We can do this by setting up systems that hold government and officeholders responsible for their actions, and by holding ourselves individually responsible for our own actions.

It is all too easy to banish children to other states, to send convicted criminals to large rural prisons. We think that by doing this we rid ourselves of our problems. Out of sight, out of mind, but the solution is only temporary. We do not like to admit it, but Charles Manson and Gary Gilmore are products of our culture. Obviously, most of the products of our society are not Mansons or Gilmores. Just the same, we cannot simply ignore these men as deviants. Our society—our institutions—made them, too. They may be an extreme, the failure rate of our large institutions may not be always as dramatic as it was with these men, but it is a failure rate that should temper our righteous anger at individual parents who fail. If we want them to do better, we must set a better example.

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Children—The New Social Deviants

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Our panel was assigned the topic of the state as parent, specifically as this relates to institutions designed to provide for children. There are several ways to approach the subject. We can talk about residential instititions made of bricks and mortar. We can talk about social institutions to serve children in their homes. The former includes the sprawling edifices filled with those children the community does not want to look at, for example, many of the mentally retarded. The largest community institution for children is Aid to Families with Dependent Children (AFDC), designed to ensure there are no swollen bellies on the streets. Children, however, are abused in both instititions, and each was established or expanded following revelations about abuse or shortcomings in the other.

In 1909, a now-famous White House Conference on Children, reacting to abuses under the nineteenth century orphanage concept, concluded it was wrong to separate children from their families because of economic hardship. The ultimate result was AFDC, subsequently found wanting. So the "treatment" orientation began, designed to cure the children of the poor of the ills that were often created by the system.

In 1977 we are reacting again to abuses in residential institutional care. The move is toward deinstitutionalization, and my question is whether we will do any better this time.

I believe the institution v. community care debates we go through every few decades generally bypass an important underlying issue. The state role of parent grew as a consequence of its children becoming social deviants, not needed and thus not valued by the society. The institutions, brick and mortar and the other kind, are set up to treat deviants. The social sciences and helping professions helped put them in this position and help keep them there.

For the purpose of this examination, a deviant is defined as "one to whom the label has been successfully applied" (Becker, 1963). The 1974 Merriam-Webster Dictionary defines the verb "deviate" as "to turn aside from a course, standard, principle, or topic," and a "deviant" as "one who deviates from some accepted norm." These definitions depict deviant behavior as acts of will, and coincide with the traditional stance of the social sciences, in which the cause of deviance is sought within the deviant individual.

Howard Becker (1963, 1966, 1973) in sociology and Thomas Szasz (1961, 1970) in psychiatry, both of whom first challenged the traditional position, became leaders in the so-called "labeling" school, in which it is posited that the society makes rules which a deviant breaks, therefore, the deviant is labeled an outsider (see also Erikson, 1964; Friedson, 1965; Hobbs, 1974; Lemert, 1951; Scheff, 1966; Schur, 1971). Rules are broadly interpreted to include the positive value placed on good health as well as codes of conduct. Thus, an individual who possessed alcohol in 1920 was no deviant. That same individual, however, was a criminal a few years later under Prohibition. Similarly, an aged person who lost his memory in a nineteenth century community broke no rules defining sanity. Fifty years later, though, he had a psychiatric label and was confined to an institution. Another study shows that persons with perceptual handicaps such as blindness have been singled out for treatment as deviants in areas not related to their handicaps (Friedson).

Rulebreakers will fall under the rubric of social problems, and Becker described the process by which a condition becomes a problem:

> In an early stage some person or group perceives a condition as a potential threat to their values. Widespread concern develops gradually after that person or group points out the condition to others and convinces them that it is a problem. When enough people are concerned, institutions are established and charged with the responsibility of monitoring, controlling, and eradicating the problem. At this stage, an official agency assumes responsibility...The public slowly loses interest. But agency personnel, whose lives and careers have become dependent upon the problem, must now act to insure its continued existence by repeatedly redefining the problem as great and widespread to various segments of the population. The agency must continue to generate cases, information and data to support these claims. Thus, there is the continuous process of valuation and public definition of "problematic conditions" (Becker, 1966).

The production of statistics, rates of prevalance of problems, produced in the early stage are suspect among followers of the labeling school. One researcher observed that even rates for suicide, which would appear to be most objective, depend upon a complex social process involving place, status of the deceased, actions of family members, physicians, and public officials which precedes the designation "suicide" on a death certificate (Schur).

Another aspect of the institutionalization of social problems, discussed by Hobbs in his study of the consequences of attaching labels to chidren, is professionalization, in which systematized methods are applied to resolve social problems. The technical limits of a profession become territorial boundaries to be jealously guarded. But Hobbs noted that even though the same types of children are to be found in all the different territories, no professional will relinquish turf (Hobbs).

Labels also serve a society by naming its scapegoats. Psychologist Jeffrey Eagle said, "The nation needs scapegoats for survival, especially during an economic cycle. (For instance, a relationship has been established between cotton prices and lynching incidents.) Changes occur when people protectively identify with the scapegoat or when the needs of a group change. But the process will be activated when it is needed" (1976).

Because of the ease of communicating today, various groups, ranging from gays to lepers, who have been scapegoats in the past or who are potential scapegoats, have been organizing, creating their own media, and lobbying for the rights available to others, and to acquire the organizational power which is a primary antidote to scapegoating. It is this paper's contention that today's new scapegoats are children, who alone lack the power of organization. Furthermore, the social position of children has changed from economic asset to liability, making them dispensable and likely candidates for scapegoating.

Child deviants differ from other deviants in several ways. They may be labeled deviant without due process of law or any of the other ceremonies attending the assignment of deviant status to adults (e.g., mental hospital commitment, or conviction of a crime). They cannot organize into power blocs. Their status is future investment or consumer, both of which depend upon others to provide for their development and the means of consuming.

An estimated 7,083,000 individuals under age 20 are labeled retarded, emotionally disturbed, perceptually, neurologically, or orthopedically handicapped, with speech defect, learning or developmental disability; another group called antisocial and appearing in juvenile courts numbered over one million in 1972, or 2.9 percent of all children ages 10-17 in the United States; and, another 10 million were classified as poor in the 1973 census (Hobbs). That these numbers reflect an increase in the trend to attach labels, with its consequences, is evident in the increase of 150 percent in mental hospital admissions of teenagers between 1960 and 1970. And children were the only group whose rate of mental hospital admission did not decrease between 1961 and 1970 (NIMH, 1972). In addition to state institutions which house all age groups, in 1965 there were 4,000 residential children's institutions in this country, ranging from large state training schools for adjudicated delinquents to small establishments for emotionally disturbed children. In 1923 there were only 1,599 orphan asylums (NASW, 1971).

A century ago a child was an essential part of a family economic unit, although change was underway as a result of industrialization and the consequent need of the nation for a different sort of laborer. The first step in the change was the establishment of free public schools after the Civil War. In following decades, children were needed to supplement the labor force during wartime, to join the industrial work force during expansion and curtailed immigration, and to replace war dead. From the turn of the century until the late 1950s, children were publicly acclaimed to be valuable assets.

Three events drastically altered their condition: (1) the *Brown* v. *Board of Education* ruling of 1955, which forced a change in our school systems that is still resisted in many localities; (2) the migration of two million rural Blacks to urban centers in the 1950s, which ended the invisibility of their children; and (3) the launching of Sputnik I by the Russians in 1957, which was immediately followed by emergency appropriations to accelerate training in the sciences, mathematics, and foreign languages and to train school counselors to locate potential scientific talent.

Samuel Bowles' study demonstrated that the American educational system has had a built-in class bias from its beginnings, with differing expectations of working-class and middle-class children (Lightfoot, 1976). A 1972 study showed that teachers reward working-class children for passivity, withdrawal, and obedience, qualities needed by unskilled labor; and middle-class children for individuality, aggressiveness, and initiative, qualities needed by scientists and executives (Lightfoot).

New demands made on the educational system in the late 1950s required the production of a greater number of individuals trained in the sciences but also with the docility required of workers in a technocratic economy. One result has been a hard official line toward those children unable to perform according to new expectations. Suspensions and expulsions of children from schools for minor infractions or inability to perform became commonplace and widespread. Behavior-controlling drugs are said to be administered to an estimated one million children, labeled minimally brain damaged, a diagnosis which is acknowledged even by those who apply the drugs as having no supporting medical evidence other than the children's nonconforming behavior (Messenger, 1975). Corporal punishment, if practiced in the 1940s, was done furtively and apologetically, but is now official practice in most school systems. In 1977, that practice was upheld by a U.S. Supreme Court decision.

Children have been kept out of the labor market for longer and longer periods, beginning with prohibitions against child labor at the turn of the century. By the 1950s, various direct and indirect public subsidies to higher education and the raising of minimum age requirements for work kept the young out of the economy for as long as their mid-twenties. Hence, children are economic burdens to their families for longer periods. But, given new requirements for entering that work force, as the Coleman Report shows, neither the family nor the school can provide guidelines to secure the children's economic future (J. Coleman, 1974).

However, the prevailing milieu of what Howard James (1975) calls "hedonistic consumerism" requires that children as well as adults perform as consumers. One consequence has been the commission of more violent crimes by the young (Seide, 1976). A few years ago, I spoke with a group of four teenage house burglars, all of whom were Black, illiterate, expelled from school during their junior high school years, and living in a ghetto in which 80 percent of their peers were unemployed. Like the good social worker I was trained to be, I told them of my concern for them, pointing out that their activities would harm them. (One was subsequently killed by police bullets during an armed robbery; another is serving a sentence in a state penitentiary.) The leader replied, "That's all well and good for you to tell us not to be burglars. But you tell us how we are to get the things we need if we don't steal." The hedonistic consumer ethic taught these boys that they needed suede boots and a ready supply of cash to spend in fast food stores.

What few attempts have been made to change the circumstances of children have generally emanated from the parents of certain children, notably the mentally retarded, who have succeeded in the courts in establishing the rights of all children to a public education, an action which runs counter to the national purpose of using the schools to produce technicians while the rest are relegated to the streets. Other moves came from legal groups concerned about excesses in the juvenile court system which resulted in denial of basic constitutional rights to children. These groups (e.g., American Civil Liberties Union, Children's Defense Fund) have taken to the courts on behalf of children in class actions.

Hobbs, answering his own question about public apathy toward the plight of children today said, "part of the problem grows out of the preemptive power of categories and labels...The citizen perceives the seriously handicapped or the delinquent as being categorically different and is thus unable to involve himself effectively in the humane treatment."

Even the women's movement has avoided the issue of the condition of today's children in the society. If children are mentioned at all by the movement, it is usually in connection with demands for day care or other services, not because these services are good for children but because they will free women from the "dirty work" of raising them (Claiming that dirty work should be shared with men merely begs the question). And those making such statements forget that children will hear and react to them just as those persons who spoke of "depraved niggers" or the "yellow peril" pretended that black and yellow people were invisible and deaf.

Early in 1976, Ann Landers asked her readers, "If you had to do it over again, would you have children?" A startling 70 percent of those replying said no, a finding which produced a few headlines and irate letters from dissenters. However, Dr. Harcharan Sehdev, director of the Children's Division of the Menninger Foundation, commented, "The Landers letters appear to reflect the general changing trends and opinions of family systems and the place of children in our homes and society. It is a myth that Americans love their children" (Landers, 1976).

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The Legal and Social Limitations Upon State Involvement in a Parent-Child Relationship

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The discussion of protective services for children generally focuses upon a search for the "child's best interest" and the means to obtain it. There are, however, more fundamental questions—questions which generally concern the courts, often to the frustration and bafflement of the social work profession.

The family is a vital social institution, and its integrity is protected by the United States Constitution. Those two fundamental and interrelated considerations, one social and one legal, often support the continuation of a family relationship even when it is contrary to the child's best interests. They generally prevent the severing, even temporarily, of the custodial parent-child relationship, except where:

1. The danger to the child, as judged by standards on which there is a concern of social opinion, is severe;
2. The interference is less detrimental than noninterference; and
3. There are no less drastic means available which will accomplish substantially the same purpose (known in law as the doctrine of "least restrictive alternative").

Some of the legal and social considerations which give rise to those guidelines are set out below with the hope that their understanding will, to some degree, demystify the reluctance of the law to consistently pursue what is best for a child—a reluctance which may otherwise appear callous and insensitive.

CONSTITUTIONAL PRECEDENT

There is a fundamental constitutional right—encompassed within the "liberty" protected by the Fifth and Fourteenth Amendments—to the integrity of the nuclear biological family unit. It has been most frequently articulated by the Supreme Court in terms of the rights of parents to maintain the custody and control the upbringing of their children.

The seminal case for this principle is *Meyer* v. *Nebraska* in which the Supreme Court upheld the rights of parents to have their children taught the German language.[1] The Court, referring to the integrity of the family as a "basic civil right of man," for the first time squarely held that the "liberty" guarantee of the Fourteenth Amendment "without doubt...denotes...the right of the individual...to marry, establish a home, and bring up children."[2]

In dictum, the Court considered Plato's recommendation that children be raised, not by their parents, but by "official guardians," and concluded:

> Although such measures have been deliberately approved by men of great genius, their ideas touching the relation between individual and State were wholly different from those upon which our institutions rest; and it will hardly be affirmed that any legislature could impose such restrictions on the people of the State without doing great violence to both the letter and the spirit of the Constitution.[3]

Two years later, in *Pierce* v. *Society of Sisters*, the Court struck down an Oregon statute which required that parents send their children to public rather than private or church-sponsored schools.[4] That law, the Court held, interfered "with the liberty of parents and guardians to direct the upbringing and education of children under their control."[5]

Similarly, in *Prince* v. *Massachusetts*, the Court, in holding that a state may prohibit the sale of magazines by children (even if of a religious nature) on the public streets, noted, nonetheless:

> It is cardinal with us that custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the State can neither supply nor hinder.[6]

Later decisions have reiterated the principle that the family is a constitutionally protected enclave encompassed within the concept "liberty." In *Skinner* v. *Oklahoma*, the Court included within the scope of this right the right to procreate, and invalidated a statute providing for the sterilization of habitual criminals.[7] Likewise, the Court denied interstate recognition of an order from a custody hearing (obtained without notice to all proper parties) in *May* v. *Anderson* In that case, the Court described the rights of the family as "far more precious...than property rights."[8]

More recently, the Court described the right as "freedom of personal choice in matters of marriage and family life," and invalidated the city of Cleveland's mandatory leave provision for pregnant school teachers. *Cleveland Board of Education* v. *LaFleur*.[9]

In *Stanley* v. *Illinois*, the Court held the Illinois dependency statute, which did not accord the protective status of "parent" to unwed fathers, to be constitutionally defective.[10] The Court described the right as one which "come(s) to this Court with a momentum for respect lacking when appeal is made to liberties which derive merely from shifting economic arrangements."[11]

The integrity of the family also finds protection within the scope of the right of privacy which, although not spelled out by the Constitution, is implicit in the Bill of Rights. Upon that theory, the Court has upheld the right of a married couple to use birth control devices as noted in *Griswald* v. *Connecticut*.[12] And, most recently, in *Roe* v. *Wade*, the right of a woman to obtain an abortion was supported by the zone of constitutionally protected privacy which surrounds the family relationship.[13]

A CONSTITUTIONAL RATIONALE

Apart from encompassing the family within the concepts "liberty" and "privacy"—a process which is more one of definition than analysis—the Supreme Court has, curiously, never explored the fundamental constitutional rationale for the family's protected status. They have treated it, indeed, as if the constitutional foundation for the right was too self-evident to be discussed.

The principles may be elusive precisely because they are so basic. More fundamental even than the liberties of the Bill of Rights is the concept pervading the Constitution that the government it creates—and, indeed, any government consistent with its principles—be one of limited powers. The family, as an institution, is essential in maintaining that system.

The two most important institutions which affect our behavior and influence our lives are the family and the state. If you weaken one, you strengthen the other. Any system of laws which has as its touchstone a curb on the powers of the state must rely for its survival upon the strength of some countervailing force. The family, if only for the reason that it fills what would otherwise be an enormous power vacuum, is that force.

Where the family dissolves or functions below a socially acceptable level, the state inevitably intervenes. The state will, thus, take in the abandoned child, rescue the neglected and abused one, coerce compliance with the duty of parents and children to support each other, and direct in the most minute detail parental behavior of divorced spouses. If the family were to dissipate as an institution or its vitality were sapped, the state would inevitably sense the vacuum and inexorably fill the void. It would, by that one stroke, cease to be a government of limited powers.

The unspecified rights reserved to the people by the Ninth Amendment and those guaranteed by the concept "liberty" include the family because constitutional government cannot function without it. That principle is a silent premise in any child protection proceeding and serves as an inflexible limitation on any postulated "rights of children" which rely for their efficacy upon sovereign intervention. The question is, thus, not just, "Is this in the child's interest?" but also "Do we want the state to have this power?"

FOOTNOTES

[1]Meyer v. Nebraska, 262 U.S. 390 (1923).

[2]Ibid., 262: 399.

[3]Ibid., 262: 402.

[4]Pierce v. Society of Sisters, 268 U.S. 510 (1925).

[5]Ibid., 268: 234-235.

[6]Prince v. Massachusetts, 321 U.S. 158 (1944).

[7]Skinner v. Oklahoma, 316 U.S. 535 (1942).

[8]May v. Anderson, 345 U.S. 528 (1956).

[9]Cleveland Board of Education v. LaFleur, 94 S. Ct. 791 (1974).

[10]Stanley v. Illinois, 405 U.S. 645 (1972).

[11]Ibid., 405: 651.

[12]Griswald v. Connecticut, 381 U.S. 479 (1965).

[13]Roe v. Wade, 410 U.S. 113 (1973).

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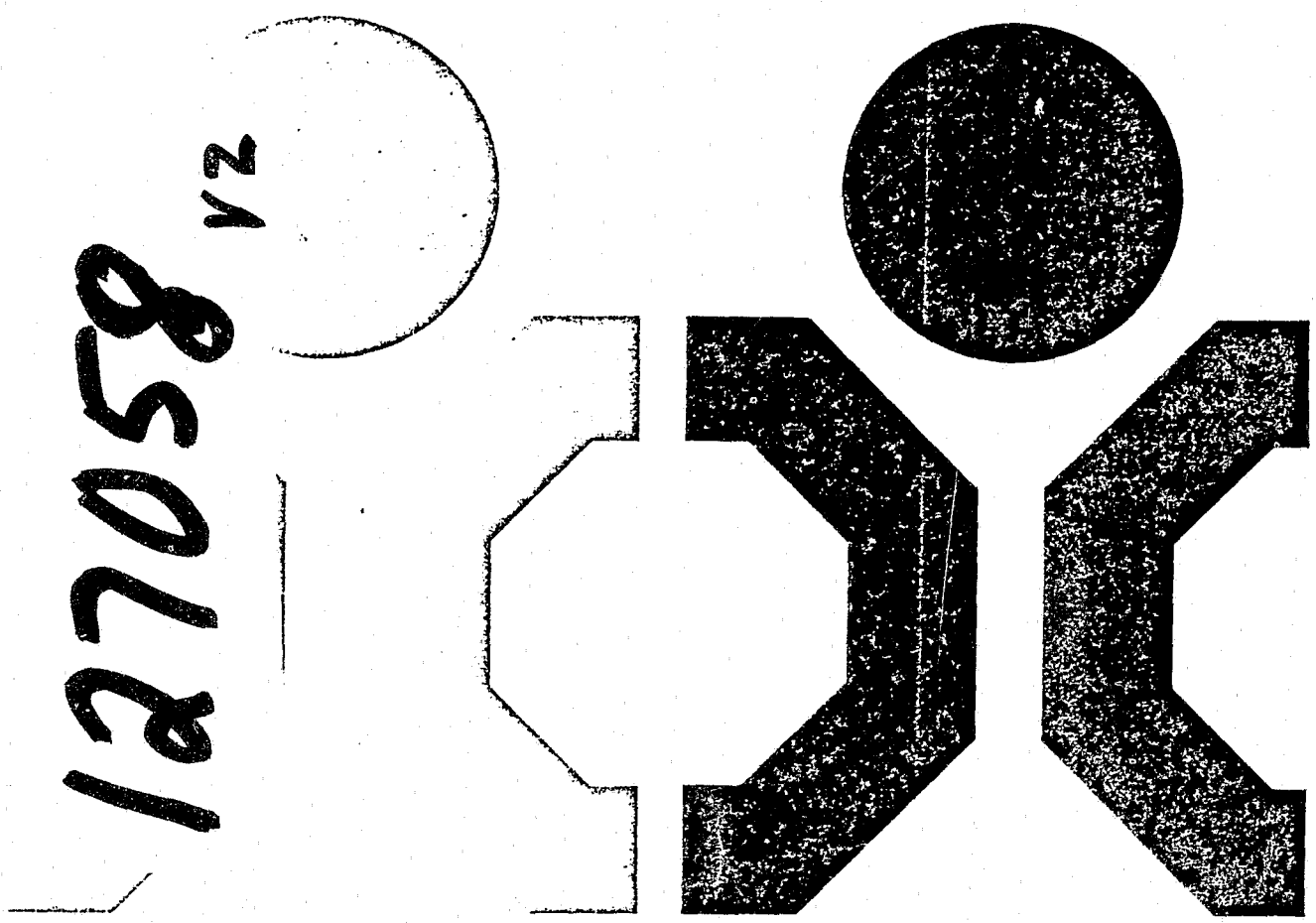

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Edited by:

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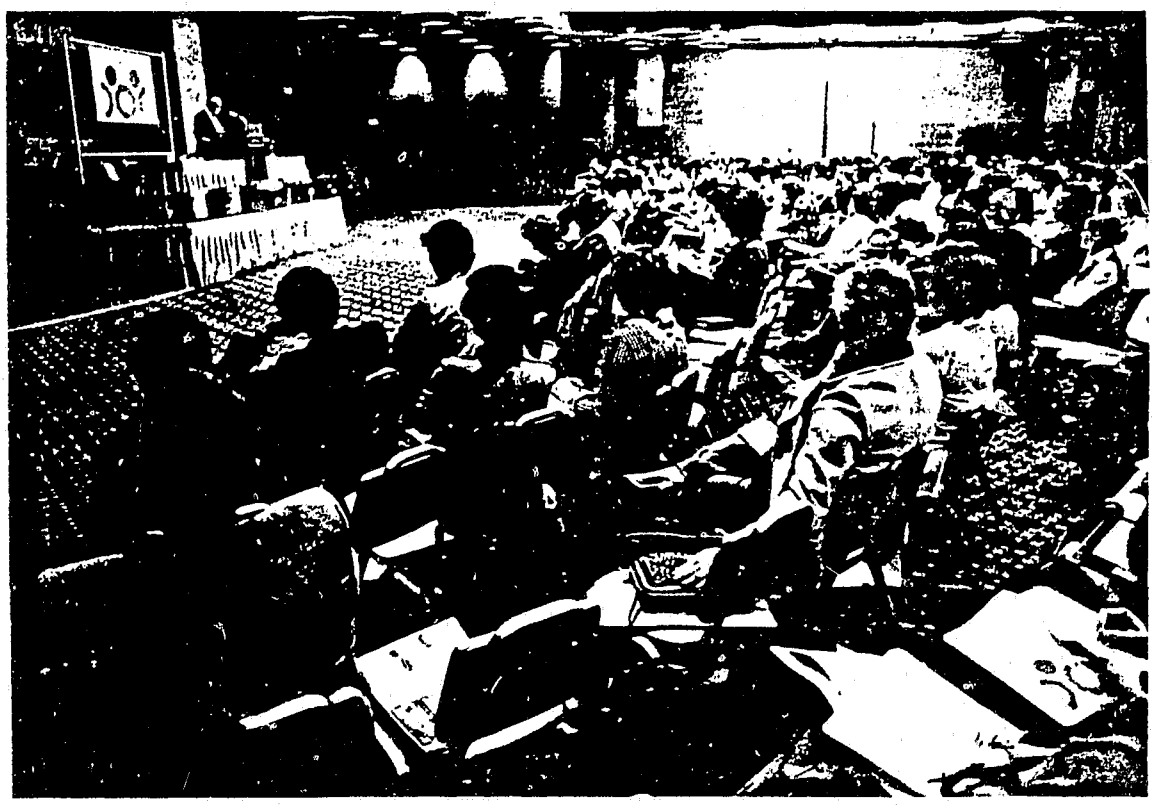

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DELIVERY SYSTEMS

The concept of delivery systems as discussed here goes far beyond the traditional caseworker-client interaction. An important issue is the form that the delivery systems will take: the sorts of professionals or non-professionals who will serve as the primary service providers and the relationship of the various disciplines involved in providing services to the family. An essential of any service delivery system is a means of evaluating the results of the intervention, both for accountability and for case management decisions. Management, organizational issues, and staff development also receive emphasis in this section, especially as they relate to the phenomenon of burn-out.

In the area of *community resource development*, ideas range from establishment of child abuse and neglect programs in unique settings, such as Indian reservations, to expanded use of existing systems, such as school systems, Head Start, and nursing education. Important considerations for any resource development effort are the relevant legislation and funding sources (e.g., Title XX), the values and priorities of the community to be served, the inclusion of a spectrum of community representation, and effective liaison and communication within the system.

Papers on *comprehensive services to families* include the multi-disciplinary comprehensive emergency systems (CES) as well as specialized services such as foster care. An important consideration is the provision of services to the total family, in order to strengthen, and not fragment, this already stressed entity.

Special populations may be defined by personal characteristics, affiliations or subculturel, or area of residence (i.e., urban vs rural). Although points of entry may be different, it becomes clear that the potential for positive intervention in preventive aspects, such as parent education, as well as in assisting abusive and neglecting families, is present in many locations. The attempts of the United States Armed Forces to deal with child abuse and neglect within the military population are an interesting example of the former.

The success of *alternative approaches*—volunteers, lay therapists, self-help—poses a difficult question for professionals: whether to invest resources to further develop existing service models or to move to completely new models of service delivery.

Burn-out is a large concern in the area of *management and staff development*. Related to personnel characteristics, management processes, and organizational structure, burn-out can be minimized through flexibility, support, responsibility, and, paradoxically, through increased—not decreased—emotional involvement with clients. Management techniques such as nominal group process, functional job analysis, and case management evaluation can also serve to increase efficiency and effectiveness to the benefit of clients and staff.

Community Resource Development

Planning Community Protective Services Through Organizational Development

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While much of the recent interest on child abuse and neglect has been stimulated at the federal level, many local communities are taking important steps toward improved protective services. In order to develop innovative protective services, a supportive public, as well as service agencies must plan strategy and programs which fit community values and standards.

In pursuing improved protective services, local planning groups must face the difficult tasks of developing and maintaining public support, identifying goals and objectives, and implementing change in the system. Accomplishing these tasks is often a lengthly and frustrating process, especially for those groups who do not follow a specified planning methodology.

One method which has been used successfully in local planning is a seven-step process called the "Organizational Development Planning Model". The steps in this model were designed by combining a series of techniques which have been proven in management, decision making, and community development. The model is presently being used by the Region IV CA/N Resource Center to assist three rural South Carolina counties in planning a multi-county protective service system. It is also being used in Florida, where several communities are developing child abuse and neglect prevention programs. This paper will discuss the seven steps of the model and the desired outcome of their application.

Step I - Entry

In this initial planning step, an external or internal planner gains recognition, legitimization, and acceptance among a broad group of decision makers. Several organizations are identified as essential to the planning effort. In each of these key agencies, a key person is identified who endorses the planning effort. The key people are responsible for recruiting others in the community for the planning effort. This is a simple procedure for network building.

In order to prevent the development of a closed planning group, the planners require that four "constituencies" be represented in the network. The constituencies are as follows:

1. Resource Providers—This includes groups and individuals who provide program resources such as money, manpower, or material for local services. This group may include federal, state, and local funding agencies as well as foundations and industries.
2. Direct Service Providers—This group includes people who work directly with abused and neglected children and their parents.
3. Technology Developers—This group includes people who manage local programs which are relevant to protective services.
4. Service System Supporters—This includes the advocates who are interested in child welfare but not a formal part of the service system.

The network is organized to represent these four constituencies. The network may be formally or informally organized. Networks of several hundred people are not uncommon.

Step II - Needs Assessment

Needs assessment is a traditional aspect of planning. In this model, however, this step involves the use of nominal group process, a structured decision making technique. In this process a group of ten people, representing all of the four constituencies, attends a planning workshop, completes a needs assessment, and establishes preliminary protective service goals. The nominal group process requires five hours of group participation.

Step III - Negotiation

In the nominal group process, a great deal of data is generated. The data should indicate points of conflict among the perceptions of the four constituencies or among agencies. In the negotiation step, a facilitator helps the group resolve conflicts which might be a barrier to

planning. The aim of negotiation is to establish, by consensus, a set of priority goals for the improvement of protective services. Once established, the consensus goals are discussed in the total network where suggestions for modification are considered.

Step IV - Diagnosis
In this step, groups are organized to develop strategies to achieve the negotiated goals. Strategy sessions are conducted using the force field analysis technique, which involves analyzing the forces present which would encourage or discourage accomplishment of the goals. When an overall strategy is agreed upon, a formal committee or task force is established to implement the strategy.

Step V - Action
This step is translating the strategy into specific activities. In the process of implementing the strategy, opportunities for achieving the goals are identified. The task force works to eliminate the forces which hinder the realization of improved protective service goals.

Step VI - Systems Change
In this step, a full or partial goal is realized. The network takes specific action to ensure that groups and agencies institutionalize the changes brought about by goal achievement.

Step VII - Synthesis and Maintenance
This is an evaluation step where the network determines if the changes in the protective service system have brought about desired results. The positive changes are continued and some aspects of the changed system such as short-term projects may be discontinued. The network now returns to the Needs Assessment step to address new issues.

DISCUSSION
This Organizational Development Planning Model must be facilitated by a trained internal or external consultant. While the techniques of the steps are simple, the supporting theory is complex. In addition to the technical expertise in using the model, a consultant is often in a better position to analyze group and inter-group dynamics in the community and make positive interventions where conflict, frustration, or apathy might exist. The consultant's role is to keep local planning moving by facilitation.

While a consultant is almost always required, the model is specifically designed to develop self-reliance among local groups. While a consultant is indispensable in the network building, the nominal group process, the negotiation, and the force field analysis by the Action step, community groups should have developed enough organization and self-motivation to continue the process. The Action, Systems Change, and Synthesis steps should require little consultant intervention.

One advantage of this methodology is the positive effect of tangible results of planning. The first four structured steps produce a working network, a needs assessment, consensus system goals and a formally analyzed strategy in a short period of time. These results and the idea generation and negotiation experiences that produce them provide a firm foundation which maintains local planning efforts.

CONCLUSION
The Organizational Development Planning Model can be used in any planning or decision-making situation requiring group action. The model concentrates at a task level, building networks, assessing needs, and establishing goals and strategies. More important, the model structures group processes where decision makers can work together in a setting of collaboration and cooperation. The development of issues, exchange of information, and shared decision making in the network ensures that diverse sectors of the community have input into planning better protective services.

Mobilizing Communities to Deal with Child Abuse and Neglect

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For abused and neglected children to receive effective intervention, there must be a consistent adult working side-by-side with the child, on behalf of the child, and exclusively responsible for the child's best interests.

With the complex multitude of programs addressing different aspects of child abuse and neglect, it is paramount that there be one person whose role is to appreciate the impact of those programs from the child's perspective. At a minimum, this means that the strengths in a child's life, both internal to the individual himself as well as the external supports, must be assessed and enhanced. Simultaneously, deficits must be identified and either eliminated or neutralized so that they do not distract from the strengths. This requires viewing the child's life from his perspective in order to gain clues as to appropriate interventions.

An important consideration is that workers serving children have at least two clients, their agencies and the child. Since multiple clients invariably produce a potential for conflict of interest, it is imperative that people who work with children not be obligated to their organization should conflicts arise.

For agencies and organizations, the above statements imply that there needs to be at least one person alert to these potential conflicts of interests among clients who has the freedom to appreciate the child's perspective and to comment upon programs intended to serve the child. The child medical evaluation physician and the guardian ad litem are two examples of programs whose participants serve the child's needs exclusively and are not primarily responsible to organizations. The mixture of people serving the child's needs and those of organizations and agencies can be productive and enhancing to the child's life, but this is possible only if the person working directly with the child has skills, credibility, and power to be heard when conflicts of interests arise.

One organizational placement for programs that has served the North Carolina Child Abuse and Neglect Resource Center well is the Department of Pediatrics, Division of Community Pediatrics. This organization provides an impartial place of credibility and direct access to both children and agencies as well as professional individuals. In addition, the inclusion of interested citizens in working with families has become an increasingly invaluable resource.

Mobilizing Communities to Deal with Child Abuse and Neglect

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This paper briefly describes two programs in North Carolina which are designed to increase the quality and quantity of community participation in child abuse and neglect programs. The first program, the North Carolina Child Abuse and Neglect Resource Center, is a federally-funded project whose primary function is to assist individuals, groups, and organizations in the state in improving child abuse and neglect services. The second, the Child Medical Evaluation Project, is funded through Title XX and provides funding and support for physicians who evaluate abused and neglected children referred by local departments of social services. Both programs are unique: the Resource Center is one of the few in the United States that serves only one state instead of a region and can afford to work directly with local counties; the medical evaluation program is the only state-funded program of this nature that has attempted to organize local physicians and monitor their reports.

NORTH CAROLINA CHILD ABUSE AND NEGLECT RESOURCE CENTER—WORKING WITH LOCAL COMMUNITIES

Although the Resource Center is engaged in many activities, its primary goal is to help create and support groups in local communities which will accept the responsibility for the way their communities handle child abuse and neglect. The Resource Center defines its clients as all agencies and groups within the state's one hundred counties. Some of these groups, such as social services, mental health, and public health, are traditional services providers. Others, such as Junior League and Agricultural Extension, have not been traditionally identified with child abuse and neglect.

This particular focus grew partly from our assumptions about the nature of the environment:

1. Community services to abused and neglected children are unorganized and fragmented;
2. Child abuse and neglect is a community problem, not solely the responsibility of any one agency or group;
3. The best way in which to provide effective change in the services offered to families is to work directly at the level where those services are offered. Changes in state agency policies and procedures will occur as local communities organize and demand them;
4. The best way to create change at the local level is to increase the number of people and groups who accept responsibility for child abuse and neglect.

The Center's approach is also determined by the political and financial realities of how the state provides services to needy families.

North Carolina is made up of one hundred strong counties with a relatively weak state government. Many state agencies are weak both in their ability to directly affect what happens in each county, and also in their ability to provide support and direction to the agencies at the county level. For instance, the regional representatives of the Division of Social Services have thirty-one different programs to monitor in each county. The situation of limited manpower and a large number of counties means that some regional representatives visit each county on the average of once every six weeks. The State Protective Services Office has only three staff members, one of whom works full-time on the Central Registry, and must go through higher administrative units before having access to the field representatives. Their budget is small and time to work directly with counties is limited. There are no field staff who have protective services as their sole responsibility.

Within the counties themselves, there is often little cooperation between agencies. Departments of social services, mental health centers, and public health departments generally have separate administrative staffs and are not located together. Although they serve many of the same clients, they perceive their missions as being different and, consequently, real coordination, such as joint staffing of cases, is rare. In some cases, they do not even refer cases to each other. Neither the Division of Health Services nor the Division of Mental Health Services at the state level presently has policies or procedures for the local agencies' use in working with child abuse and neglect cases.

The child abuse and neglect law in North Carolina mandates reporting to the department of social services in the county in which the alleged offense occurs. But local departments vary widely in their resources and training. Some counties have separate child protective services staffs, while others assign the cases to the general service staffs. Because local county governments decide on budget and staff for each agency, counties also vary in their allocation of resources to protective services. Staff turnover is often high, training is usually done by the "sink or swim" model, and caseloads are high. Generally, county department of social services protective services workers are hard pressed to keep up with emergency situations, and long-range planning for prevention programs and inter-agency coordination is difficult.

Our first step was to increase the awareness of the community about the nature of abuse and neglect. During the first year of the grant, the Center participated in over twenty-two conferences involving over 2,500 people. While the stimulus for the conferences came from local individuals, the Center increased participation by asking that steering committees, involving local people of differing backgrounds, be formed to plan and advertise the conferences. Center staff then worked with these committees in providing speakers and materials. Where possible, we also asked that the second day of the conference have time for participants from each county to meet together and talk about ways in which they could work together. Nominal group process techniques were used to help the groups set goals and objectives. A number of these local groups have continued to meet and the Center has provided consultation to help them in their programs and organization.

We have found that these activities have become self-initiating. One county hears about another's conference and wants to put together one of its own. The Center has supported these local activities while incorporating our own agendas of increased participation, local program planning, and the use of local professionals as "experts".

In the past year, a number of other organizations have become involved in increasing citizen awareness of child abuse and neglect. Local chapters of the State Mental Health Association, with guidance from the state organization, have organized conferences in their communities and used the Resource Center for materials and speakers. County Agricultural Extension Homemakers have organized conferences in the counties to make citizens aware of abuse and neglect of children, adults, and the handicapped. The State Protective Services Office brought together a large group of interested professionals to plan a state-wide public awareness program (S.C.A.N.P.A.C.), which is based on local committees in all one hundred counties. The Resource Center helped by gathering information and identifying local personnel to serve on committees. In many of these activities, our role is limited to supporting others' efforts.

Although public awareness programs and conferences have covered nearly all of the counties in the state, skills training for professionals in the counties has been limited. The most comprehensive training has been provided by Group Child Care Consultants, an organization working out of the UNC School of Social Work. Group Child Care Consultants received an HEW contract to put on eight training programs in the state during 1977. The Resource Center developed a one-half day program on the medical and emotional aspects of child abuse and neglect to complement these training sessions.

In all of our activities with other groups and communities, the Center has two agendas: (1) to provide accurate and stimulating information, and (2) to bring together local resources and groups which can continue to work in the community. For example, in the Group Child Care training sessions, the Center identified local physicians and mental health people to be on the discussion panels. This allowed participants to identify local resources and, as a by-product, appears to have stimulated the professionals involved to "bone-up" on child abuse and neglect. Through their participation, they have become more visible and knowledgeable about their communities.

Because interest in child abuse and neglect is so widespread in North Carolina, it has become clear during the past year that the Center need no longer stimulate communities to hold conferences for public awareness. Others are doing this and request our support when they need

it. The focus of our activities has changed to working directly with groups and individuals in the counties to improve working relationships between agencies, and helping with staff development for professionals seeing abused and neglected children and their families. Some of our activities have been:

1. Work with local school districts in developing policies and procedures for reporting and dealing with abuse and neglect cases identified in the schools;
2. County visits in which we ask that interested staff of county agencies meet to explore how they can better work together with abuse and neglect cases and how they can effect change within their own agencies;
3. Through the use of NCCAN and other curricula, to help professionals increase their skills in dealing with cases;
4. Work with local hospitals, especially emergency room staff and hospital social workers, to develop policies and procedures in reporting and treating abuse and neglect cases;
5. Continued work with local committees to talk about prevention and services to all families in their communities.

An important contribution to making people aware of our services in these areas has been the mass distribution of the Center's brochure. This brochure outlines the history of the project and has a tear-off mailer with a list of services we provide. It was mailed to every social service office, mental health center, public health department, and Agricultural Extension office in the state. We also mailed brochures to all hospital social workers and NASW social workers. Together with the state department of public instruction, the Center has prepared a packet of information to be sent along with the brochure to every principal, school social worker, and superintendent in the state. Through the brochure, interested people can request the specific help they want, whether it be simple information or a consultation visit. It allows us to focus on those activities that seem to be most productive and provide specific services where they are needed.

In all of the Center's services, the staff attempt to build on local organization and leadership, to increase the participation of local agencies and groups, and to model our primary message: Child abuse and neglect is a community responsibility, requiring everyone, whether professional or non-professional, to be aware, involved, and active.

INVOLVING COMMUNITY PHYSICIANS

The non-involvement of physicians has been a major barrier in the treatment and prevention of child abuse and neglect. North Carolina has developed and implemented a program that has sought out motivated and concerned pediatricians and general practitioners willing to become part of the community support system to medically evaluate the child who has been abused or neglected.

Within the last three years, the Office of the Chief Medical Examiner (OCME) identified and autopsied almost fifty children who died from multiple injuries due to non-accidental causes. The OCME then discovered that it could also provide an extremely needed and useful service to the live children of North Carolina. The Child Medical Evaluation Project was developed and subsequently funded, through Title XX of the Social Security Act, to provide medicolegal evaluations of children suspected by county departments of social services of being abused or neglected. The evaluations are performed by certain physicians under contract to the project. In its initial year, there is enough money to implement the project in fifty of the state's one hundred counties.

RECRUITMENT AND ROLE OF PHYSICIANS

Recruitment of physicians was begun by asking each county department of social services to respond to a questionnaire. We asked them to estimate the need for the program and to recommend physicians in their county who would be likely to help. The six hundred medical examiners and one hundred regional pathologists in North Carolina were also asked to contribute names of physicians.

The most effective means of gaining physicians' involvement proved to be in-person discussions. Although a full explanation of the project was given to each physician, some physicians refused to cooperate. Their most common reason for their refusal to participate was that they were reluctant to sign a contract obligating their participation. We tried to overcome

this barrier by eliminating the contract, but the federal regulations governing Title XX forbade this. Other reasons they gave for not participating included: (1) the amount of time involved; (2) inadequate financial compensation (maximum of $100 per case); and (3) questionable effectiveness of the local social service agency. Nonetheless, to this date, one hundred and eight physicians (called child examiners) in forty-five counties have signed contracts obligating them to participate in this project. Their roles include: (1) to be available at all times; (2) to complete a standardized Evaluation Report Form; (3) to perform any diagnostic or laboratory tests required to objectively assess the health status of the child; (4) to arrange with the social worker for a case conference that may include other health or social service professionals; (5) to photograph each maltreated child and any visible injuries; (6) to be available as a witness for court testimony; (7) to attend annual training sessions on aspects of child abuse and neglect; and (8) to allow each evaluation to be reviewed by another physician.

INTER-AGENCY CONSTRAINTS

After eight months of operation, our project has seen only twenty-five children, which is certainly less than we expected. A number of barriers to implementation have been identified, both within and between other state and local agencies.

The greatest obstacle to implementation of the Child Medical Evaluation Project was the unresponsiveness of some state and local agencies. From our point of view, the child's overall interests seemed to take a back seat to conflicts of territory and philosophy. At least twice in the first six months of the project, objective arbitrators had to be called in to facilitate a useful discussion between two state agencies. Another major obstance to implementation was that the communication mechanism between the state agency and the case workers was slow, ineffective, and often confused. For example, the Division of Social Services Agency notified the county departments of social services of the project through their "Dear County Director letter". The project staff soon realized that each county director receives hundreds of these letters each year about many different programs. Although the letters may contain important information, they are more often filed than read. As a result, our project was not understood by the directors and the supervisors; many caseworkers had not even heard of the project that they were supposed to be implementing. To solve this communication breakdown, the project staff has been going back into the counties to speak directly with caseworkers concerning implementation and organization of the project in their communities. This seems to be an effective strategy, because the counties making the most use of the project are the same counties in which the project was explained to the caseworkers.

Another problem the project is facing is the evaluation method used by the state agency. The evaluating agency has informed the project that a certain number of evaluations must be performed by a specific date. This is a problem because many benefits of the project cannot be measured in numbers. For example, the following are essential ingredients in developing a successful community support system, but cannot be assigned numerical values: (1) the knowledge about child abuse and neglect gained by the physicians in the state; (2) the new level of communication between the medical community and the social services agencies; and (3) the simple fact that social workers can get a physician's opinion if necessary.

These are not simple problems to overcome when considering that the state agencies are as understaffed as the county departments of social services. However, we are hopeful that by making the overall interest of the child a goal, the state agencies will become more responsive to the need for effective community support systems. Our new Governor and his recently appointed Secretary of Human Resources have both publicly stated that the interests of children are the number one priority of their administration. Our project will continue to remind them of their priority and will do whatever we can to support it.

RECRUITING PHYSICIANS IN YOUR COMMUNITY

It is possible for you to involve and motivate physicians in your own communities to provide a medical resource in child abuse and neglect cases. Concerned physicians in each community can be initially identified by yourself and other community agencies and professionals. Prior to approaching physicians, it is helpful to understand a physician's background. Dr. Ray E. Helfer's article, "Why Physicians Don't Get Involved in Child Abuse Cases and What To Do About It" (*Children Today*, May-June, 1975, Children's Bureau, DHEW) is most beneficial in gaining this understanding.

An effective way to initiate the support of local physicians is to organize a community program or seminar on child abuse and neglect. The social worker is often the most

knowledgeable person about abuse and neglect in the community and must often take the initiative to develop this type of community program. All of the local physicians should be invited, and at least one should be asked to participate in the program. This can accomplish two major steps: (1) developing a practical level of communication between social service agencies and the medical community often leads to (2) the physicians discovering the magnitude of the problem and trying to learn more about it.

CONCLUSION

Our involvement in this project has led to the understanding of an old problem. It is now called (thanks to Drs. Kempe and Helfer) the "Battered Bureaucrat Syndrome". The symptoms of this chronic problem are fairly easy to recognize. First, it begins by having to take a crash course in memorandum warfare. Second, copies of all these memos are now sent to anyone tangentially related to the subject. This is a form of disease-perpetuating treatment known as CYR (Cover Your Rear). The third component is "Xerox Fever" which is clearly observable in continuous trips to and from the filtered files and the almightly duplicating machine. Fourth and last, a convincing symptom to substantiate the diagnosis of the BBS is the relentless pursuit, development, and completion of forms. It is certainly easier to identify the problem than to solve it. However, I would like to suggest an old approach familiar to most of us. It is referred to as the Team Approach. This has shown to be the most effective community tool in handling individual protective service cases and it is time that the so called "bureaucrats" accept limitations, gather, and grow together, and begin to communicate. We are hopeful that North Carolina has reached this point.

Realistic Expectations for Children and Families: Maximization of Educational Resources

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INTRODUCTION

Any discussion of an improved quality of life for children and families must be approached with the realities of community resources and priorities in mind. This, however, does not negate the fact that existing resources could be used more creatively. One approach to meeting the needs of a changing society with changing family structures is through a more effective use of educational personnel and facilities. Exemplary programs exist, and are expanding under the rubric of education, which focus on children with special needs, parent education, continuous or lifelong learning, and community education. Many educational agencies are already providing special services which offer support to abused and neglected children and their families.

EDUCATORS AS PART OF THE MULTIDISCIPLINARY TEAM

A major accomplishment we probably all can share is that more people in this country can now identify child abuse and neglect and know their individual responsibilities. This is supported by the increased number of cases reported each year. However, the reporting of child abuse and neglect to an agency unprepared to respond may be both futile and potentially damaging to the family and child. While tremendous strides have been made in the prevention and treatment of child abuse and neglect, effective programs are still needed.

Most would agree that the abuse and neglect of children is a problem that cannot be managed by one profession. However, one of the major problems of the multidisciplinary approach is that its members are separated by professional barriers and often fail to communicate or cooperate with each other. A basic contradiction to the multidisciplinary approach is apparent in the child abuse and neglect literature. While specific recommendations may be found which describe the responsibilities and practices of educators, a disproportionately small number of multidisciplinary teams actually include educators as integral team members. Training programs for educators on the identification and reporting of child abuse and neglect often fail to credit educators with having skills useful in case management. Educators, sensitive to the indicators of abuse and neglect, are often reluctant to report, since they do not always receive adequate feedback once a report is made. Reported cases are frequently removed from the school's responsibility and given to purported "multidisciplinary teams," which already have impossible case loads.

With limited human and financial resources available to cope with the number of child abuse and neglect cases reported annually, emphasis must be placed on a more careful analysis of multidisciplinary case management. The needs of children are as much a part of the treatment program as are the needs of abusers. Any analysis must demand a more creative use of existing resources, specifically, those of the educational community.

EXISTING EDUCATIONAL RESOURCES

Examination of current educational systems reveals a cadre of highly skilled professionals and comprehensive programs covering much more than traditional educational services. Many preparation programs designed for special education personnel attempt to develop competencies in screening, diagnosis, and individual program planning for children with special needs. Numerous schools involve parents in their child's program by including instruction in home care, nutrition, parenting and child development. Many educators are skilled in family counseling and know how to locate and use appropriate community resources effectively.

Although school systems have budget constraints which limit special personnel, most schools have available to them the varied services of school nurses, counselors, social workers, psychologists, and special educators. Children who are abused or neglected are likely to come in contact with one or all of these professionals. Often their initial contact may be due to a medical, learning, or behavioral problem which interferes with their school performance. Continued professional involvement with children may reveal incidents of child abuse and neglect. During this time, the involved professional has had the opportunity to learn how to work or communicate with the child. More often than not, contact has been established with the

child's family. Precise professional diagnosis and program development is believed to be enhanced by parental involvement.

Additional statistical data is needed on the number of abused or neglected children who receive special services in a school setting, yet research has shown that many abused and neglected children exhibit certain identifying behaviors which may imply special needs:

1. Overly compliant, passive, undemanding behaviors aimed at maintaining a low profile, avoiding any possible confrontation.
2. Extremely aggressive, demanding, and rageful behaviors.
3. Overly adaptive behavior.
4. Developmental lags.

These behaviors are quite visible in the school environment, and while the root causes may not be clear at first, the symptoms are treated. Programs can be designed cooperatively with professionals or other disciplines, both for specific diagnosis and treatment. Before a report is made, educational specialists frequently have initiated an appropriate educational program which may include psychological counseling for the abused or neglected child. In most cases, they are also familiar with the family's needs and problems.

Some regard school personnel and parents as adversaries rather than allies. The ubiquitous parent-teacher conference frequently cemented this alienation. Seemingly, momentum to enforce what may be referred to as the "parent-professional partnership," is rapidly increasing. Formally, this is being done through the requirement of Public Law 94-142, the Education for All Handicapped Children Act of 1975. This law specifies certain parental rights, as well as the corresponding responsibilities of the state and local education agencies to provide handicapped children with a free and appropriate education. Again, the mandates of this Act were established to foster a cooperative approach to comprehensive educational programming. Less formally, evidence may be found of the educator's response to the needs of special children:

1. Children with learning, behavioral or emotional problems have been diagnosed and are being treated by skilled special educators (many of these children may also be abused and neglected).
2. Many programs are operating both for preschool and school-age children which offer parents training in child development and specific help in working with their own children.
3. Informal counseling to both children and parents occurs in school settings.
4. Programs are being offered to students in the area of parenting and family life skills.
5. Early childhood programs exist which work with parents from the birth of their child and provide individual instruction in health, nutrition, and child development.
6. A number of Direction Service Centers have been established during the past year which offer diagnostic and treatment services (several of these have the capability of identifying abused and neglected children and working cooperatively with community services).
7. A growing number of state and local education agencies offer information and referral services to assist families in locating comprehensive services to meet the mutual needs of the child and the family.
8. Professional preservice or inservice programs exist which emphasize a multi-agency approach to abuse and neglect as well as child and family services.

Consideration must also be given to school programs, which are beginning to assume slightly different characteristics and are more capable of meeting the growing educational needs of the community. A declining school enrollment has encouraged many educators to examine the needs of other age groups, as well as ways in which to use school buildings. The result has been an increase in adult education programs, the development of community education programs, health-care education, preschool programs and after-school care. Aware of the increase in the number of working mothers or single-parent families, educators are developing quality comprehensive child care programs which respond to the needs of families and children.

IMPLICATIONS

The problems inherent in the prevention and treatment of child abuse and neglect cannot be viewed in isolation from the larger needs and problems of children and families. Abuse and neglect serve as indicators of a wider breakdown of family stability, and effective treatment programs often uncover other variables influencing the family. Changes in the structure of the American family have taken place over the past 25 years. Professional groups need to rethink their roles in helping the whole family. Resources which support community services need to be identified. Programs which already serve children and families need to be coordinated. Barriers which prohibit a professional exchange of information and planning will have to be circumvented.

Some priorities can be identified which represent expanded professional responsibilities: training, policy development, treatment, and prevention. The following discussion centers on the responsibilities of the educational community; however, it is not intended for educators alone. The purpose is to highlight the educator's role as part of a multiagency effort.

TRAINING

Training efforts have been effective in their attempt to increase public understanding of the complexities of child abuse and neglect and to make state reporting requirements and individual responsibilities known. Some states have even appropriated monies to pay for public education; others have offered special training programs for those required to report. Various professional groups have offered training within their respective fields. While it may be assumed that a large number of people have been apprised of the problem and their corresponding responsibilities, it is now appropriate to expand training and emphasize follow-through service.

Granted, training is needed for school personnel in the identification of child abuse and neglect so that they become more sensitive to the possible occurrence of cases of physical abuse, neglect, emotional maltreatment, and sexual abuse. However, pre-service and in-service programs also need to emphasize the potential for greater educational involvement beyond the identification, policy development, and reporting of child abuse and neglect. It does not seem either sensible or fair to put energy into training programs which provoke a strong emotional response on the part of school personnel and then exclude them from the prevention and treatment process. This is even more baffling when one considers that many highly skilled professionals in school systems are already working with abused and neglected children and their families.

Programs need not be contained within single professions. Multidisciplinary training efforts which focus on cooperative planning can be appropriately introduced at the local level and within institutions of higher education. Moreover, support can be mustered from community groups which are prepared to cooperatively contribute to the prevention and treatment of abuse and neglect. Colleges and universities can offer both interdisciplinary courses or programs on the prevention and treatment of child abuse and neglect, as well as direct services for children and families.

At the in-service level, professionals are resources for each other. Just as educators can profit from training on the legal ramifications of foster placement, so too can law enforcement personnel profit from counseling techniques or instruction in child development. Training opportunities are essential for people with varied professional backgrounds in a variety of settings.[1]

Besides emphasizing the identification and reporting procedures, the program content must clearly include specific information about the treatment capability and responsibility of cooperating professional groups, and coordinated preventive techniques, as well as the psychological, social, and economic variables which affect the child and the family.

POLICY

The impact of public policy on abused and neglected children cannot be denied. Simple school reporting procedures have saved many children from serious injury. However, in addition to guiding agencies' reporting practices, policies can also foster cooperative case management.

According to a recent report by the Education Commission of the States, amendment activity has increased state involvement in the treatment process. Six states now mandate the creation of child protection teams, two more recognize the interdisciplinary nature of the problem and allow for such services to be made available.[2]

Due to the growing public awareness of the plight of abused and neglected children, many school districts are becoming actively involved in the reporting, prevention, and treatment of child abuse and neglect. Many are working quite hard to develop clear and concise reporting

procedures, others are expanding follow-through efforts to set up in-school teams which will work cooperatively with children, their parents, and the local child protection teams. The policy statements of many professional associations reflect national support of this effort.

More comprehensive policies stress various approaches to prevention or treatment. For example, the American Association of School Administrators recommends that its members become "active protectors of abused and neglected children and use the resources of the district and the law to see that such abuse is stopped." They do so by aiding with the identification and reporting of abuse and neglect. Moreover, the National Association of State Boards of Education encourages state and local school boards to align their policies and procedures with those of other abuse-related agencies. Specific language aimed at treatment is found in the policy of the Council of Chief State School officers:

> The Council calls upon all states to review and revise statutes for the mandatory reporting of suspected abuse and neglect of children so that legislation (1) expands the definition of abuse to include not only physical but also emotional and sexual abuse; (2) includes provision for preventive and remedial measures and not simply punitive ones; and (3) increases the number of persons required to report to include teachers, social workers, and other professionals coming into contact with children in addition to medical personnel. Uniformity among state laws is encouraged. State departments of education must provide training for teachers and administrators in the recognition of abuse, legal reporting requirements and methods of working with abused children and child abusers.

The policy statement of The Council for Exceptional Children encourages schools to go beyond their traditional role as coordinators or users of other community services and lead the way in developing new and experimental forms of comprehensive child and family services. In 1974 the CEC Delegate Assembly, which represents the Council's 900 local chapter units, 50 state and 13 special interest divisions, adopted a resolution which defined "abused and neglected children as exceptional children" and encouraged "efforts to develop a role for educators in child protection."

Many of the issues which arise in the identification, prevention, and treatment of child abuse and neglect appear to have strong parallels to the federally mandated components for improved services to handicapped children. An understanding of these provisions possibly would benefit abused or neglected children. For example, the proposed regulations of P.L. 94-142, the Education for All Handicapped Children Act, require an annual program plan to be submitted by the state education agency on the behalf of all political subdivisions involved in the education of handicapped children (such as the Department of Mental Health and state correctional facilities). This plan must provide: individualized educational programs for all handicapped children; improved personnel preparation programs; surrogate parents;[3] and such related services as psychological counseling for families or parent education on child growth and development if needed. Moreover, special services already exist which respond to the mandates of P.L. 94-142.

If indeed policies are to be comprehensive, they need to address that which occurs after reporting. Policies must bring service providers together to collaboratively design and implement prevention and treatment programs.

TREATMENT

Further consideration needs to be given to the function of the child protection team. What are the ramifications of the word "protect?" Does it mean to remove a child from the home without ensuring a nurturing environment, or does it mean to ignore the psychological needs of the child and family? Schools have been referred to as the second most important socializing institution in American society next to the family. Most abused and neglected children come in contact with some type of child care or school program. The staff of these programs, particularly those who have reported a child for suspected abuse or neglect, want very much to "protect" these children.

Beyond an initial treatment for physical injury, most abused or neglected children suffer an emotional pain and need nurturing. Children who have only known a stressful family environment may need additional role models. Most child care or school programs have the capability to provide such a positive, protective environment.

New programs are being offered to foster the cooperation of parents and teachers. Groups such as the American School Counselor Association have already gone beyond supportive policy statements and have developed and disseminated resource materials which outline intervention techniques for counselors in the treatment of abuse and neglect. The Council for

Exceptional Children has encouraged participants to address the needs of abused and neglected children and their families in training programs which currently involve parents. Another aim of the program is to develop policies which use the skills of school personnel in the treatment process.

Educators must address the needs of the abused and neglected because of their responsibilities for children. This implies an increased involvement with families and correspondingly with the multidisciplinary team. Cooperative treatment programs can both improve services for children and families and reduce the strain on human and financial resources within a community. Specific policies and procedures are needed which clarify the various role responsibilities of the multidisciplinary team. Training programs must include specific information on what these responsibilities are and the types of programs which already exist.

PREVENTION

Available research indicates that parent education is one of the most effective ways to prevent child abuse and neglect. Fortunately, numerous parent education programs already exist which can serve as models for increased parent education. A significant portion of these programs involve parents and teachers of handicapped children.

The Bureau of Education of the Handicapped supports over two hundred early childhood projects which help parents of normal and handicapped preschool children participate in their child's program. Numerous other federally funded programs are operational which teach school-age children and their parents about child development. Many personnel preparation courses for potential teachers of young children with special needs include techniques for working with families. A growing number of school districts have initiated child development courses for junior and senior high school students.

Parents of handicapped children have become a very powerful lobby in the past several years and have influenced policy affecting their children. Correspondingly, parents have stimulated self-help as well as cooperative programs with professionals. Their strategies and the effects of their efforts have had results which should be considered beneficial to abused and neglected children and their families. However, these existing coalitions must be made aware of the problems of abuse and neglect.

Again, many educators are involved in programs for parents and children which have implications for the prevention of child abuse and neglect. These people need to become aware of their expanded role responsibilities so that they may address the problem of abuse and neglect. Adult or community education programs, as well as programs for school-age children and preschool programs (which include parents), have the capability to expand their resources to better meet the needs of children and families. These too must have the opportunity to understand their role. Besides offering courses in child development or family life, educational programs can be expanded to offer information on nutrition, homemaker skills, career education, and vocational counseling. More personnel preparation programs are needed which focus on improved community services.

A vast array of resources exist in the form of educational programs and personnel. In order to maximize their capability, it is necessary to: provide information on the problem of child abuse and neglect; provide other professional groups with specific information on these educational resources; and stimulate cooperative program planning in the prevention and treatment of child abuse and neglect.

CONCLUSION

It cannot be denied that abused and neglected children have many special needs which could be better met by planned use of existing educational programs, the scope of which already provides many necessary services to children and families. Therefore, if maximization of the quality of life is a goal, it makes sense for agencies serving families and children to cooperatively use what is already operational.

Several overlapping priority areas can be identified which imply an increased set of professional educational responsibilities: training, policy development, prevention, and treatment. Correspondingly, several recommendations can be made for active consideration.

1. In order to maximize community response to abuse and neglect, more training programs should be offered in communities for all interested community members.
2. Educational institutions or organizations responsible for preservice professional training as well as in-service programs must be made aware of the problems of

abused and neglected children and develop a multidisciplinary response to their needs.

3. Training efforts must emphasize follow-through for educators after the report is made and develop techniques for improved multidisciplinary action planning.
4. Besides developing specific single agency policies or procedures for handling cases of abuse and neglect, educational agencies need to collaborate to develop multiagency procedures which address follow-through. Such policies are needed on the national, state, and local level.
5. Educators need to reanalyze their role responsibilities with respect to both child abuse and neglect and improved services to children and families.
6. Educators and other professionals need to use each other as resources in training activities as well as treatment and prevention.

Realistic expectations for abused and neglected children and their families depend on a maximum use of all community resources, including the creative use of educational resources.

FOOTNOTES

[1]The Council for Exceptional Children is currently involved in a federally funded training project to assist professionals involved in the prevention, identification, and treatment of child abuse and neglect. During the course of this project, several professional training designs are being implemented at the local or community level in the form of replication training teams or multidisciplinary university courses. Cooperative planning has begun with several multiagency service delivery systems for the prevention and treatment of abuse and neglect. The intent of the CEC training project is twofold: to reach as many interested professionals as possible by utilizing a multifaceted approach; and to build upon the program development and management skills of concerned professionals at various levels within the association's structure.

[2]These eight states are: California, Colorado, Louisiana, Michigan, Missouri, Pennsylvania, Rhode Island, and Virginia.

[3]Children in need of special education services whose parents are unknown, unavailable, or are a ward of the state are assured, by law, the appointment of a parent surrogate to safeguard the rights of the child in specific educational decision making—identification, evaluation, placement, and provision of a free and appropriate public education. State education laws specify the criteria for the selection of surrogates working with local professional associations to match the child with the surrogate. In order to prepare surrogates to be effective in their role responsibilities, he or she must be well informed. Moreover, training programs have been designed to clarify the role and responsibilities of surrogates, the special needs of handicapped children, the specific rights of children, services available within a state, and the options for insuring appropriate placement.

The Prevention and/or Treatment of Child Abuse and Neglect in Head Start: An Eclectic, Ecologic Hypothesis

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"The only thing we have to fear is fear itself." Franklin D. Roosevelt.

PREFACE

The above quote is most appropriate when talking about child abuse/neglect and Head Start, because fear is the main obstacle to Head Start becoming a major national force in prevention and treatment of child abuse/neglect. To talk about Head Start and child abuse and neglect raises fearful images in some minds that Head Start is full of abusive/neglectful parents (FALSE); that Head Start would betray the trust of parents (FALSE); that child abuse and neglect is too complex for Head Start (FALSE); that for Head Start to become involved in child abuse and neglect would be a violation of its original objective: to help poverty families encourage their children into a successful school experience with as much potential as possible (FALSE); and that Head Start already has too many special emphases to accept the issues of child abuse/neglect (FALSE).

It is crucial that we remember the words of Dr. Martin Luther King, Jr.: "I have a dream...." While my dreams are not as potent as Dr. King's, I too have a dream--and a nightmare. The nightmare is the 22,216 cases opened for service by the Children's Protective Service in the State of Washington in 1975. Here child abuse and neglect is already epidemic; how is your state? My dream is the thousands of families that could and should receive preventive/treatment services through Head Start nationally each year. Head Start can and does have a role—an active role—in providing professional quality services to its families, services that can prevent some cases of malnutrition, of chronic illness, of children exposed to acts of immorality, of broken bones, of sexual abuse, of incest, of murder, and of mental anguish and trauma that scar for life.

In my life I have wandered from country club to street gang to suburban church to Head Start. Child abuse and neglect exists in each of these settings, with minimal differences of intensity. Benton Franklin Head Start makes an average of six to ten reports of abuse/neglect each year, out of a clientele of 120 families. If Head Start is to live up to its objective of helping the poverty family enhance the potential of their child, if Head Start is to keep its trust of full service with the families that it accepts and serves, then it must develop the skills of working with families trapped in the potential for abusive/neglectful behavior. To say that Head Start already has too many special emphases is to deny the effect that Head Start has in its social service, parent involvement, and handicapped services components. To say that child abuse and neglect is too complex for Head Start is to deny the complexity of Head Start's services and their potential for preventing/treating child abuse and neglect.

As must be obvious by now, I am an advocate of Head Start—to which I have become addicted--and of service to families involved in abusive/neglectful behavior. I hope that some of my hope and enthusiasm rubs off on you. The credit for the ideas in this paper should go to the multitude of researchers, writers, and staff who have kept me honest. Errors and misjudgment are mine. Much credit must go to my wife and two children who suffer my obsessions with love and understanding.

THE DYNAMICS OF CHILD ABUSE/NEGLECT: SOME STARTING PREMISES

Before the peculiar dynamics of child abuse and neglect can be discussed, three cross-currents of American social history must be identified:

1. The use of physical discipline in child rearing has a long and "respectable" history in the American heritage of violence. The fact that it took laws preventing abuse of animals to protect Mary Ellen in New York in the 1890's testifies strongly to our culture's devotion to the concept of "Spare the rod and spoil the child." Only recently has a child come to be viewed as a legal entity with unalienable rights, rather than a piece of property or a beast of burden on a farm or in an urban sweat shop. Only with the advent of Dewey and Spock did education and parenthood begin to move beyond physical punishment as a means of

"coercion into adulthood" for children. Even today, a child is often denied the right of legal protection from first, second, and third degree assault committed by a family member.

2. At the same time that psychology was denying the family the "old" methods of discipline such as strapping and switching a child, another shift was occurring in family structure itself. Prior to the Depression and World War II, the nuclear family was an integral part of a horizontal and vertical extended family that shared the responsibilities for nurturing children with aunts, uncles, cousins, grandparents, and in-laws. The extended family was often nestled comfortably in the midst of a secure, structured community where the social values of right and wrong were explicitly shared. Since that time, America has become a mobile society with the stress of child rearing focused almost solely upon the parent(s) in the nuclear family in the unsupportive context of a multifaceted, shifting social value system.
3. The third social cross-current is the so-called sexual revolution, in which the concept of pleasurable gratification has become the central factor in male/female relations, including marriage. Marital stability and child rearing have become secondary values and divorce rates have increased geometrically.

In this social context researchers have identified a triad of factors that must be present for abusive/neglectful behavior to occur:

1. Parental Predisposition: There must have been some experience in the history of the offender that allows violence or apathy toward a child. Most often this is found in a history of the parent having been abused/neglected as a child himself. Occasionally it is due to mental illness, brain damage, or mental retardation.
2. A Perceived "Different" Child: For some reason the parent identifies a child as being different from other children. This child then becomes the focus of the abuse or neglect. The child may be precocious. It may remind the parents of some part of themselves or another person they dislike. The child may be handicapped and require special attention. It may be that the child is the unconscious receptacle of the parent's lost dreams and expectations. Whatever the reason, the child is "different."
3. Precipitating Stress: Parents are frequently involved in stressful situations and not all parents in stress become trapped in abusive/neglectful behavior. However, when the parent has a predisposition toward abusive/neglectful behavior and when there is a child (children) perceived to be different, the loss of personal support systems (e.g., health, employment, family, avocation, religion, etc.) and the concomitant increase in stress for the parent can result in the parent either taking it out on the child or becoming apathetic to the real needs of the child.

IMPLICATIONS FOR PREVENTIVE/TREATMENT MODALITIES

If the above analysis of the dynamics of abusive/neglectful behavior is true, then there are certain interventions that should prove effective in prevention and/or treatment of the family. It has been observed in stress management and crisis intervention that the act of making a decision, of assuming personal responsibility, provides for the release of anxiety built up by stress. That holds true even to the point that deciding to commit suicide may release enough anxiety to prevent the act. If child abuse and neglect is the result of a precipitating stressful event, then the first task is releasing the stress in some decision-making process, preferably a process that reaffirms the responsibility of the parent for his/her own actions.

Once the parent has accepted his/her responsibility for some decision, the next step in the prevention/treatment process is to help the parent gain some sense of control over the events in his/her life, to minimize the possibility of recurrence of the precipitating stress. Since stress is based upon perceptions, the minimizing of stress should be based upon decisions that reflect hope.

The third and final (and longest) level in treatment/prevention is helping the family deal with the two original factors leading to the abusive/neglectful behavior: why is the child perceived to be "different" and what predisposes the parent(s) to abusive/neglectful behavior? This intervention may occur at a variety of levels, ranging from classes in parenting/child development, to support groups such as Parents Anonymous, to individual and/or group counseling or therapy.

A crisis intervention model holds promise in preventing/treating child abuse and neglect, but it must be coupled with a wide range of other personal, family, and community services.

HOW DOES HEAD START FIT INTO ALL OF THIS?

Theoretically at least, Head Start, as a comprehensive, family-oriented child development program, has a wealth of resources to assist disadvantaged families involved in abuse/neglect. It provides opportunities for the individualized physical, social, emotional, and cognitive growth of the preschool child. It offers full diagnostic and treatment services for the medical, dental, auditory, visual, psychological, and developmental needs of each child enrolled. And it has a bias that effective work with preschool children can only be done in the context of the family. Consequently, Head Start also offers a wide range of services, training, and advocacy for Head Start families as well.

By closely coordinating Head Start's services for the child and the family with the services of Children's Protective Service and/or any other agency working with the family/child and by involving other social and health services in meeting the needs of these families, Head Start can have an impact toward ending the immediate danger to the child, toward meeting the individualized needs of the child in a safe, non-threatening milieu, toward helping parents deal with their individual self-perceived needs, and toward assisting the parent(s) in mobilizing the needed community resources to help them solve the problem(s). In other words, Head Start's "bag" is not investigation, which belongs to CPS, nor judgment, which belongs to the court, but rather an active role of concern, support, and advocacy for children and their families.

By integrating the preschool child into a comprehensive child development program and preschool classes, Head Start is able to:

1. Assess and treat the total needs of the child;
2. Provide the child with a safe, normative, mainstream experience with peers; and
3. Provide the family with a daily relief from the constant stresses of parenting.

By accepting the family, Head Start is able to offer a reality-oriented, nonthreatening, nonpunitive, supportive, socially-acceptable milieu in which the parent can receive:

1. Training in effective parenting, nutrition, health, child development, family economics, and community resources;
2. Socialization services;
3. Access to family therapy and counseling services; and
4. Advocacy and support to overcome the alienation and mistrust of other agencies which can help meet the family's self-perceived needs.

However, a word of caution must be added. Head Start should never be the only agency providing treatment to a family involved in abusive/neglectful behavior. Head Start, despite its wealth of resources, is drastically limited by two: money (sound familiar?) and, most particularly, time. Most Head Start projects work with a family for a maximum of eight months. Eight months is sufficient time to work through the crisis intervention stage and to provide for referral/advocacy/coordination to an agency to continue the treatment plan. It is unknown (due to a lack of funds for summative research) whether or not this is sufficient as a therapeutic service for the family. By establishing a closely coordinated working relationship with other agencies (preferably Children's Protective Service, the juvenile court system and a community mental health facility) you ensure two things: (1) Continuation of services, and (2) The opportunity to accept families/children after the start of the year.

THE VULNERABLE CHILD PROJECT: A HEAD START—CA/N DEMONSTRATION

On June 30, 1975, the Department of Health, Education, and Welfare; Office of Child Development; Region X granted Benton Franklin Head Start/Mid-Columbia Mental Health (grantee) $23,045 to operate a one-year mini-demonstration project. Ten of Head Start's 108 slots were reserved for children/families where there was a strong suspicion of child abuse and neglect by a referring professional.

From 1972 to 1974, the number of cases reported to CPS in Benton and Franklin Counties increased from 239 to 941, for a 294% increase. Of 211 professionals surveyed in the area, only 25% felt that services for abusing/neglectful families were adequate. The grant was designed to test Head Start's effectiveness as an agency of "first resort" for treatment referrals from CPS

for low-income 3 to 5-year-old children where the families were trapped in abusive/neglectful behavior. It also contained a prevention group of at-risk families identified from the regular Head Start population. Families served:

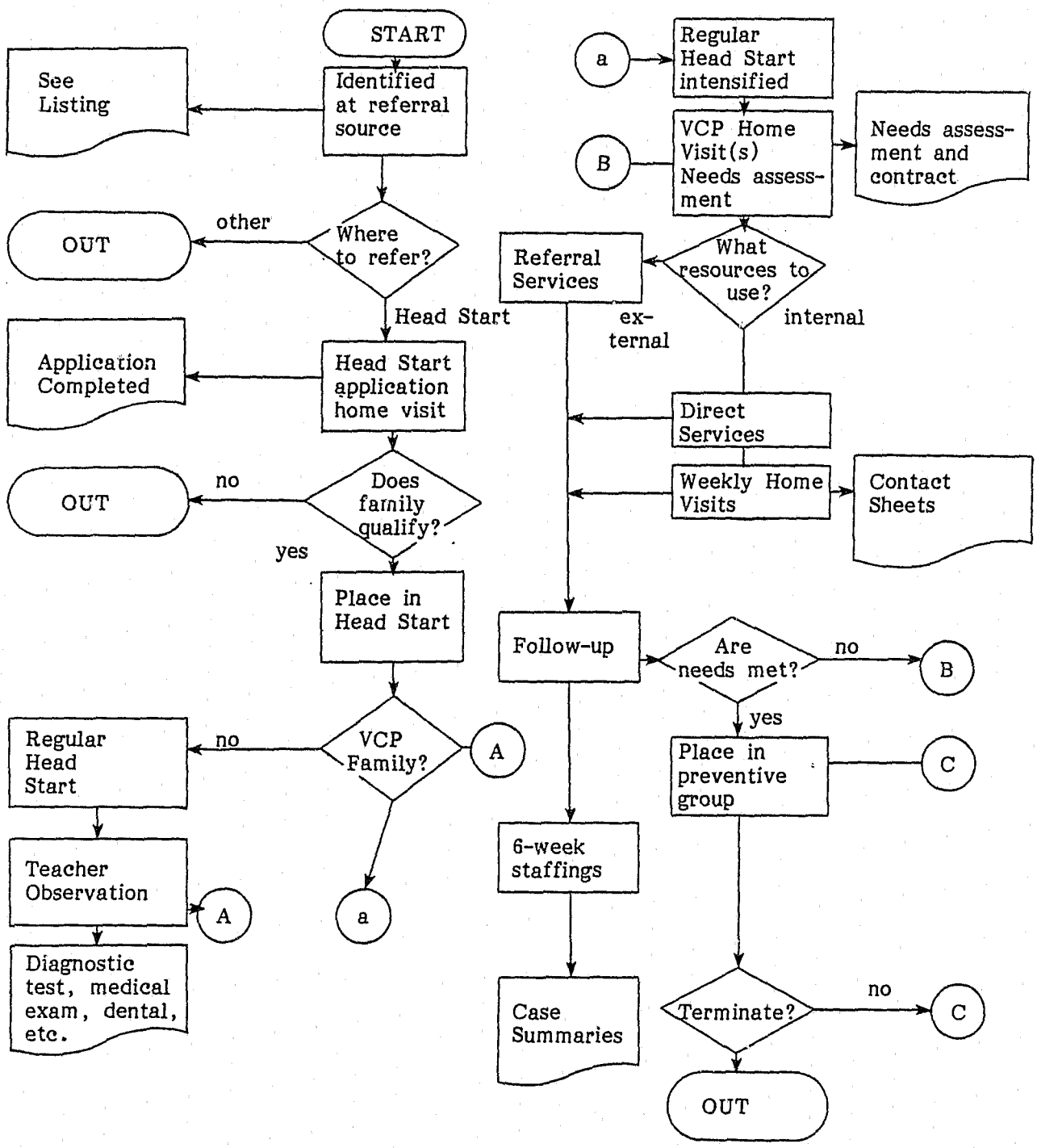
Active Neglect	6 families,	23 children
Active Abuse	4 families,	9 children
Abandonment	4 families,	5 children
Preventive	24 families,	66 children
TOTAL	38 families,	103 children*

(*39 children enrolled in Head Start)

Objectives: By closely coordinating Head Start activities with the referring agency and CPS, and by involving other social and health service agencies in meeting the needs of the families/children, Head Start hoped for impact on ending the immediate jeopardy, meeting the individualized needs of the child, helping the parent(s) deal with their own needs, and assisting the parent(s) in mobilizing the needed community resources.

The decision-making process flow chart (below) illustrates the identification, referral, resource allocation, and evaluation processes of the VCP. The five key questions in the decision-making process are identified by◇.

Flow Chart—Vulnerable Child Project—Decision-Making Process for "Active" Families



Choosing the Families: Some families were referred to the VCP directly by Head Start when abuse/neglect was discovered in the recruiting process or by the teacher. The VCP also distributed a flyer to community sources and visited the agencies personally to interpret the project services—specifically, that it was a nonpunitive resource, and that confidentiality would be maintained since the families would be seen as primarily participating in a Head Start program. CPS was the third source of referrals, referring families in need of intensive protection services.

Community Resources Utilitized in Referral/Follow-up:

Homemaker services	3	Mental health	18
Family planning	2	Legal aide	12
Food Bank	1	Volunteer assistance	2
School District	6	Housing	6
Children's Protective Service	15	Juvenile Court	2
Furnishings/clothing	12	Family services	1
Handicapped assessment	9	Medical services	37
Foster care placement	5	Dental services	36
Community Action Agency	1	Parents Anonymous	15

Miscellaneous Services:
- transportation
- babysitting
- driver education
- attending court hearings
- advocating parent needs
- confronting/consulting on family problems
- accompanying parent(s) to referral agency
- crisis intervention

REASSESSMENT

The VCP staff followed-up on all direct or referred services through its weekly home visits with each family. Every six weeks the VCP staff and appropriate staff from other agencies reviewed each family's progress. If the family/agency objectives had been met and no new priority needs had emerged, the family was moved to the preventive group for monitoring and maintenance activities. After six successful weeks in the preventive group the family was terminated from the VCP but remained active in the regular Head Start programs.

BENEFITS TO FAMILIES

Unfortunately, the VCP was funded for only one year. In that time Portland State University was able to complete formative research (case study method), but time was insufficient to measure the long range summative benefits of the project. DHEW/OHD/OCD is currently unable to identify funds for further research. However, two informal measures are available: (1) Nine children were maintained in their homes as a direct result of the VCP, according to the local CPS; (2) The degree of VCP parent involvement in Head Start was significantly higher than that of non-VCP Head Start parents, indicating that some needs were being met.

In the formative research comments by Portland State the conclusion was reached that "the implications for National Head Start and other child caring agencies are obvious. The Benton Franklin Head Start Program has demonstrated a way to be more responsive...without a major agency face-lift...The expanded services have added to the community estimations of Head Start's ability to supply more comprehensive child services."

POSTSCRIPT

As I mentioned, and as should by now be obvious to you, the only thing Head Start has to fear in providing service to children and families involved in abusive/neglectful behavior is fear itself. It can and has been done. It will be done in the future. Someday we will do the summative research to isolate individual variables to develop a general Head Start model for serving abuse/neglect families. The problem of child abuse and neglect is here. I only hope and dream that my nightmare can be averted and Head Start nationally can address the needs of these families systematically and professionally with the quality of service that Head Start offers.

A word of caution must be added, however. Please don't jump into service without adequate training, without adequate time, and without adequate knowledge/mobilization of your community resources. The families that we serve in child abuse and neglect and in Head Start have had their hopes dashed and their trust broken too many times to be hurt again.

From the referrals received, the VCP first determined if the families met Head Start guidelines, and then reviewed each family at a staffing. Those not selected for the VCP were routed into Head Start if they met admissions criteria, often into the preventive group. Families were selected on the basis of need: CPS referrals were given preference with others prioritized according to the degree of danger to the child.

Identifying the Problems: The problems of the referred families included physical abuse, temporary or chronic neglect, and shuffling of children back and forth between parental homes. Peripheral problems of health, sanitation, and delayed development were evident. Several families had prolonged histories of abuse or neglect; some had had children removed from the home.

When a family was accepted, they were visited in their home by a paraprofessional outreach worker who openly and candidly discussed the reports of abuse and/or neglect, the required need for CPS involvement (if referred by another agency), concerns for the children, and services offered by the Head Start/VCP. The worker then helped the family develop a needs assessment as well as a list of long and short term objectives. Whenever appropriate, a contract was written specifying VCP and family tasks. The needs assessment and contracting process were useful tools developed to promote "up-front" discussions of problems not easily discussed by either parents or staff. The needs assessment/contract process demanded considerable knowledge of community resources as well as a good grasp of problem-solving methods to assist the family in sorting out problems, developing enthusiasm, and initiating a successful decision-making process. It was a real challenge; determining where to start with a family consisting of a working father and five unsupervised children living in a small, stinking trailer, with open food on the kitchen counters, garbage piled in the corners, broken windows, moldy food on the floors, and piles of dirty clothes everywhere?

Which Resources to Use: The type of service provided through the VCP did not differ significantly from that offered to other Head Start families. However, VCP families required longer and more frequent assistance. The children often needed more medical attention. The situation demanded considerably more referrals, and the staff visited each family weekly in their homes. Throughout the process, strict confidentiality was maintained.

Once the VCP staff knew the needs and objectives of the families, the family worker and the family attempted to match needs with services. Both direct and referral services were used, and all families participated in the range of general Head Start parent services.

For each child, Head Start offered full diagnostic/remedial programs including access to mental health services beyond the classroom, if needed. However, the VCP staff concentrated on service to parents, as the educational and social/emotional gains of the child would endure only if family life-styles changed.

Parent Services:

Parents in therapy	18
Parents in P.E.T.	13
Parents in College/Head Start Child Development/Parent COOP	12
Parents trained as class volunteers	17
Parents trained in nutrition	11
Parents trained in first aid	2
Parents attending Social Activities	11
Parents receiving home training for classroom follow-up	6
Parents involved in: Center Meetings	26
Classroom Vol.	17
Policy Council	8

Multidisciplinary/Multiagency Approaches to Families-at-Risk: Prevention and Treatment of Abuse and Neglect

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Child abuse continues to be conceptualized from a variety of divergent, and sometimes conflicting, value perspectives. Gil (1969 to 1976) continues to regard violence directed toward children as a function of "national insanity," a direct result of our competitive, capitalistic system.

Although the family plays a major role in directing social developments, it is embedded in a network of other social systems that support, neutralize, or counteract that direction. For several years, such groups as Parents Anonymous and such influential figures as Vice President Mondale have been emphasizing aid to family support systems as the focus for identifying, treating, and preventing child maltreatment and other forms of family violence. But although some medical authors (Poussaint, 1976; Newberger, 1976) have adopted positions that emphasize the interrelatedness of child abuse and social values, still most pervasive are those medical, law enforcement, and social work models that emphasize individual pathology and individual case-by-case intervention.

Thirty-five years ago, C. Wright Mills asserted that educational institutions train such people as judges and social workers to think in specifically constrained terms: "Their activities and mental outlook are set within the existing norms of society; in their professional work they tend to have an occupationally trained incapacity to rise above a series of 'cases' " (Mills, 1967).

More recently, Lennard and Bernstein, in addressing the constraints against achieving health-giving institutions, said: "In one form or another, in spite of considerable lip service to the contrary...The operative focus of professional activities has revolved around attempts to change the behavior of individuals rather than situations, and the manipulation of psychological variables rather than social system and interactional variables" (Lennard and Bernstein, 1970).

CURRENT DEFINITIONS OF CHILD ABUSE AND NEGLECT

Current definitions of child abuse and neglect are both limited in scope and, on the whole, ambiguous and/or incomplete. They are limited because (1) they tend to focus on physical abuse alone, and (2) they are formulated almost exclusively by professionals (usually from medicine, social work, or law/law enforcement). They are ambiguous and/or incomplete because (1) they confine definition to outcome; that is, they focus on physical manifestations of injury (Buss, 1961), or (2) they confine definition to physical manifestations effected by intent (Helfer and Kempe, 1972), (3) they emphasize that most definitions are merely culturally-determined labels derived from social judgments made by particular observers (Walters and Parke, 1964), or (4) they constitute essentially a priori definitions that attempt to incorporate the foci of all the definitions above; e.g., Parke and Collmer's (1975) definition of an abused child as: "Any child who receives non-accidental physical injury (or injuries) as a result of acts (or omissions) on the part of his parents or guardians that violate the community standards concerning the treatment of children."

In summary, current definitions, when based primarily on the experiences of professionals, are either limited in focus, highly eclectic, or both.

CURRENT ATTEMPTS TOWARD IDENTIFICATION

Despite the efforts of such organizations as the National Clearinghouse on Child Abuse and Neglect and of such scholars as Gil, current statistics on the number of children abused and/or neglected each year range from forty thousand to four million. Such a discrepancy suggests that the much-discussed problems inherent in defining, finding, diagnosing, and treating child abuse are so numerous and complex that most of us have resorted to interpreting very simplistically and then trying to meet the minimum requirements of the state laws.

As Helfer and Kempe (1972) point out, the strong emphasis in many state laws on having selected professionals report, while serving some useful purposes, has also encouraged the public to believe that professionals are taking care of the problem and even that we are doing so

through existing institutional mechanisms in effective ways. In addition, this emphasis on professional reporting has encouraged many overburdened professionals to believe that once we have done the minimally decent thing (i.e., once we have reported), we have absolved ourselves of further responsibility.

Unfortunately, the responsibilities of professionals toward allegedly abusing parents and allegedly abused children are neither limited nor completely autonomous. The very pragmatic reason for this is that the information necessary for a case disposition must be gathered by several sources working in various ways to achieve the common goal of helping a family or family surrogate system to make their home safe for their child or children.

Today, we have increasingly impressive evidence that a multidisciplinary, multiagency, genuinely concerted effort directed toward the problem of child abuse defined within very specific parameters can result in a significant amount of improvement in seventy to ninety per cent of problem families—often within six to nine months after treatment begins (Helfer, 1975; Fontana, 1973; Helfer and Kempe, 1972). How, then, do we build on the pioneering efforts of the last ten years and begin to achieve the goals of protecting the victims of child abuse/neglect and strengthening parents' functioning within the context of strengthening the functioning of their support systems?

ONE MULTIDISCIPLINARY/MULTIAGENCY MODEL

One "community treatment" model which has been tested seeks to place child abuse in an ecological perspective. According to Drs. Helfer and Kempe (1972), without a consortium that draws on the abilities of the many disciplines within a community to develop a combined treatment plan, child abuse programs will not only fail, but the problems inherent in the family structure will be exacerbated.

Responsibilities within Helfer and Kempe's "Ten Steps to Treatment" (1972, pp. 177-184)—in which they insist that parents be guided "with delicate precision"—are listed below. Steps 1 and 6 are designated "community" responsibilities: Steps 2 and 3 are designated "hospital" responsibilities; Steps 4, 5, 7, 8, 9, and 10 are designated responsibilities of both community and hospital. The model begins:

(community)	Step 1.	Child welfare worker (or police) to whom report of suspected abuse is made takes the child to a hospital emergency room.
(hospital)	Step 2.	In the emergency room or office, the physician and nurses, concerned about the diagnosis of non-accidental injury or finding of neglect, arrange for the child to be admitted to the hospital for diagnostic assessment and for the initiation of early treatment for the child and his/her family.
(hospital)	Step 3.	Hospital personnel phone report of suspected case to child protective services.
(hospital)	Step 4a.	Hospital initiates evaluation of the case by the child abuse consultation team.
(community)	Step 4b.	Protective services begins evaluation of the home.

Helfer and Kempe suggest that these four steps be taken within twenty-four hours and, further, that to omit any one of them is to risk intensification of the family's problem. They are particularly insistent on requiring a multidisciplinary diagnostic team for the Diagnostic Assessment Phase of their process. They feel that the three crucial questions are:

1. Does the family situation meet the criteria for abuse to occur?
2. Is the home safe for the child?
3. How can the home situation be made safer?

These questions can be answered only by mobilizing the multiple data-gathering skills of teachers, social workers, nurses, psychiatrists, psychologists, pediatricians, and others. Thus, Helfer and Kempe recommend that either the hospital-based or the community-based child protection team consist of representatives from:

1. Community protective services.
2. Hospital social work.
3. Pediatrics or family practice.
4. Public health nursing.
5. Psychology or psychiatry.
6. Law.
7. Law enforcement.

Ideally, in addition to gathering the necessary data to make diagnoses, this team should function as would a cardiac diagnostic team to:

1. Meet regularly to discuss referrals.
2. Respond to consultation from physicians and others.
3. Support the family throughout the process.
4. Collect data at case conferences.
5. Recommend a treatment plan.
6. Follow up on this treatment plan.

THE DETERMINATION OF FAMILY POTENTIAL FOR ABUSE

In order to make a diagnosis, the physician needs information on physical findings such as those discussed by Weston in "The Pathology of Child Abuse" (1974), such as laboratory data specific to abuse and/or neglect, changes apparent in X-rays, and in addition, assessment about the safety of the home. The crux of the "safety" issue is whether or not a family meets the three major criteria for abuse:

1. The parents or caretaker has a potential for abuse when:

   a. The parents have been reared in a physically or emotionally traumatic way.
   b. One or both parents have a poor self-image.
   c. One or both parents are isolated and distrustful.
   d. Either spouse is non-supportive.
   e. Parent(s) have an unrealistic expectation of children.

2. The child suspected of having been abused is:

   a. Either seen as "special" or "different" and/or
   b. Really is "different" (e.g., physically or emotionally handicapped, gifted, etc.).

3. A crisis is present, which may be either:

   a. Physical (e.g., lack of food, money, heat) or
   b. Personal (e.g., death, divorce).

After the evaluation is completed, Helfer and Kempe suggest that a dispositional conference attended by all parties involved (Step 5) be held, within seventy-two hours of admission, either to the hospital or at protective services, and further, if applicable, that the courts (Step 6) be involved.

The Case Conference Review is intended to:

1. List the problem;
2. Complete a "Home-Safe checklist";
3. Make plans for treatment;
4. Delegate responsibilities;
5. Designate the long-term case coordination.

Delaney (1972), Isaacs (1972), and many others point out that the roles played by the courts and by lawyers, like the role played by law enforcement, are in child abuse cases experienced as punitive. However, these professionals increasingly must be viewed by their communities and must view themselves as adjuncts to the therapeutic process involving parents

and children rather than as adversaries of abusive parents and/or traditionally therapeutic professionals.

What Delaney says of the judge who must deal with problems of child abuse is equally applicable not only to the lawyer and to the law enforcement officer, but also to the teacher and the school administrator:

> (Such a person) must be more than merely "learned in the law." To approach the problem intelligently, he must know the pathology of child abuse and the family dynamics which produce it. He must be able to see it as more than the willful act of a cruel or depraved parent which can be corrected by punishment. He should know that a criminal prosecution, even if the charge is sustained, may have little real effect in the parent's emotional growth and that if the charge is dismissed or the parent acquitted, such action may reinforce the parent's conviction of the rightness of his conduct and increase his hostility toward those who might have helped him. (He) should remember that even though the parent is punished, the child (and perhaps others yet unborn) will again be in the parent's custody. Surely if the factors which produce child abuse have been ignored, further abuse will most probably occur, the only change being greater care on the parent's part to conceal his conduct. (Delaney, 1972, p. 197.)

Thus, Step 6 of Helfer and Kempe's "Ten Steps to Treatment" is to be treated cautiously, for the decision regarding court intervention is highly dependent on the individual case and the cooperation of the family, protective services, and the courts in achieving the goal of protecting the child and strengthening family functioning.

Step 7 of this model should begin two weeks after identification of the problem; it is to implement the dispositional plan with either out-of-home or at-home treatment. During the first three months of the treatment phase, the coordination of "acute treatment" falls on the hospital social worker until the report is made, and then gradually shifts to the protective service worker. Step 8a (community responsibility) is the maintenance of the case as long as the problem warrants, and Step 8b (hospital responsibility) is the tracking of all children in the family in a special follow-up clinic.

Step 9 requires both community and hospital resources, as it involves the long-term (six to nine month) treatment program. Helfer and Kempe suggest that it start as soon as possible and that coordination of this phase be transferred from the protective services worker to someone. They suggest that all of the following resources be explored for involvement in the long-term treatment process:

1. Protective services social worker.
2. Hospital social worker.
3. "Private" agency social worker.
4. Supervised "parent aides".
5. Day care centers.
6. Crisis centers.
7. One-to-one psychiatric care.
8. Group psychiatric care.
9. Mothers or Parents Anonymous.
10. Neighborhood centers.

and we would add:

11. Teachers, school social workers, other appropriate school personnel.

Step 10 is the return of the child to the home when the home is determined "safe."

ANOTHER MULTIDISCIPLINARY EFFORT

The Montgomery County (Maryland) Child Protection Team is another example of a multidisciplinary, multiagency "community" effort. The members of this team are:

1. The Child Protection Coordinator,
2. A supervisor of Protective Services,
3. A pediatrician and a community health nurse from the Health Department,

4. A supervisor of pupil services from the Montgomery County Public Schools,
5. An attorney from the County Attorney's Office,
6. A child psychiatrist from the community under contract to the Health Department,
7. An officer from the Police Juvenile Department.

The Task Force has been meeting weekly since February, 1974. Leila Whiting (1977) effectively counters, by presenting the Montgomery County Team's "case," the notion that multidisciplinary, multiagency community efforts are doomed to failure:

> A community multidisciplinary team can be established in many communities. In general, it is viewed as a supportive, helpful tool by those using it...On the whole, the team has been a useful, productive group which has been successful in developing better communication among relevant agencies, in supporting difficult decision making on the part of mandated agencies, in devising plans and intervention strategies for complex situations which no one person alone could evolve, and in providing training and high visibility regarding children's problems for many professional and lay community groups.

SUMMARY

Although child abuse and neglect reporting laws have served useful purposes, they have also encouraged the public to believe that professionals are effectively taking care of the problem. Reporting laws have encouraged both the public and professionals to believe that once they have reported, they have absolved themselves of further responsibility. Unfortunately, the problem demands multidisciplinary, multiagency action in what may be identified as a "community team" approach.

Oviatt (1972) points out that child abuse and neglect laws were enacted in fifty states within the very short period of the five years between 1962 and 1967 because of the combined efforts of (1) mass media, (2) individual professionals and/or active laypersons, (3) voluntary organizations, and (4) agencies of the executive departments of states. If such persons/organizations have been effective in arousing their communities to advocate and support passage of state-level reporting legislation, surely they can also mobilize their communities to demand the provision and availability of one or another sort of community team approach, one most useful to their "community."

Our experience in DHEW Region V leads us to believe with Helfer, Kempe, DeFrancis, Isaacs, Oviatt, Newberger, and Delaney that problems of violence toward children can be coped with effectively only if citizens and professionals contribute their various kinds of commitment and expertise to a genuinely cooperative effort to protect children from death or permanent damage and enhance family (or family substitute) functioning.

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How to Start Local Child Abuse Programs with Love, Enthusiasm, and Very Little Money

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THE SAN ANTONIO CHILD ABUSE COUNCIL

HISTORY OF ORGANIZATION

Because of her concern for the treatment of abused children in San Antonio, Mrs. David (Karen) Menger organized WAIF (Women Aiding Infants and Families) in January, 1971. WAIF was incorporated in May, 1972, and in July, 1972, WAIF members, all volunteers, organized a Mayor's Conference on Child Abuse. The conference focused on the nature and severity of child abuse, as well as providing information on child abuse programs throughout the country. Its recommendations served as the impetus for the formation of the Coordinated Child Care Council's (the coordinating agency for child care programs) Ad Hoc Committee and the broader-based Task Force on Child Abuse and Neglect established by the Community Welfare Council in October, 1972. Dr. Ronald Keeney, a pediatrician, was appointed Chairman of the Task Force. The Statement of Purpose as originally adopted by the Task Force stated:

> "The purpose of this Task Force is to define neglect and abuse of children in San Antonio, to discover its scope and severity, and to propose orderly and rational means of relating to the problem in a therapeutic, non-punitive manner. In this context the abused and/or neglected child is (1) defined as any child whose health and development are impaired or endangered by non-accidental trauma by parents and/or caretakers or a failure of said caretakers to provide adequate care and protection and (2) recognized as a symptom of severe family pathology. The Task Force will assume the responsibility for discovering, coordinating, and directing existing appropriate community resources in a centralized effort to offer the community an open and accessible procedure for adequately aiding these families in distress. These efforts will start with immediate establishment of a centralized community registry of all childhood trauma, for the determination of the extent of the problem, as an ongoing consultation service available 24 hours a day, 7 days a week, to aid community professionals and respond appropriately to problems of abuse and neglect."

The Task Force initiated a Countywide Childhood Registry but discontinued it when the State Department of Public Welfare created a Statewide Central Registry located in Austin and accessible through a toll-free telephone number. Additionally, the Task Force identified and

widely publicized the 24-hour availability of a Crisis Center Child Abuse Line, and also Bexar County's Child Welfare Intake Unit. A review of the Task Force's goals and accomplishments was made to the Community Welfare Council in May, 1973. The following outline comprises the Task Force's Status Report:

A. Define Child Abuse to Task Force members and the community:

1) Presentations were made by speakers from October, 1972 to May, 1973.
2) Newspaper articles. Publicity about the Task Force appeared regularly.
3) A videotape on interviewing the abusive parents in the hospital emergency room was taped at the University of Texas Health Science Center (medical school and county hospital) Television Department.
4) Literature and bibliographies on child abuse were distributed.
5) A mock trial on child abuse was held June 8, 1973, in the Probate Court. The Task Force offered this trial in an attempt to provide a forum for the many attitudes and issues that come before the Judge in civil proceedings. Representative agencies realistically portrayed their roles in the courtroom, and the medical, legal, and social approaches were thoroughly explored.
6) Television interviews highlighted our concerns. This medium was most cooperative in helping transmit our message to the public.

B. Discover the scope and severity of child abuse and neglect: Total cases reported to Bexar County Child Welfare were tabulated. The number of cases by hospital were statistically tabulated.

C. Proposed Therapy:

1) Protection of the children whose welfare is endangered requires the attention of the Police, Bexar County Child Welfare, the Judiciary, and the District Attorney—Juvenile Bureau.
2) Potential rehabilitation services for the family include: child abuse teams in the local hospitals—military, public, and private—and the University of Texas Health Science Center; parents' groups; adolescent groups through Youth Services; Legal Aid for the parents; court action; day care centers; police; private physicians; and community health centers.

D. Community resources which could be mobilized and specifically trained to better meet the needs of the abusive/neglectful family:

1) Primary: crisis day care, crisis phone line, volunteers, private physicians, Bexar County Child Welfare (Child Protection Services under the Texas State Department of Public Welfare), police, and courts.
2) Secondary: treatment centers, foster grandparents, lay therapists, and mental health centers.
3) Tertiary: housekeeping, transportation, media, and funding.

E. Coordination and Director of Resources: The potential exists for an unincorporated consortium involving Bexar County Child Welfare, San Antonio Police, District Judges, University of Texas Health Science Center, Santa Rosa Medical Center, Wilford Hall Air Force Medical Center, Brooke Army Medical Center, primary physicians, media, San Antonio Metropolitan Health District, Department of Public Welfare, public schools, and other home visiting agencies and mental health agencies to initiate services and better coordinate present programs.

F. Community-Based Central Effort: To aid families, San Antonio needs:

1) Coordination: Extension of the Task Force Membership,
   a) Development of treatment resources.
   b) Ongoing education and Speakers' Bureau.
   c) Surveillance—Reporting of statistics to a Central Registry.

2) Central Coordinator—salaried position.
3) Consultation Teams.
4) Funding
   a) Fee for service.
   b) Donations.
   c) Grants.
5) Ongoing research.

Upon completion of its study, the Task Force was dissolved in May, 1973, and the San Antonio Child Abuse Council, a voluntary community effort, was created to implement the Task Force's recommendations. WAIF continued as a member organization of the Child Abuse Council and supported its programs with volunteers and fund raising. Dr. Keeney continued to direct the volunteer effort until he left San Antonio in June, 1973. At that time, Myra Lappin, MPH, Instructor in the Department of Family Practice, University of Texas Health Science Center at San Antonio, was elected Director of the Child Abuse Council. In August, 1974, the responsibility for directorship of the Council was given to James and Judith Scanlon, ACSW. Directorship of the Council reverted back to Myra Lappin from August, 1975 to August, 1976. Since 1976, co-directorship of the Council has been held by Dr. Dale Wood and James Derr.

ORGANIZATIONAL STRUCTURE

The San Antonio Child Abuse Council presently consists of the following committees and advisory teams:

Steering Committee

The Steering Committee meets monthly and has a membership consisting of the coordinators of the various committees and other individuals from the community whose roles are considered vital to the efforts of the Council. The Steering Committee is the policy-making body of the Council, and directs the work of the committees. Members of the Steering Committee include the project directors, the medical advisor, Director of Bexar County Child Welfare, representatives of hospital-based support teams, and the coordinators of the various committees of the Council which include: physicians, private practice attorneys, psychologists, media representatives, housewives, and educators in early child development.

Medical Advisory Team

The Medical Advisory Team was organized to keep the medical community informed of the Council's activities, to facilitate professional education regarding child abuse, to elicit approval from the medical community, and to respond to their recommendations regarding issues raised by the Council and new programs being presented. Members of the team include: private practice physicians, pediatricians, orthopedists, Dean of the Health Science Center School of Medicine, Chairman of the Department of Pediatrics of the local children's hospital, psychiatrists, radiologists, and ophthalmologists.

Lay and Professional Advisors

The Lay and Professional Advisors serve in an advisory capacity related to their special competencies (legal, community, medical, social, and educational). Advisors ensure needed input from their representative agencies. The advisors include representatives from the following: Bexar County Mental Health-Mental Retardation Agency; Council of Churches; Crisis Center of San Antonio, Inc.; Mexican-American Unity Council; Residence Associations; Family Services Association; Medical Social Service Departments; Alamo Area Council of Governments; San Antonio Police Department; Ecumenical Center for Religion and Health; and area universities. Eleven supporting committees conduct the ongoing work of the San Antonio Child Abuse Council.

Lay/Professional Education Committee

The purpose of this committee is to promote public awareness of child abuse, acquire and develop child abuse training materials, and assist in the development of in-service training for the helping lay and professional, who make presentations to any interested group—professional, civic, student, etc. The Education Committee has also sponsored a community-wide Child Abuse Seminar, seminars for the clergy, a pre-clinical elective at the University of Texas Health Science Center, and two certificate courses in Child Abuse Management in conjunction with San Antonio College. The Committee is made up of the following: School of Nursing, Health Science

Center, Family Services Association, Planned Parenthood, Continuing Education Department of a local junior college, AVANCE (parenting education for Mexican-Americans), and the Foster Home Division of the State Department of PublicWelfare.

Media Committee
The purpose of this committee is to foster a non-punitive approach to the reporting of the problems and ramifications of child abuse through individual contact with press and public communication personnel, and to create public service announcements emphasizing the therapeutic services available. The members of this committee are representatives of the various media in the community. This committee also served as a principal advisor for a documentary on child abuse in the community, "Sticks and Stones."

Research Committee
This committee is made up of representatives of all area institutions of higher learning and has a twofold purpose: (1) to provide on-campus representation of the Child Abuse Council to direct students in their individual research projects and to help with the development of modules for inclusion in the curricula of their institutions, and (2) to stimulate and facilitate research in the area of child abuse in general.

Legislative Committee
This committee offers educational programs to the legal community of San Antonio, and lobbies for the passage of statewide and national legislation pertaining to child abuse. It has carried out a thorough review of the present child abuse legislation of the State of Texas and recommended appropriate amendments. The committee consists of: private practice attorneys, pediatricians, clinical psychologists, representatives of the American Civil Liberties Union, District Attorney's Office and Bexar County Child Welfare.

Central Registry Committee
This committee's purpose is to research other trauma registries in existence throughout the country, to explore the possibility of reestablishing the Central Trauma Registry, and to evaluate the effectiveness of the State Central Child Abuse Registry CANRIS (Child Abuse and Neglect Reporting Information System).

Adult Therapeutics Committee
This committee serves as a consultation resource in the development of new programs or techniques, and in the expansion of existing programs to enhance the work of agencies and/or disciplines in their therapeutic services offered to the abusive or potentially abusive family. Members of this committee include psychiatrists and social workers. This committee has agreed to act as a consultant for volunteer groups working with abusive families. Its members are also available to consult with caseworkers who handle child abuse cases.

Foster Care Committee
This committee was organized to formulate recommended principles and standards which Bexar County should follow in providing foster care. Members of this committee include social workers, President of the local Foster Parents Association, and lay people.

Day Care Committee
The Day Care Committee develops in-service training programs for day care center workers and provides input to educational programs in the field of early child development and day care center worker training. Members of this committee include representatives of Educational Service Center, State of Texas; San Antonio Association for the Education of Young Children; National Council of Jewish Women; National Organization of Women; State Department of Public Welfare; and employees and owners of public and church sponsored day care centers. This committee helped outline the training workshop for volunteer church women who wished to become boarding day home mothers.

Adolescent Therapeutics Committee
The purpose of this committee is to investigate existing therapeutic services in San Antonio for the adolescent and make recommendations for needed consultation to enhance their services; work with educators to include parenting education in family living courses at the junior and

senior high school levels; establish rap sessions; and identify those adolescents in need of further therapy. Members of this committee include specialists in adolescent medicine and psychiatry, educators, and representatives of the San Antonio Police Department, Bexar County Probation Department, Youth Services Project, and local children's service agencies. A course in Counseling the Adolescent Girl was recently taught under the auspices of University of Texas at San Antonio Continuing Education Department.

Juvenile Justice Committee
This committee was established to review the various Texas statutes pertaining to the treatment of juveniles, make recommendations for their amendment, and to provide a common meeting ground for the development of various programs for the treatment of juveniles within the community.

Grants Committee
This committee reviews requirements for public and private foundation funding, and formulates grant applications in cooperation with the Research Committee in anticipation of the future needs of the community.

COMMUNITY CHILD ABUSE CONFERENCES
In March, 1975, the San Antonio Child Abuse Council and the State Department of Public Welfare jointly sponsored a visit by Diana Kirkpatrick, Regional Director of Parents Anonymous, in the hope of gaining community support to begin a Parents Anonymous Chapter in San Antonio. As a result, a Parents Anonymous Chapter was organized and sponsors for the group were secured.

Additionally, the council planned and conducted a conference entitled Cycle of Abuse: Treatment for the Family, March 7-9, 1975, and secured national child abuse authorities to participate. A second conference entitled Child Abuse Prevention: A Community Responsibility was held in San Antonio, May 15-17, 1975, at Trinity University. The San Antonio Child Abuse Council planned the conference with the support and sponsorship of many interest groups. A third conference entitled Behind Closed Doors: A Candid Look at Difficult Family Problems was held in San Antonio, June 17-19, 1976. The conference, a joint effort by the military and civilian communities, was sponsored primarily by Project CARE.

The Council is presently formulating plans for a fourth conference to be held early in 1978. The conference's focus will address the theme of adolescence and will include topics on abuse and neglect; teenage parenthood; family planning; juveniles in trouble; drug use and abuse and treatment modalities; crisis intervention and counseling of adolescents; and alternatives to incarceration.

IMPACT OF THE CHILD ABUSE COUNCIL
The council's impact on the community's response to child abuse and neglect has been felt in several areas. The Council has served as an impetus for more than two million dollars being channeled into the community to demonstration projects as well as to existing agencies. Sixteen child abuse programs have been initiated during the past three years of the Council's existence. The Council's role in increasing awareness of child abuse in the lay and professional communities, coupled with the intensive media campaign conducted by the Texas State Department of Public Welfare, resulted in nearly tripling the number of child abuse cases reported between 1974 and 1975. During 1976, reported cases stabilized at the record 1975 level.

The following is a listing of cases reported toBexar County Child Welfare for the period 1972 through 1976:

	1972	1973	1974	1975	1976
ABUSE					
Beating		359	493	1210	1282
Burning		35	42	68	38
Sexual		49	49	162	153
Total:	481*	443	584	1440	1473
NEGLECT					
Food Deprivation		252	287	374	483
Emotional		279	561	970	938
Physical		698	887	1316	1326
Supervisory		1188	580	2710	2496
Total:	1330*	2417	2315	5370	5243

* Figures were not categorized prior to 1973

An additional contribution which the Council has made has been the formulation of a policy and goals for a comprehensive approach to child abuse and neglect. The following statement was submitted to the Alamo Area Council of Governments for inclusion in its five-year program for action:

POLICY

Treatment services for abused/neglected children should be expanded and incorporated into a coordinated network of comprehensive child abuse/neglect prevention, detection, and management services which would be an integral part of the health care delivery system and would emphasize reaching and serving troubled families through culturally relevant modes of intervention, seeking to maintain and support intact family units and minimize separations.

GOALS

To establish a coordinated network of services that are comprehensive in approach, cooperative in design and with the paramount aim of reducing the duplication of efforts in the prevention, detection, treatment, and management of services available to families.

To reduce the mortality rate of children due to abuse/neglect.

To improve reporting mechanisms to make possible the early detection of child abuse and neglect and subsequent protection of children.

To make services for families with abused and/or neglected children more accessible.

To develop inter-disciplinary teams which will be an integral component of a service-network in the detection, diagnosis, and treatment phases of family care.

To improve existing services in the areas of prevention, detection, treatment, and education for child abuse and neglect.

To develop supportive services that enhance the direct treatment services for families in crisis.

To develop innovative, comprehensive and coordinated treatment services in those areas in which they presently do not exist, either locally or regionally.

To develop primary prevention services which will be aimed at breaking the cycle of child abuse and neglect through education and mental health services for youth and young families.

To expand educational and informational programs for the lay and professional communities aimed at describing the causative factors, prevention, and treatment programs and availability of services for troubled families.

To explore and actively pursue funding sources for child abuse and neglect programs.

To develop new job descriptions and positions in the field of child abuse and neglect, and to train qualified professionals and para-professionals to serve members of troubled families.

To maintain the provision of quality supportive and therapeutic (mental) health services to children and parents.

To develop a mechanism of accountability, monitoring, and quality control for all services.

Family Advocates: Is There a Need?

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My topic of discussion is the student home nurse intervention program. Three years ago, I established the need for a home outreach program to serve the families referred to Dr. Arthur Green's clinic. The performance of the student nurses who staffed that program has been outstanding, and I want to note some examples of their fine work in the Brooklyn community. We all realize, I am sure, the dramatic need for family advocacy, and the significant differences between it and the more limited concept of child advocacy.

Brooklyn can be extremely brutal. It differs from the rest of New York in that latency-aged children are those most frequently abused, with hair brushes the most frequent method of abuse. Because of the community's size, and the extent of the problem, we faced a seemingly gargantuan task at the onset of the program.

That we worked with nurses helped lighten the problem. A nurse traditionally has been a patient advocate, explaining to the patient the confusing jargon, offering reassurance in time of pain, and is the most frequent attendant during hospital confinement. Our program represents an extension of the nurse's role, an extension from treatment to prevention. As result, the whole effect of illness upon the family—upon humans outside the hospital—has been a just concern of the nursing profession. The New York State University College of Nursing exemplifies a curriculum designed to meet the profound ramifications of illness, from both effectual and preventive perspectives. Once child abuse is understood as illness, the involvement of nurses on a community basis with the problem becomes comprehensible.

Who are these nurses? They are upper-division students who each have volunteered to care for one family for one year. After six months, they are asked to consider a replacement for themselves, assuming the family has not, by the end of the year, achieved functional independence. By planning ahead for suitable replacements, we have achieved notable continuity of the program.

The volunteer status eliminates much bureaucratic red tape. Other systems are pressed for time, and case load abrogates a great deal of effectiveness. Under the student nurse program, however, with one student per family, there is more than sufficient time and no case load.

One can probably see from this bare outline how family advocacy differs from child advocacy. The nurses we send into these situations deal with the whole context in which abuse occurs, not merely with its grisly aftermath. Prevention thus becomes something more than merely isolating the child from the abusing parent, an isolation which proves less than effective. Our prevention treats the roots without chopping down the tree. Is it possible to advocate for a child outside the family context? It is possible, but only by further crippling the family. Ultimate effectiveness comes only by treating the child as part of the problem.

Indeed, ours is an outreach program in the truest sense of the term. Each student's primary task is to be a friend to the family. The subject of child abuse is rarely, if ever, discussed. Once he or she is with the family, the nurse's tasks are extremely varied. Nurses help parents shop, cook, and perform other homemaking tasks. They oversee the family's medical regime, and, if necessary, they help secure better housing and school changes. They counsel mothers in the handling of newborns, intervene in court situations, and aid in peer relationships on all generational levels. They encourage parents to attend weekly parent group therapy sessions and assist in difficult meetings with foster parents. In short, the nurse intervenes but does not interfere with the quality of family life.

We find many of our families living with complicated social or physical problems which have never been diagnosed, or, if diagnosed, are never sufficiently explained to the patient. Many live in a crisis situation without realizing their condition. One mother struggled to handle a mentally retarded and hyperactive nine-year old, a six-year old who had not been immunized or physically examined since the family moved to New York from Puerto Rico, a two-year old with no indication of speech development, and a four-year old who had been hospitalized with atresia of his trachea from drinking lye accidentally given to him as water! Her husband, meanwhile, was unemployed and drinking excessively. Suddenly, not only did her 13-year old daughter arrive from San Juan, her apartment also burned down!

Though she tried to "cope" as gallantly as possible, the mother would frequently release her frustrations by insisting that her nine-year old wash dishes, cook, clean, and care for the two-year old. When these demands exceeded the child's capacities, the mother would abuse him. The student nurse proceeded slowly in modifying the mother's approach to these crises—without being purely negative or critical. A negative approach would have mirrored the client's mother and thus have been wholly counterproductive. After assessing each family member as well as the general environment, the student used positive reinforement to tell the mother what a marvelous job she wa doing to keep her family together under such difficult circumstances. Now, the mother could more easily accept a homemaker to stay with the children while she visited her hospitalized child. Moreover, the student offered preoperative and postoperative teaching for the hospitalized child, the parents, and the siblings, including instruction in psychological as well as physical aspects.

With such a situation in mind, one can no doubt assess how limited a concept child advocacy is, and how a whole new conceptualization, family advocacy, is indispensable. Our students are available to the family 24 hours a day. In addition, students have access to my supervision via telephone at all times. Our success is measured in our family court activities, our attendance at childbirths, at the welfare office, and with school teachers. In summing up our contribution, I believe we have diffused the hostility that leads to abuse by strengthening the family mechanisms necessary to cope with the outside world.

We have found it necessary to be flexible and persistent. We have tried new approaches, but only with the foreknowledge that they were to be abandoned if proved unworkable. For example, we presently have a mother who suffers from kidney disease and fears the fate of her two-year old child once her illness worsens. More than likely, the woman is terminally ill. Our student is negotiating for a set of future foster parents that both mother and child can meet well ahead of the critical moment. The procedure is unorthodox, but we will do our best for as long as it seems proper.

Finally, I want to stress the need for federal as well as local support for systems such as ours. In our case, for instance, due to insuficient funds our affiliation with Dr. Green will soon terminate. We plan, however, to continue as autonomous volunteers in the Brooklyn community, with referrals accepted from the Visiting Nurse Service, Special Services for Children, and private individuals. I also will take advantage of every opportunity and platform, such as this conference, to encourage the growth of family advocacy.

The Victim Advocate: A Proposal for Comprehensive Victim Services

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OVERVIEW

The plight of victims is being addressed worldwide, mostly through monetary compensation measures and scientific studies. The Victim Advocate Project attempts to add another dimension to the concern for victims. It extends a helping hand to victims who, for the most part, are ignorant of what services or funds are available, are unfamiliar with bureaucratic procedures necessary to secure assistance, and are usually too traumatized to know how to cope with their dilemma. This project would help bridge the gap between the victim and the resources, and finally make the victim a bona fide recipient of needed services rather than a stepchild who, heretofore, only suffered at the hands of the criminal justice system.

THE PROBLEM

Every year, throughout the world, thousands upon thousands of crimes are committed upon untold numbers of victims. Billions of dollars are spent to process and rehabilitate the perpetrators of these crimes, but little is done for the victims. A recent national survey demonstrated that the risk of being victimized is highest among lower income groups for all offenses except homicide, larceny, and vehicle theft; is higher for nonwhites for all offenses except larceny; and is higher for men except in cases of forcible rape. The greatest risk occurs in the 20 to 29-year age group, except for larceny against women and burglary, larceny, and vehicle theft against men (President's Commission on Law Enforcement, 1967). In the United States, the National Crime Commission stated that, "One of the most neglected subjects is the study of the effects of crime on its victims." The problem has several important dimensions.

The first dimension is the immediate harm inflicted upon a victim (i.e., monetary, physical, or emotional). Victims may be direct victims (the recipients of the criminal act), and indirect victims (those who suffer as a result of the direct victim's injuries). The idea of reimbursing the victim for his injuries is not new. In ancient Babylon, sections 22-24 of Hammurabi's Code specified that, "If a man has committed robbery and is caught, that man shall be put to death. If the robber is not caught, the man who has been robbed shall formally declare what he has lost...and the city...shall replace whatever he has lost for him. If it is the life of the owner that is lost, the city or the mayor shall pay one maneh of silver to his kinsfolk."

In ancient Arabia, the responsibility for the dependents of homicide victims was placed on the community. The Bible (Deut. 21:1-9), refers to the shedding of innocent blood as defiling the land until some form of atonement is made. This notion continued through Middle English history to provide a murdered man's family with a werguild of four pounds (at that time, a large statutory sum).

From a monetary standpoint, many states and the federal government have developed victim compensation legislation. In some instances, reimbursement is provided for specific types of injuries resulting from a crime. In other instances, special insurance is provided for unusually vulnerable people. Other countries such as England, Canada, New Zealand, and Australia have comprehensive victim compensation programs. In the United States, legislation is presently pending designed to compensate the victims of violent federal crimes or their survivors, plus those who intervene to prevent such crimes. A specially appointed Victim Compensation Board would administer the program through the Department of Justice. Compensation up to $50,000 could be provided following a claim-filing procedure by a victim or his surviving dependents if specific amounts of money lost were verified. Such claims could include medical expenses, physical and occupational therapy, loss of earnings, support payments for dependents, and even funeral expenses which resulted from the crime committed.

Some victims are repaid for property losses if the offender is able to make restitution. A unique notion that restitution to the victim is the personal responsibility of the offender as an integral part of the correctional process was early posited by the noted victimologist Steven Schafer. He also suggested that "correctional restitution" could be woven into the total rehabilitative process, underscoring the "functional responsibility" of the criminal (1968).

Another victimologist, Zvonimir Separavic, claims that compensation to victims should not be made automatically, but that the offender should be charged with the responsibility of restoring his victims to their precrime position. This would significantly increase the rehabilitative potential of the correctional system (Ford, 1973). President Johnson's Commission on Law Enforcement and the Administration of Justice (1967) found that only about 50 percent of all crimes are ever reported. The Federal Bureau of Investigation concluded that of those crimes reported only about 20 percent are cleared by arrest. Of those cases cleared only 28 percent of the offenders are convicted. This 28 percent represents three percent of the total number of persons committing crimes. Of this three percent, few are able to make even token restitution to the victim. The majority of these offenders come from the lowest income groups. Leroy Lamborn (1968) pointed out that:

> All types of crime are committed by persons from all economic levels of society, but a substantial proportion of crime is committed by persons with little property. Forty-three percent of the persons tried for all felonies are found to be indigent for the purpose of court appointment of defense counsel and fifty-six percent are not released prior to trial because they cannot raise bail. Whatever assets there are of those able to afford counsel are often consumed by the legal costs of the defense and finally fines reduce or eliminate the assets of the criminal while imprisonment restricts his earning power.

Thus, little real aid can come from the offender. Yet, each criminal should at least be required to make a token restitution.

Assistance to victims of both property and personal crimes is nonexistent in most local communities. The emotional upheaval of a person assaulted, a girl raped, or a family who has had one of its members murdered has been virtually ignored by the criminal justice system. One recent exception is the University of Chicago's Billings Hospital. Special treatment is provided to rape victims dealing both with immediate and long-term problems. In an article by Ronald Kotulak (1972) of the Chicago Tribune Service this program was explained as dealing with the emotional and physical needs of assault and/or rape victims. Child victims of adult sex offenders are the community's least protected children. Vincent De Francis (1971) notes that most of our communities fail to answer the needs of children who are victims of sex crimes. The means to accommodate the physical needs of victims have always been available as a matter of course. Yet, for the poor, even minimal medical attention is often avoided due to expenses the victim must pay. Thus, free medical services, though available through local clinics, are usually not known to those who require these immediate services.

The second dimension concerns the protection of the victim from resultant social stress. Stress may come from either direct exploitation by the media in the promotion of sensationalism and/or community rejection due to distorted information surrounding the incident, and harmful stereotyping of certain victim types. Especially relevant to victims of personal crimes is the community's response and its effect on the injury frequently compounded and prolonged inadvertently by the media. Not only does this tend to perpetuate the emotional injury but it also weakens the rational treatment of offenders. It generates excessive hostility, accentuating retribution, often at the expense of rehabilitation.

Much of the retribution meted out toward offenders by the system is a formal attempt to collectively carry out vengeance on a criminal to compensate for the injury done to the victim. In large part, the punitive attitude toward an offender is expressed in proportion to the degree of perceived injury to the victim. It is reasonable to hypothesize that if victims were systematically treated for their actual injuries, the degree of perceived injury would be effectively reduced and the resultant hostility toward the offender, especially in the sentencing process, significantly mitigated. Thus, the process of sentencing and classification could be more objective and less emotionally clouded, affording more rational decisions with offender treatment programs.

A third dimension concerns the victim/offender relationships. In many instances victims play a significant role in the commission of crimes. Franz Werfel, in his well known novel *Der Ermordete Ist Schuld* (The Murdered One is Guilty), goes so far as to claim that in some instances the victim is the guilty party. However, most victims are innocently involved in crimes and should be given all the assistance necessary to restore them to their original state. In many cases, victims are found to be repeatedly involved in crimes. Yet, this "victim recidivism" continues unchecked, creating situations which produce further crime. Thus, in many instances,

the attention to the victim/offender relationship could have been of relevant preventive value. Victim files should be kept. Presently, few municipalities have files on the extent of victim involvement in a crime. In many instances, victims need therapeutic services in order to alter their victimogenic behavior. In Yugoslavia, if a victim is found to have contributed to his fate, no restitution is made (Ford). Specific treatment modalities need to be developed for the type of client who is inextricably part of the crime problem. In Schafer's Florida study, it was found that six percent of the cases studied involved direct provocation by the victim, and an additional four percent involved passivity by the victim (Schafer, p. 81). In words of the noted victimologist Hans Von Hentig, the crime precipitant victim is an "active sufferer" and modifier of the offender's criminal behavior (Von Hentig, 1948). Another victimologist, Wolfgang (1958), states that "except in cases in which the victim is an innocent bystander, the victim may be one of the major precipitating causes of his own demise."

THE OBJECTIVES

The point of this proposal is to provide a community with victim advocates who would assist victims by intervening in crises and acting as community facilitators directing victims to community resources.

Some specific behavioral objectives could be:

(1) As part of the preparation for the project the advocate first would identify the number of victims of felony offenses that occur within a 12-month period for a given community;
(2) To assist victims with their plight by interviewing each, and if the case warrants, following through with limited counseling and guidance. Services would not be obligatory;
(3) During this initial interview the advocates would provide victims with advice as to what existing community services are available and how they can be obtained;
(4) The advocate would provide victims with a community services packet that would contain directories and instruction for each separate community agency that could potentially assist a victim in need (VIN);
(5) In cases where the victim is unable to help himself, due to emotional or physical trauma, an advocate would act as a resource facilitator (i.e., make contact with resource agencies, and arrange for transportation of the victim to them);
(6) Upon request, advocates would provide the media with accurate information about the victim, and if necessary, act as a buffer between the victim and the media. The amount and type of information provided should be determined by its impact on the welfare of the victim;
(7) Advocates would fill out a questionnaire on each victim during an initial interview to ascertain the relationship between the offender and the victim. These data would be filed and upon legitimate request made available to the community social and mental health agencies dealing with victims. This record keeping could be mandatory depending on local sentiment;
(8) Advocates would contribute to the pre-sentence investigation, providing information on the victim that has relevant bearing on the commission of the crime in question and thus on the sentencing process;
(9) Advocates would familiarize themselves with all federal, state, and local laws pertaining to victim compensation, and thus serve as resources for victims who need information about obtaining these funds;
(10) Advocates would be expected to attend professional conferences and familiarize themselves with the current literature in the field of victimology. This would help keep their knowledge and skill abreast of changes in the field;
(11) Advocates would make themselves available to the community as a preventive resource working in conjunction with other agencies (e.g., police) in efforts to prevent people from becoming potential victims. This would include carrying on a continuous public relations program to let the community know about the Victim Advocate Project; and
(12) In an effort to make restitution part of the correctional process, victim advocates would provide the courts and correctional agencies with information on the victim deemed necessary to facilitate rehabilitation of the offender.

THE RECOMMENDED PROCEDURES AND TIMETABLE

An advocate would serve as a temporary sponsor, helper, and friend to the victim in an effort to reduce the injury suffered from the crime and to prevent the possibility of a recurring victimization.

Ideally, the victim advocates should be located near a law enforcement agency, and establish a close working relationship with the agency's operations section. This requirement would provide advocates with timely information on newly identified victims. The number of advocates should be proportional to the number of victims identified in the community.

Another essential component of this project should be to obtain hard data on the nature of the victim problem in the respective community. Research should be used to tailor the early stages of the Victim Advocate Project to the respective community under consideration.

The recommended activities and time frames are:

Phase I—Two Months

The hiring of victim advocates would be the first step of this phase. At a minimum, these persons should: have a bachelor's degree in a social science-related area; know the community well; and have a minimum of two year's experience in related community service work. Selection of advocates would be the task of the local government.

One of the main purposes of this phase would be to develop a working draft of an operating procedures manual to fit the community being served. This phase also would be concerned with devising criteria for identifying victims in need. These criteria would be related to the commission of a reported crime, and necessarily depend on direct cooperation and coordination with: law enforcement agencies, in order to provide immediate notification of a possible victim; the prosecutor, in order to minimize the dehumanizing impact on the victim by the judicial process; and, the courts, in order to protect the victim from undue emotional stress resulting from the victim's appearance in court, and to encourage the use of restitution as part of each offender's sentence.

The direct involvement of the victim advocate in the legal process should be avoided. The advocate is not a lawyer and should not offer legal advice nor represent the victim in any legal matters. Thus, specific legal questions surrounding the crime should not be addressed; rather the victim's injury and the proclivity for future victimization would be the project's main point of concern. The criteria developed would address such areas as: types of alleged crime (personal or property); type and degree of injury (monetary, physical, and/or emotional); ability of victim to recover from the injury; and, impact of the crime on the community.

Also, during this phase an initial interview questionnaire would be completed. This document would provide: data for various service agencies; assistance in the speedy resolution of immediate crises brought about by the commission of a crime; accurate information for the media; information that would provide an understanding of the offender/victim relationship; and, basic data on the victim's background for research purposes.

Phase II—Three Months

This phase would be concerned with limited implementation. It would require working closely with criminal justice and welfare agencies in the community. During this phase, the project would test its forms and procedures, possibly using only special categories of victims, (e.g., property crimes or personal crimes). One week before the end of this phase an evaluation of these three months would be conducted. This week would be used principally to revise the overall procedures manual and the project's forms in preparation for Phase III, which would address services for all eligible clients.

Phase III—Seven Months

This phase will place the project into full operation using a revised procedures manual draft and new forms. At this point, all victims of personal and property felonies might be considered for inclusion as clients. Another important part of this phase, separate from the actual services rendered, is the preparation for subsequent funding of either federal, state, or local resources. At this final phase, and not earlier, public awareness of the project should be maximized.

THE AVAILABLE RESOURCES

It is expected that extensive resources would be utilized. Resources may be divided into: manpower, money, material, and expertise.

Manpower resources would logically involve the Victim Advocate Project's staff, related support agencies' staff (i.e., doctors, nurses, psychiatrists, counselors, police, prosecutors, judges, journalists, etc.), and volunteer workers who could assist in those cases where community resources are either nonexistent or too expensive.

Money resources refer to those funds required to operate an office for the Victim Advocate Project as well as funds to purchase private services. These may come from several sources: local government, private doctors, state revenue, or federal monies.

Material resources address the physical needs of the project, to include such items as office space, furniture, office equipment and supplies; donated, borrowed, or purchased.

Expertise resources refer to the knowledge which can be brought to bear on the operation of the project, how sophisticated are those who make the key decisions for the project, and what auxiliary expertise is immediately available through libraries, refererce services, and consultants.

Two key agencies that would be required to cooperate to ensure the viability of this project would be the local police agency and the local mental health agency.

THE EVALUATION PARAMETERS

To assess the impact of this project, a tripartite approach should be used to mirror its three main components, viz, immediate injury, media buffer, and victim/offender analysis. Thus, records should be kept on each client as he is identified, and each service received should be recorded. The client's progress should be monitored and assessed at various points during his/her recovery.

Evaluation of the immediate injury component would be to determine the length of time required to restore stability of a functional level of activity commensurate to that enjoyed prior to the crime.

Evaluation of the media buffer component is more subjective and would be addressed in the client's record. A brief narrative evaluation would state the extent of media involvement and the role played by the victim advocate in that involvement.

The evaluation of the victim/offender analysis component would be reflected in the analysis per se, and would also be part of the client's record. Statistics would be collected and analyzed to determine the effectiveness of the treatment recommended for those persons identified as victims in need and/or victim recidivists.

The total spectrum of victim advocate services should be evaluated, especially those relative to the subsequent behavior of the victim recidivist as well as the behavior of the offender. Practitioners who use restitution as a rehabilitative tool should make a concerted effort to publish the results of this practice so as to aid other similar projects (Galoway and Hudson, 1972). The future of victimology will depend on the broad dissemination of information which ultimately has serious ramifications for the greater understanding of the dynamics of the total crime problem (Fattah, 1967).

The necessary end product of this evaluation component would be to incorporate program changes, project modifications, and new directions generated from the evaluation into a final victim advocate manual. This document would represent a more stable set of operating procedures to guide the program until such time as another evaluation is performed.

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Defining Strategies for Family Advocates: Federal Funding, State Spending, and Local Provision of Child Protective Services Under the Title XX Program

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Family advocates should look to all sources of federal funding when defining strategies for implementing child protective services. A most significant federal program, Title XX of the Social Security Act, provides funding for services which are directed to the goal of "preventing or remedying neglect, abuse, or exploitation of children (and adults) unable to protect their own interests, or preserving, rehabilitating, or reuniting families."[1] Services directed to this goal may be provided without regard to the family's income in documented cases of abuse and neglect. States plan to spend over $240 million or 8% of the total Title XX expenditures on child protective services during fiscal year 1977.

What is Title XX? Where has it been? Where is it going? These are questions which can be answered by providing the historical context of Title XX. Title XX was signed into law on January 4, 1975, as the twentieth amendment to the Social Security Act. It established a new statutory and administrative framework for the public social services program. The services provisions of Title IV-A and VI were replaced by Title XX, which allocates 2.5 billion federal dollars to the states based upon population and the amount of 25% matching money. Although Title XX is not new money, the law does provide added flexibility and responsibility to the states for determining needs, defining services, and planning for a coordinated and comprehensive delivery of services. This planning process requires a public review process in which citizens may participate.

Title XX is the newest program of the Social Security Act of 1935, which first redefined the federal government's role in providing income security to needy citizens. Not until twenty-one years later, in 1956, was the need for social services to encourage the goals of self care and self support recognized. At that time, states were to fund services as part of the administrative costs of the income maintenance program with a 50% federal matching rate. In 1962, states were encouraged to use services to meet the goals of rehabilitation and reduction of welfare dependency and were provided an incentive of a 75% federal matching rate for funds.

By 1967, services were proposed as a means to curb the expanding welfare rolls. With an emphasis on work-related services, a provision for states to purchase services from the private sector was introduced and implemented. During the next five years, states for the first time began to develop social services programs of their own. One effect of such program development was an increased use of federal money. The estimated expenditures in 1972 were $1.7 billion. However, the estimated amount for 1973 jumped to $4.7 billion. In response to this "uncontrollable" spending, Congress placed a ceiling of $2.5 billion on funds available for services effective in fiscal year 1973.

In response to the Congressional action, HEW issued new regulations to require the states to allocate the limited funds more carefully. However, these proposed regulations received enormous negative public comment, and Congress rejected them and would not allow HEW to publish any other regulations for the program until January 1, 1975. During 1974, HEW, in collaboration with governors, representatives of state and local government, and the voluntary services sector, worked closely with Congress in developing a new social services program—Title XX. This coordinated effort resulted in a public social services policy based upon planning and public accountability rather than federal regulations.

This $2.5 billion program with federal matching of 75% (90% for family planning services) is now in effect. Although no services are mandated, each service provided must be directed to at least one of the five goals. These goals are: (1) self-support, (2) self-sufficiency, (3) prevent or remedy neglect, abuse, or exploitation of children or adults and preserve families, (4) prevention of inappropriate institutional care through community based programs, and (5) provision of institutional care where appropriate. Eligibility for services is no longer related to a person's status with the welfare department, but is instead based upon income. Federal funds are available for services to anyone whose income is below 115% of the state's median income. States must charge fees for services which are provided to individuals whose incomes are above

80% of the state's median income, and have the option to charge fees to individuals with incomes below 80%. Services which may be provided on a universal basis include: information and referral, protective services for children and adults, and family planning.

The states are required to publish a Comprehensive Annual Services Program (CASP) Plan which describes how service needs were assessed and defines what services will be provided to whom at what estimated cost. The public review process requires the state to announce the proposed plan by a display advertisement in newspapers of widest circulation around the state. The proposed plan must be published 90 days before the final plan and public comments must be accepted for at least 45 days. The final plan, also announced by an advertisement, should describe the public comments and how they were taken into account. Amendments to the final plan require a similar process, although the comment period is only 30 days. Title XX, with its provisions for rational planning, citizen participation, and non-categorical eligibility, can thus be the impetus for an improved system of public social services.

Protective services for children, as previously noted, may be provided without regard to the income status of the child and his/her family. Since the publication of the first final regulations on June 27, 1975, the definition of what services can be provided for protection has been broadened. Originally, the regulations limited the services which were universally available to this eight step process: (1) identification and diagnosis, (2) receipt of reports and investigation, (3) determination that the individual is vulnerable or at risk of neglect, abuse, or exploitation, (4) counseling and therapy for individuals at risk, (5) counseling, therapy, and training courses for parents or guardian of the individual, (6) emergency shelter, (7) legal representation of, or advocacy for, the individual, and (8) arranging for the provision of appropriate services.[2]

These final regulations met with much opposition from child advocates who were concerned about the need for additional supportive services to the family in order to keep the child with his/her family. The provision of some needed services in this area required an income eligibility determination process with families who in many cases were not requesting the services voluntarily.

In response to public comments, HEW did publish revised regulations on April 2, 1976, which broadened the services which may be provided to children to remedy abuse, neglect, or exploitation. States are now permitted to provide any services described in their services plan to these children without regard to income. In each case, the state agency must document the circumstances which lead it to believe that the child is subject to or at risk of abuse, neglect, or exploitation. Redocumentation and evaluation of each case must take place no less frequently than every six months.[3]

Due to this change in the regulations, there has been a significant increase for 1977 in the number of services states plan to provide in protective cases compared to their Comprehensive Annual Services Program Plans for 1976. Over 8% of the total planned Title XX expenditures for 1977 are for child protective services. This represents a $3.5 million increase over the planned expenditures for 1976. These changes are presented in the following table:[4]

	Expenditures (Millions of Dollars)			Percentage of Total Budget	
	FY 76	FY 77	Change	FY 76	FY 77
Child Protective Services	206.8	241.3*	+34.5	8.8%	8.2%

*For states excluded from the total, see chart #5.

All 51 states again plan to provide protective services for children. In contract to estimates for information and referral and protective services for adults, expenditure estimates for protective services for children increased .9% in fiscal year 77. Although the spectrum of expenditures is wide, with Alaska planning to spend 47.9% and Illinois planning to spend 2.7%, the largest number of states can be grouped into the 5-15% range of expenditures. This is an increase over last year, when the average range was 5-8%. Illinois was low at 2.9% and Texas

was high at 17.1% in FY 76. States with the most significant increases, 3%, include: Alaska, Arkansas, Georgia, Nevada, New York, Pennsylvania, and Tennessee.

In addition, 16 states include separate emergency shelter services for children in their Title XX plans, rather than including emergency shelter as a component of the protective services for children definition. In all cases, emergency shelter services for children expenditure estimates have been included in either chart #5 or #6, protective services for children or protective services for children and adults. The 16 states are: Indiana, Iowa, Kentucky, Maine, Massachusetts, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, Rhode Island, Texas, Vermont, Virginia, West Virginia, and Wyoming.

PROTECTIVE SERVICES FOR CHILDREN AND ADULTS, FY 77

Ten states again combine protective services for children and adults in their final FY 77 Title XX plans. These states are: Colorado, Connecticut, Kansas, Louisiana, Mississippi, Missouri, New Hampshire, Oklahoma, Rhode Island and Utah. In Oklahoma, data is also provided for other protective services provided only to children. The range in expenditure estimates is wider than it was in FY 76: 1.9%-21.5% in FY 77, compared to 3.2%-21.5% in FY 76. Changes between the two program years was marginal except in Mississippi, which decreased estimated expenditures 4.2%. For a state-by-state breakout and comparison between FY 76-77, please refer to chart #6 below.

CONCLUSIONS

Overall, the differences between states as to the percent of total budget allocated for information and referral (I&R) and protective services for children and adults is narrowing. Protective services for children reflects some growth in expenditures while I&R and protective services for adults reflect a slight decrease. It is quite possible that the decrease in protective services for adults expenditures is misleading, since a number of states are providing other services without regard to income in protective cases involving adults. However, it is also quite clear that services directed to the protection of children are growing at a far more rapid rate. The following list of states and other services provided without regard to income in abuse, neglect, or exploitation protective cases illustrates this point:

Alabama: Diagnostic and evaluative services; legal services; mental health counseling; residential care for alcoholics.
Alaska: Day care services; homemaker services.
Arizona: Day care services; foster care; home management; housekeeper services; social problem solving; transportation services.
Colorado: All services except adoption and employment services.
District of Columbia: Adoption services; chore services; crisis services; health related services; homemaker services; substitute care services for adults, substitute care services for children.
Florida: Child day care; escort services; health support services; home management services; transportation services.
Georgia: All services.
Idaho: Adoption services; child foster care; disaster relief; homemaker services; services to unmarried mothers; state youth services center program.
Illinois: Adoption; day care for children; day training for special needs; foster care for children; homemaker services; outpatient drug abuse services; residential treatment; services to handicapped children; services to unmarried parents; short-term evaluation; social and rehabilitation services; outpatient services.
Indiana: Chore and housekeeping services; services to assist runaway children; interstate placement services; drug and alcohol education information and referral; friendly visitors for adults.
Iowa: Commitment/placement of juveniles; day care for children; foster care-family home; group home care; homemaker services; in-home treatment; legal services; mental health services; residential treatment-children; special day care.
Kentucky: All services.
Louisiana: All services.
Maine: Connecting; counseling; foster care placement; legal advocacy; protective day care; social diagnosis; evaluation and direct services.
Maryland: Day care for children; foster care for adults; health related services; homemaker/chore services; legal services.

Massachusetts: Day care services.
Michigan: All services except: adoption services; employment services; mental health treatment and rehabilitation services; and placement services for adults.
Mississippi: Counseling for self care; transportation services; prevention of parental neglect.
Missouri: Adoption service; alcohol and drug abuse counseling; day care counseling; educational counseling; employment related counseling; evaluation and diagnosis; family and interpersonal counseling; family planning counseling; foster care related services; health related counseling; home management services; improved living arrangement service; legal assistance; psychiatric and psychological testing; service plan development; special foster care services.
Montana: Day care for children; foster care for children; homemaker service for children; and components of other services related to adoption and services to unmarried parents.
Nevada: Adoption services; day care; improved family functioning; homemaker; institutional care for children; transportation.
New Hampshire: Child-parent; health guidance service; home and family management service; individual behavior and development; placement service.
New Jersey: All services.
New Mexico: All services for child protection only.
New York: Adoption services; foster care services for children; preventive services (children); unmarried parents services; and other services for children (not specified).
Ohio: Counseling; day care for children; family life education; foster care for adults; foster care for children; guardianship; homemaker/home health aide; home delivered and congregate meals; legal services; protective payee; residential treatment.
Oklahoma: Community youth services.
Rhode Island: Homemaker services.
South Carolina: All services.
South Dakota: Basic services to families and children; mental health evaluation and treatment; placement services for children; residential treatment for emotionally disturbed children; services to adoptive families; special services for the handicapped; transitional residential treatment; transportation services; volunteer services.
Tennessee: All services.
Texas: Foster care services for children; adoption services; services for unmarried and/or school age parents; emergency homemaker services; community treatment services; transitional services for juvenile-age children; day care for children; outreach services; community services; crisis services.
Vermont: Day care; legal service.
Virginia: Foster care for children; adoption; court services and all but three of the services provided by the Commission for the Visually Handicapped. The three exceptions are: acuity screening; library services; and occupational adjustment services.
Washington: Child foster care; homemaker services; child day care; adult day care; chore services; mental health services.
West Virginia: Youth services; community delinquency services and social, educational and training services for adolescents and single parents are funded with non-Title XX monies when they are available without regard to income.
Wisconsin: All services except: adoptive services; family planning; sheltered employment; special living arrangements.
Wyoming: All services except family planning services.

CHART #5

PROTECTIVE SERVICES FOR CHILDREN[4] (Universal) Title XX Final Plans FY 77	Estimated Number of Clients FY 77 #	Protective/ Children Estimated Expenditures FY 77 $	Title XX Final Plan Budgets FY 77 $	Percentage of Total %	Percentage Change in Estimated Expenditures FY 76-77 %	
Alabama	14,000	3,892,217	56,219,896	6.9	+1.9	
Alaska	1,901	2,538,800	5,299,900	47.9	+38.7	
Arizona	6,115	3,124,300	32,411,119	9.6	+1.9	
Arkansas	3,400	2,722,850	32,150,166	8.5	+3.0	
California	117,710	31,543,070	407,395,431	7.7	-2.5	
Colorado	Service includes children & adults; see chart #6					
Connecticut	Service includes children & adults; see chart #6					
Delaware	1,500	828,316	9,021,498	9.2	+1.2	
District of Columbia	1,400	515,300	14,709,500	3.5	-.9	
Florida	104,492	12,415,825	125,625,549	9.9		3/
Georgia	82,000	6,296,945	79,633,239	7.9	+3.8	
Hawaii	1,145	398,910	13,558,327	2.9	0	2/
Idaho	9,124	1,260,259	12,630,000	10.0	-1.7	
Illinois	12,571	5,129,143	188,662,743	2.7	-.2	
Indiana	24,570	3,779,227	40,796,661	9.3	0	2/
Iowa	17,198	4,877,346	45,627,645	10.7	+2.7	
Kansas	Service includes children & adults; see chart #6					
Kentucky	17,869	3,250,067	53,473,582	6.1		3/
Louisiana	Service includes children & adults; see chart #6					
Maine	Service available but data not obtainable					
Maryland	8,132	3,869,857	64,505,690	6.0	+.3	
Massachusetts	25,399	4,381,309	117,031,336	3.7	-.7	
Michigan	10,350(monthly)*	13,927,706	143,340,269	9.7	-.1	
Minnesota	19,664	5,385,304	61,720,224	8.7	+.2	
Mississippi	Service includes children & adults; see chart #6					
Missouri	Service includes children & adults; see chart #6					
Montana	1,143	1,110,672	11,270,000	9.9	0	2/
Nebraska	1,855	1,747,797	24,333,333	7.2		3/
Nevada	3,647	886,325	8,741,596	10.1	+3.2	
New Hampshire	Service includes children & adults; see chart #6					
New Jersey	10,004	5,254,774	115,019,825	4.6		3/
New Mexico	1,742	1,858,172	17,298,160	10.7	+2.0	
New York	92,535	33,429,098	285,600,000	11.7	+5.6	
North Carolina	20,000	3,765,109	82,362,493	4.6	+1.2	
North Dakota	Service available but data not obtainable					
Ohio	90,613	13,952,045	169,397,133	8.2	-4.1	
Oklahoma **	83,081	4,063,126	42,330,000	9.6	0	2/
Oregon	11,802(monthly)*	2,057,923	33,670,000	6.1	0	2/
Pennsylvania	37,905	14,195,732	206,691,000	6.9	+3.0	
Rhode Island	Service includes children & adults; see chart #6					
South Carolina	13,125	1,884,079	43,544,277	4.3	+1.4	
South Dakota	2,300	842,295	11,359,811	7.4	+1.5	
Tennessee	31,466	4,255,937	56,253,038	7.6	+3.5	
Texas	138,508	31,116,210	187,545,708	16.6	-.5	
Utah	Service includes children & adults; see chart #6					
Vermont	2,868	1,083,699	7,919,319	13.7	+2.1	
Virginia	30,503	5,111,110	78,734,459	6.5	-.8	
Washington	25,200	2,726,716	54,590,029	5.0	+.1	
West Virginia	12,150(monthly)*	1,892,403	28,907,521	6.6	-1.4	
Wisconsin	Service available but data not obtainable					
Wyoming	Service available but data not obtainable					
TOTAL	1,114,685 1/	$241,369,973	$2,969,380,477	8.1%	+.9%	

** Also see chart #6

CHART #6

PROTECTIVE SERVICES FOR CHILDREN & ADULTS[4] (Universal) Title XX Final CASP Plans FY 77	Estimated Number of Clients FY 77 #	Protective/ C/A Estimated Expenditures FY 77 $	Title XX Final Plan Budgets FY 77 $	Percentage of Total %	Percentage Change in Estimated Expenditures FY76-77 %	
Alabama						
Alaska						
Arizona						
Arkansas						
California						
Colorado	13,875	2,743,596	39,191,700	7.0		
Connecticut	19,139	2,402,058	58,608,241	4.1	+.9	
Delaware						
District of Columbia						
Florida						
Georgia						
Hawaii						
Idaho						
Illinois						
Indiana						
Iowa						
Kansas	8,644	2,915,504	35,678,095	8.2	-.8	
Kentucky						
Louisiana	14,707	1,898,577	58,905,539	3.2	0	2/
Maine						
Maryland						
Massachusetts						
Michigan						
Minnesota						
Mississippi	1,770	284,890	15,223,522	1.9	-4.2	
Missouri	13,499	2,839,692	75,442,978	3.8		3/
Montana						
Nebraska						
Nevada						
New Hampshire	2,891	754,253	12,605,948	6.0	+.2	
New Jersey						
New Mexico						
New York						
North Carolina						
North Dakota						
Ohio						
Oklahoma **	168,348	9,106,228	42,330,000	21.5	0	2/
Oregon						
Pennsylvania						
Rhode Island	4,349	710,592	16,394,312	4.3	+.1	
South Carolina						
South Dakota						
Tennessee						
Texas						
Utah	10,555	2,359,075	18,500,100	12.8		3/
Vermont						
Virginia						
Washington						
West Virginia						
Wisconsin						
Wyoming						

** Also see chart #5

EXPLANATORY NOTES ON TITLE XX

PROTECTIVE SERVICES FOR CHILDREN,
-ESTIMATES FOR FY 77

(Charts #5 and #6)

N/A = data not available

1/ Estimated number of clients for Chart #5 served excludes monthly population estimates for Michigan, Oregon, and West Virginia. In addition, the West Virginia estimate includes non-Title XX recipients.

2/ Twenty-one (21) month plans with no change in program year estimates.

3/ Comparable data was not provided in the FY 76 plan.

The most important step for family advocates, once they have an understanding of the Federal program, its requirements and implementation around the country, is to know as much as possible about how their own state is planning and implementing the Title XX program, especially its universal services for protection of children. Participation in the state's Title XX planning process is hard work. Advocates must read and analyze the Title XX plan to discover the answers to questions such as these:

What services are available for protective services under the Title XX program?
What services are available universally for protective services cases?
How much money is being spent for services to protect children and support their families in your state?
How many children does the state plan to serve?
Does the state agency provide these services directly or are these services purchased from voluntary agencies?

With complete information on the Title XX services program, advocates must find out who the relevant actors for the program are:

Are decisions made by the legislature or the executive branch?
What state departments are involved with the program—the public welfare agency, the child welfare agency, the budget office, the Governor's office?
What role do the counties or local governments have in the planning?
How are service providers, consumers, and concerned citizens involved?

Advocates must also be aware of the complexity of social services programs. Many other federal programs are related to the needs of children in protective cases. For example, Title IV-B, Child Welfare, Title IV-A, AFDC-Foster Care, Comprehensive Emergency Services (CES) projects, the Head Start program, and the National Center on the Prevention and Treatment of Child Abuse and Neglect are all programs with funds which could be used for protective services. Advocates need to know what programs are currently being utilized in the state.

Advocates must gain public support for their programs, which requires illustrating the services provided and showing why such activities should be established as a priority for the state. Such an effort requires support from many groups. Most effective advocacy efforts for child protective services require the organization of local agencies, parent groups, and community leaders.

As advocates and their organizations become involved seven points should be remembered:

1. Decide on one goal and stay with it. When people ask what is your purpose, all in your group will be clear on this.
2. Ask for specific commitments which are single, time-limited activities from the various groups and volunteers included in the coalition.

3. Work to involve people from all sectors and groups. Be willing to modify focus if the goal can still be met.
4. Do not take an adversary position with the bureaucracy which must administer the program. If differences arise, work them out privately. Public disagreements do not support the united front needed to be effective.
5. Develop good information to use as a lobbying tool. Accurate information is gold.
6. Work hard to be visible; do not be afraid of getting labeled, as long as the image is credible.
7. Pick specific issues which have promise of positive return. Nothing succeeds like success!

Following these prescribed steps, family advocates' tasks will become more manageable. As family advocates become more knowledgeable about Title XX and other Federal programs and develop strategies for participating, opportunity will increase for the receipt of Title XX or other public funds. Most importantly, a cooperative process will be established for planning effective and accountable services for children and youth.

A calendar follows which divides the Title XX planning process into three arenas of activity: (1) The State's Appropriation Process, (2) The State Agency's Planning Process for Title XX, and (3) The Advocates' Action.

FOOTNOTES

[1]Public Law 93-647, 93rd Congress. Second Session (H.R. 17045), January 4, 1975.

[2]45 CFR, Part 228, Section 65 (a) (1) (i-viii), *Federal Register*, Volume 40, No. 125, June 27, 1975.

[3]45 CFR, Part 228, Section 65, *Federal Register*, Volume 42, No. 20, January 31, 1977.

[4]Technical Notes: Summaries and Characteristics of States' Title XX Social Services Plans for Fiscal Year 1977, prepared by Eileen Wolff, et al, Office of Assistant Secretary for Planning and Evaluation, HEW, March 1, 1977, page vi.

Child Abuse Training: A Practical State Model

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INTRODUCTION AND MAIN CONCERNS

Passage of Public Law 93-247—The Child Abuse Prevention and Treatment Act—has generated many areas of activity throughout the United States during the past two and a half years. One specific endeavor mandated by the passage of this law was the creation of demonstration programs and projects which would focus on the prevention, detection, and treatment of abuse and neglect. This article describes one such program, and highlights its role and accomplishments during the past year.

The Region VII Child Abuse and Neglect Resource Center was established July 1, 1975, with a federal grant from the Office of Child Development, Department of Health, Education and Welfare. The grant extends over a three year period. The Center is located at the University of Iowa and serves the states of Iowa, Kansas, Missouri and Nebraska. The bulk of services focuses on rural and semi-rural communities.

We were under no illusions concerning the difficulty of formulating a program serving four states with different laws, attitudes, and priorities regarding abuse and neglect. Federal funding was for only three years and probably would be discontinued after that. Our task, therefore, was to develop a program that would have the greatest impact at the local level and have enough momentum and state support to become self-sufficient after three years.

The Center assists and provides supportive services to practicing professionals, community groups, and other individuals interested in child abuse and neglect programs. These services are directed primarily at practitioners rather than as direct services to children and families. Our idea was to utilize the professionals already practicing in each state and to train them to train others. We also widened the concept of the multidisciplinary approach by including parents, law enforcement officers, school personnel, preschool and/or day care staffs, etc. as trainers. Our philosophy was that each state has different problems, different personnel and different priorities. By allowing each state to select its own trainers and priorities, and to plan its own activities, the needs of both the state and the professionals would best be served.

The programs are oriented to provide technical assistance to communities within each state in order to enhance the prevention, detection, and treatment of abuse and neglect. They are also intended to encourage the development, extension, and coordination of local abuse and neglect service delivery systems in these areas. Unique aspects of the Center's operations have been attempts to convert the image of the law from punitive to therapeutic and to promote interdisciplinary cooperation and collaboration in all programs.

ORGANIZATIONAL FRAMEWORK

Based on the above philosophy, the structure of the Center itself and its staff was formulated. The staff, of necessity, would be small and multidisciplinary in nature, and consultants would be used as needed. The four person staff of the Center is headed by a project director, on a twenty-five percent basis, who is a pediatrician. The project coordinator, a social worker, has a full time appointment. The assistant coordinator, a public health nurse who is also a pediatric nurse-practitioner, is on a ninety percent basis. All of these individuals have faculty appointments at the University of Iowa. A media consultant works on a sixty percent basis. Consultants have been drawn from other disciplines within the University such as law, psychology, geography, and statistics. Probably our most frequently used consultant is a member of Parents Anonymous. The consultants work on an "as needed" basis. The addition of two secretaries completes the total Center staff.

It was decided to place the Resource Center under the aegis of the Institute of Child Behavior and Development of the University of Iowa. This was the old Child Welfare Research Station, one of the pioneering research facilities in the area of child welfare in this country. The

project director was the acting head of the institute at the time the grant was awarded. Placement of the Resource Center within the institute allowed immediate space, organizational structure within the university, access to appropriate consultants and resources, and above all, a broader concept of the problem of child abuse and neglect as one aspect of child welfare. The Center staff was also fortunate to become involved with an ongoing service program in child abuse and neglect located in university hospitals.

To achieve the previously mentioned program intentions, the Center created an organizational structure which both maximizes and actualizes inputs from national and regional offices of the Office of Child Development and the four states. The Center works in close collaboration with the Center's national Office of Child Development project officer and the Region VII Office of Child Development Child Abuse and Neglect specialist via phone, mail, and site visits. These relationships keep the Center apprised of national and regional events which are related to or impinge upon the Center's activities.

State level involvement and cooperation has been achieved through a well-organized structure.

REGION VII RESOURCE CENTER

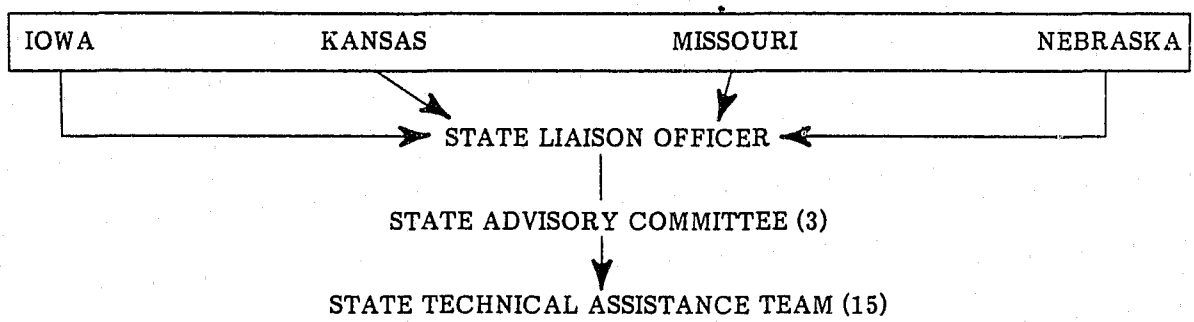

Figure 1

The Center developed a center advisory committee comprised of four liaison officers and eight committee members. Each of the four states appointed a child protection specialist worker to serve as a liaison officer responsible for that state's activities with the Center. Each liaison officer recruited two additional committee members representing different disciplines who are knowledgeable in the child abuse and neglect area. Therefore, the advisory committee includes three representatives from each of the four states or a total of twelve persons. The role of the Center's advisory committee is to provide the Center staff with information pertaining to each state's met and unmet needs which they have encountered in carrying out their professional responsibilities. To date this information has confirmed and legitimatized the programmatic themes or goals which the Center is pursuing. Out of this collaborative effort the Center designed and implemented a program delivery model called State Technical Assistance Teams (STAT).

DELIVERY MODEL

Each state's liaison officer recruited twelve additional professionals representing divergent disciplines (law, medicine, police, education, psychology, social work, etc.). These twelve, plus the three comprising the advisory committee, constitute a team of fifteen individuals. Each is currently working in the area of child abuse and neglect and resides in a different area of the state. Included on the Iowa team is the Region VII Office of Child Development consultant for Parents Anonymous. The STAT units provide technical assistance to mandatory reporters designated by state laws to report suspected abuse or neglect. STAT units also assist communities in enhancing the coordination of their child abuse and neglect delivery systems.

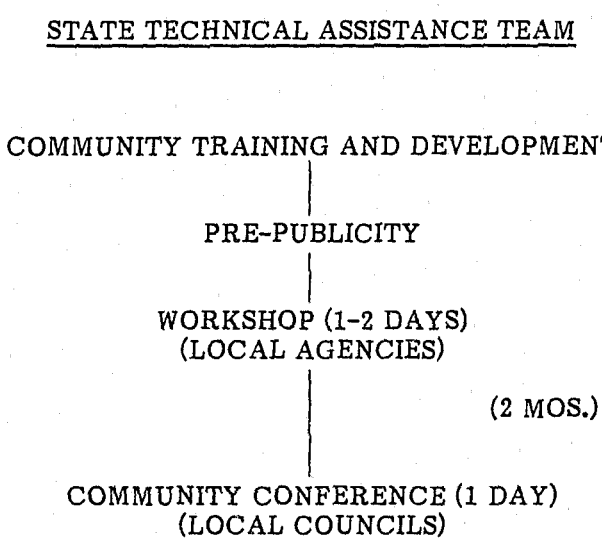

Figure 2

Each STAT will present community workshops throughout its state. STAT sessions are usually co-sponsored by local organizations (mental health centers, junior leagues, community colleges, state services for crippled children, professional associations, etc.). The STAT workshops are conducted by two to four STAT members representing different disciplines. Within six to eight weeks following a STAT session, the STAT members return to the district and offer consultation to at least two communities at the local level. The focus of their activity is on enhancing the coordination and resource capacity of child abuse and neglect delivery systems.

Funding for STAT units is provided by the Resource Center which subcontracts with each state. STAT members receive a small honorarium for their assignments, mileage, and per diem. The fact that some state regulations forbid the acceptance of honoraria and per diem allowances above the state level has been no bar to full involvement by many of these dedicated professionals.

Each STAT also may include in its budget expenses for training materials, e.g., films, video-tapes, brochures. To reduce the likelihood of intra-disciplinary "tunnel vision" the Resource Center conducts periodic workshops which focus upon interdisciplinary approaches to the child abuse and neglect problem for all the STAT members. The services of the media specialist on the Center staff are also available to the teams for assistance in the production of video-tapes and training materials.

The advantages of the STAT model are numerous:

1. The very nature of child abuse and neglect necessitates an interdisciplinary approach, which the STAT model reinforces.
2. The STAT workshops offer a neutral context for community professionals to come together and discuss their role perceptions and responsibilities.
3. The STAT members themselves are local professionals and will most likely be available to other communities after the termination of the project. Hence, the STAT concept will be perpetuated.
4. Within the guidelines of the Office of Child Development, each state's STAT enjoys a high degree of autonomy in decision making. This insures relevance of service delivery at the local level, since local agencies and professionals are involved in their own needs assessments and community problem solving.
5. For a project to reach all the communities served by the STAT, a full time staff of comparable size would be needed. The STAT model achieves both economy of scale and maximum resource utilization, making it possible for the Center staff to remain very small. Therefore, the implemented model is extremely efficient with low levels of input and high levels of output.

6. A major strength of this model is its capacity for replication, which could be achieved on a state, regional, or national level.

CURRICULUM

The Center is developing a comprehensive child abuse and neglect curriculum for use in colleges and universities. It is designed for pre-professional students who will be involved providing services to abused and neglected children and their families. The curriculum is comprised of a core unit which contains baseline information essential to understanding the phenomenon of child abuse and neglect. There are also sequential learning modules which focus in greater depth for specific professions such as health (medicine, dentistry, nursing), social work, education (primary and secondary, day care, pre-school, Head Start) and law (attorneys and law enforcement officers). The core unit was developed and implemented on a pilot basis within our university during spring semester and was recently revised. The modular units for health professionals and law have just been completed. The remaining modules will be ready for implementation by the end of the year. All modules are designed as multimedia presentations (audiotape and color slides, with written scripts). The curriculum will be evaluated before mass reproduction and dissemination are undertaken.

EVALUATION OF WORKSHOPS AND TRAINING SESSIONS

Development, implementation, and evaluation of training workshops for State Technical Assistance Team personnel and selected groups (Head Start) have followed a learner-centered approach. In essence, this type of educational process focuses on the needs and actual involvement of the individual learner as well as a self-evaluation of the learning which has occurred.

Information related to the perceived needs and general characteristics of participants was obtained prior to training sessions from a variety of sources (questionnaire, needs assessment, Advisory Committee, etc.). Educational objectives and associated content were then developed from these needs. Participants rated their own level of understanding based on these objectives at the beginning and at the end of the training sessions. Sequencing of workshop activities and teaching strategies were developed to allow a good blend of lecture material of limited length in large group settings and small group discussion sessions. Small group sessions have been particularly valuable in sharing specific concerns within geographic areas. The use of STAT members as small group discussion leaders was particularly helpful in familiarizing Head Start training program participants with STAT members in their respective states. All participants in the training sessions conducted by STAT personnel complete evaluation instruments which not only reveal the effectiveness of the STAT activity, but also elicit unmet educational needs of the participants which can be covered in future sessions.

DATA COLLECTION AND ANALYSIS

An additional Center activity is being offered to the states served by our project. This is the collection and analysis of child abuse and neglect incidence reports forwarded to the Center by state Central Registries. Demographic data in the incidence reports are also correlated with data derived from the 1970 Census reports. This allows our Center and the states to compare data sets by exploring gross demographic characterisics such as population and reporting rates.

A computerized index of selected mandated reporters, reporting agencies,[2] and their geographical locations is also being developed. This has been completed for one state and work is underway to do the same in the others. These data, coupled with the incidence reports and census information serve multiple purposes:

1. Each state can geographically locate both high and low incidence-reporting counties or districts.
2. By correlating incidence reports with census data one can estimate which communities are under-reporting and over-reporting.
3. By using both sets of data the STAT members can focus on those areas where disproportionately few cases of child abuse and neglect are being reported and concentrate their delivery of community training workshops to those areas.
4. If the incidence of reported child abuse and neglect increases in geographical areas served by the STAT activity, one might infer the STAT effort may have led to this outcome.

5. The data may also be used by STAT members in their sessions. Findings for their own counties or region of the state can be shared with participants. (The reader should be aware that all incidence data received by the Center have been de-identified and hence anonymity is guaranteed.)
6. State level managers in state departments of social services can also use these data to rationalize the deployment of child protection staff.
7. The incidence data, on computer tapes, are also being sent to the National Study on Child Neglect and Abuse Reporting for inclusion in the national incidence study of child abuse and neglect.
8. The computer program, or modifications of it, is available to the Region VII states, making it possible for each state to collect and analyze its own data. The Center's consultant has helped one state achieve this goal.
9. One of the major benefits of this activity is its capacity to be replicated by any state. This direction is being encouraged by the Center.

SUMMARY

It is our belief that the approaches utilized by the Resource Center which have been described in this article are providing a dynamic model and solid foundation for sustaining activities in each state beyond the immediate grant period. Each state has been encouraged to accept responsibility for its own programs. Initial consultation and assistance has been provided to upgrade the internal capacity for coping with unique problems, needs and resources rather than consistently relying on outside resources. Finally, the Center is not empire building; it is maintaining a low profile and is functioning within the appropriate constraints for a resource facility.

FOOTNOTES

[1]Because of internal state regulations Kansas could not participate in this program to the same extent as the other three states.

[2]Physicians, osteopaths, chiropractors, hospitals, dentists, public health nurses, nurses, public schools, private schools, special education facilities, community mental health centers, other mental health facilities, day care centers, social workers, community action agencies, social services, and law enforcement services (police departments).

Comprehensive Services to Families

Comprehensive Community Services: Model for Family Support System Development

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Child abuse and neglect is a symptom of either a parental behavior problem or a dysfunctional family. A viable program of prevention or constructive intervention is contingent upon community programs (the community being the nation, state, county, or local community) geared to the resolution of the personal or familial stress from which child abuse and neglect stems. Considering the inter-relatedness of human problems, effective prevention, identification, and treatment of child abuse and neglect require a comprehensive system of human services rather than the usual, isolated, "band-aid-like" intervention strategies.

Child protective services and related child welfare programs must be a part of the total human service delivery system. Even if the investigative responsibility is delegated by law to a single agency, the tools for effective prevention and intervention exist across a range of community resources and activities developed to enhance family life and alleviate family stress.

In essence, the comprehensive approach recognizes that all communities are complex, interacting entities composed of people relating to each other in such a way as to enhance—or impede—positive social functioning. The challenge to those concerned about child abuse and neglect is to stimulate optimal physical, social, intellectual, and emotional development of children by strengthening activities existing within the community which promote the positive growth of children and strengthen family life.

If a child has to be removed from his loved ones and his community, it poses a serious threat to the child's psychological and physical well-being. Thus, if we have any commitment to rehabilitation at all, we must recognize that removal of a child from his home and family is the beginning of a process which breaks the emotional bonds necessary to strengthen and stabilize a family.

The significant adults in the life of a child and his family as a whole are linkages between the child and his community. Any breakdown in the lives of these significant people will inevitably impact upon the child. The positive growth of a child is, therefore, dependent upon optimal functioning of his family, which in turn affects community life.

The solution of child abuse and neglect is a community responsibility. Any program to effectively identify, prevent, or treat child abuse and neglect by promoting personal and familial well-being must therefore be an integral part of the surrounding complex system we call a community. All activities bearing on the well-being of families in the community must be interwoven and interconnected. Such a process is identified as a comprehensive human services delivery system, and embodies such activities as medical care, mental health services, education, substitute child care, supplemental parenting, and law enforcement.

The promotion of adequate child abuse reporting laws, child protective services, and the wide range of possible child welfare services will enhance the community's ability to meet the special needs of neglectful and abusive parents and their families. Effective family support activities include, but are not restricted to, the following:

1. Family life education, which includes preparation for marriage, parenthood, and family living; to be offered as curriculum in public education and through community groups such as agencies, churches, clinics, and community centers.
2. Counseling services such as individual, marriage, family, and group therapy.
3. Supplemental parenting, including day care, emergency caretakers, homemakers, housekeepers, parent aides, babysitting coops, foster-grandparents, shared families or any other activity which creates a support system enabling a family to maintain a child in his own home or use available short-term respite care.
4. Substitute child care including crisis nurseries, receiving homes, foster homes, and group homes.

5. Medical care available to children and families stressing the importance of preventive health care.
6. Prenatal and postpartum services to parents which include prenatal and neonatal clinics, mother-infant stimulation programs, public health home visitation, and other related services.
7. Concrete assistance programs to provide for basic material needs such as food, clothing, shelter, etc.
8. Employment services such as vocational preparation, rehabilitation, job counseling, and job banks.
9. Spiritual activities through integrated church efforts within a community.
10. Communications, including any dispersion of information, ranging from technical assistance, information, and referral to public information libraries and public media efforts.
11. Protection of individual civil rights and public well-being, through law enforcement, the criminal justice system, civil courts, and advocacy.

These services may be provided by specific agencies in major metropolitan areas or as activities of generalist agencies in rural, sparsely populated areas. In rural areas, this may involve the mobilization of a network of resources through coordinated efforts which cover significant geographical distances.

There are several different models available for implementing a comprehensive community service system for the identification, prevention, and treatment of child abuse and neglect. We will attempt to present a model which is an integration of some existing community approaches.

This model involves the following essential components:

A. Acquire knowledge of the characteristics of the community, existing resources and services, and the existing linkage system between them.
B. Seek out significant community members or resource people who have a vested interest in child abuse and neglect.
C. Assess the needs of the community to identify gaps in services and expressed needs which would help alleviate family stress.
D. Organize, coordinate, facilitate, and attend community meetings to
    1. Promote awareness of child abuse and neglect.
    2. State specific problem areas of abuse and neglect and family stress within the community.
    3. Consider possible areas to explore in developing family support services.
E. Establish a task force to pursue the avenues available to strengthen or develop needed services for children and their families, in order to
    1. Allow the community to identify and define problems which are causing stress in family life.
    2. Identify the changes needed to alleviate existing family stress.
    3. Explore alternatives for solving these problems.
    4. Decide upon a solution to the identified problem or problems.
    5. Implement a course of action to prevent child abuse and neglect and alleviate family stress.
    6. Allow for adjustments in the activities planned so that resources are maximized.
F. Provide on-going services such as technical assistance, social action, political efforts, information, and training to assist the community in maintaining a family support system.

Underlying these components is a basic belief that the most effective solution to human problems rests with the community, with leadership evolving within the community from professional, paraprofessional, and volunteer groups.

Voluntary action could include such activities as Parents Anonymous, babysitting coops, Parents United, or any other self-help group which could be trained to provide family support services or to facilitate a new service or the expansion of an existing service.

The structure for the implementation of this community approach to the development of family support systems may include: (1) deploying existing personnel, (2) recruiting and

supervising volunteers, or (3) utilizing existing specialists working for: (a) the Office of Economic Opportunity, Community Action Programs, (b) University Extension Services, (c) Councils of Government, (d) City-County-Regional Model City Projects, (e) United Way and its Community Councils, (f) LEAP-funded demonstration projects, (g) Comprehensive Health Training Councils, (h) 4-C Committees, (i) Child Resource Centers, (j) Governors' Task Forces, or (k) Federally-funded demonstration projects through the U. S. Children's Bureau.

There is an enviable track record established, particularly in rural communities when citizens with special interests, who have had the time available, have taken it upon themselves to identify their community problems and mobilize their resources to combat child abuse and neglect. We have found that the key to a successful self-activating process of comprehensive community action stems from finding highly motivated persons and resources within a community, providing technical assistance to them, and most importantly, giving moral support to those attempting to help families in stress.

Developing Comprehensive Emergency Services

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The National Center on Comprehensive Emergency Services for Children was established in July, 1974, through a contract with DHEW, Children's Bureau, to disseminate information and provide technical assistance toward the goal of establishment of Comprehensive Emergency Services in communities throughout the United States. This effort was based on the model program which had been operated in Nashville, Tennessee, for three years under a DHEW, Children's Bureau research and demonstration grant.

The project had the advantage of an exceptionally complete data base and a thorough ongoing evaluation which enabled us to statistically demonstrate the effectiveness of the program (Burt and Balyeat, 1975). In addition, thanks to the development of broad-based community support, the project incorporated into the ongoing human services system. The National CES Center is currently assisting in the establishment of CES systems at 106 sites in 39 states.

In Nashville, CES evolved over a period of time as an outgrowth of concern and action of several fronts. Prior to the establishment of CES, families and children who came to the attention of the system were offered little in the way of services. This was especially true after 4:30 p.m. and on weekends and holidays. During these times Nashville, like almost all other communities, had to depend upon law enforcement to respond to families in crisis. In too many cases, because of the lack of training and resources, the only response law enforcement could make was the removal of children and the subsequent filing of a neglect and dependency petition. As a result, Richland Village, the metro-operated shelter program, was nearly "bursting at its seams" from overcrowding. Research showed that prior to CES nearly 80% of those children who were removed were returned to their homes after the case was heard in court. The separation that occurred often lasted six to eight weeks.

Protective service workers, with heavy caseloads and the majority of their time being required in court, were frustrated in their attempts to assist families in breaking the crisis cycle. Furthermore, because of lack of coordination and communication, the protective service unit would often not be notified of the filing of a petition and placement of children in shelter care until days later.

In early 1970 The Urban Institute began an analysis of the most pressing social service needs in Nashville. Initially, this study focused on the use of Richland Village as a shelter care facility for neglected and abused children, but soon recognized that it needed to include the State Department of Human Services and the Metropolitan Juvenile Court. To assist in the study an executive committee was formed which included representatives from a variety of public and private agencies as well as representation from the Mayor's Office, and lay citizens groups whose role was to expedite the collection of data.

The committee thus began to function as a cohesive group determined to affect the quality of care provided. The resulting work was the development of a program proposal for a new, coordinated comprehensive ongoing child welfare service program that would provide primary care for neglected and abused children. The proposal was submitted for funding as a research and demonstration program with an effectiveness and cost evaluation component.

The Comprehensive Emergency Services (CES) system that resulted sought to coordinate the social services offered to neglected and abused children by various public and private agencies and expand the existing service components within the protective services unit of the Department of Human Services to provide adequate options to respond to the needs of those children and their families.

This new system incorporated several assumptions. A basic belief was that any system serving children and their families should seek to maintain and strengthen the family and avoid separating children from their parents whenever possible. To reach this goal, the system believes that families in crisis need help to assess the alternatives available to them, in order to make decisions about their lives. Work by Kempe and Helfer, as well as others, has shown that 90% of

the parents of neglected or abused children want to provide good care for their children. It is the system's responsibility to help strengthen these families so that they can do so. Recognizing that there will be situations where children and parents must be separated, the system demands that separations and placements be planned and time-limited to minimize the separation and prevent children from being lost in the system. The system attempts to offer immediate response and rescue in times of crisis, and coordinates this with ongoing services that seek to strengthen the families' ability to deal with the stresses they face.

To assist in the coordination of this system, written agreements were developed which outlined procedures and roles of the various agencies involved, as well as how the components within the system would operate in relation to one another. This enhanced the flow of communication and availability of services by resolving the bureaucratic problems. To ensure the continuity of the system, the executive committee now assumed an ongoing role in maintaining the system as well as monitoring its effectiveness.

The system also helped reorganize and realign the two protective service units of the Department of Human Services. One unit was designated to handle crisis situations and the other to provide more traditional ongoing protective services. To ensure comprehensive protective services, the existing program was expanded to include five more program components, each of which addressed a specific need identified by the research report. The resulting system was composed of seven components which represent program response to the needs of families in crisis.

The system recognized that in all components thorough training was and is of critical importance, and found that, because many areas of training for the various components overlap, it was extremely advantageous to train staff from various components together to ensure consistency in the system.

While the following components are felt to be essential to a comprehensive system, they far from exhaust the options. The goal is to develop a system with the widest set of options to meet the needs of the community.

Twenty-Four-Hour Emergency Intake. Intake was expanded to a 24-hour, seven-day-a-week service. Personnel were made available at night and on weekends to screen calls and refer emergencies to appropriate caseworkers. Referrals are accepted for both emergency and non-emergency cases, with the latter immediately referred to the regular protective service unit (outreach and follow-through). Emergency cases are provided intake service with personal casework interviews.

Emergency Caretaker Service. Emergency caretakers are available to serve in a home as temporary guardians until the return of parents, or until an alternative plan can be developed. Caretakers are intended to be utilized primarily in cases of temporary abandonment or in cases of unforeseen emergencies where children are left without parental supervision.

Emergency Homemaker Service. Emergency homemakers are available around the clock to maintain children in their own homes in crisis situations in which it was impossible for parents to exercise their routine parental responsibility. This service is an expansion of the previously-existing homemaker service which had offered services only during the normal working day.

Emergency Foster Homes. This service provides temporary care for children who could not be maintained in their own homes by a homemaker. Children are returned home or placed in other appropriate facilities as quickly as possible.

Emergency Shelter for Adolescents. Older children often have particular problems and needs which are not or cannot be adequately dealt with in traditional foster care. Even though they are classed as predelinquent or have a court listing, they come to the attention of the system because of neglect, abuse, or crisis in their homes. Emergency shelter is geared to meet their needs and enables the system to provide a setting in a group home or institutional setting and avoids the use of jails or juvenile detention for such youth.

Emergency Shelter for Families. This is a facility which can offer shelter to entire families to avoid separating children from their parents. It responds when the crisis involves a burnout or eviction, or with transient families. Depending on the needs of the community, this component can be offered in a variety of ways, ranging from an agreement for the temporary use of a small apartment to a more formalized program. In Nashville, the service is provided by the Salvation Army.

Outreach and Follow-through. Outreach and follow-through provide ongoing casework assistance and services to families in their efforts to cope with problems. This service must be available in a formalized way so as to ensure continuity of services. The workers in outreach and follow-through assume case accountability as soon as the immediate crises has been resolved. In most cases this is the next working day.

As a result of the establishment of CES, the following results have been demonstrated:

1. The number of N&D petitions filed was reduced from 602 in 1969-70 to 266 in 1973-74, a reduction of 336 or 56 percent.
2. The number of cases screened in which a petition was not sworn out increased from 770 in 1969-70 to 2,156 in 1973-74, an increase of 1,386 or 180 percent.
3. The number of children under the age of six who were institutionalized was reduced from 180 to 0.
4. The number of children removed from their homes and placed in some type of substitute care decreased from 353 in 1960-70 to 174 in 1973-74, a decrease of 179 or 51 percent.
5. The number of recidivist cases (i.e., the number of children on whom repeat petitions were filed in given years) was 196 in 1969-70 but only 23 in 1973-74, a decline of 88 percent. The recidivism rate (i.e., the percentage of children on whom petitions are initially filed who are abused or neglected again by the end of the subsequent year) declined from 16 percent in program year 1969-70 percent in program year 1973-74.
6. While referrals to the system increased by 92%, net savings of $68,000 were realized. A solution was achieved in which effectiveness increased while cost decreased.

Toward the end of the period of establishment of Comprehensive Emergency Services to families and children in crisis, the National CES Center was founded. Further information as well as technical assistance in the establishment of such systems is available from both sources.

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Comprehensive Emergency Services: A Strategy for Implementation

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INTRODUCTION

Comprehensive Emergency Services (CES) has been identified as a significant social service tool for providing coordinated preventative services for children in crisis.[1] The purpose of this paper is to offer a strategy for implementing CES using the experience of San Francisco as a successful example.

CES requires local communities to reorganize their social service delivery system to insure that children at risk receive a maximum amount of coordinated services at the time of a family crisis in order to alleviate the crisis and to reduce the risk of out-of- home placement in the foster care system.

A typical county social service system involves a confusing multiplicity of agencies serving neglected children and their families. Service agencies such as the police, probation, detention homes, protective services, public health, community mental health, district attorney, and public defender act out their roles, but the children become everyone's responsibility, and noone agency can be held accountable. More than 350,000 children are now in out-of-home placements in America; this large number may be one result of an inability on the part of the system to provide preventive services to children in crisis.

Research studies have demonstrated that a child who enters the social service system is likely to remain until his majority. In San Francisco, 73% of the children in foster care will remain there until age 18, and will be in at least two foster homes.[2] The human and economic costs of this "system" are awesome.

CES was designed administratively and legally to bring together independent agencies into a coordinated effort for the child who is at risk. It involves the provision of nine components of service including:

24-hour emergency intake
Emergency caretakers
Emergency homemakers
Emergency foster family homes
Emergency family shelter
Emergency shelter for adolescents
Emergency day care
Emergency neighborhood crisis centers
Outreach and follow-up.

Clearly, the provision of these services becomes a noteworthy challenge to the social planner. The National Center for Comprehensive Emergency Services has provided a Community Guide[3] with steps for achieving a coordinated system. This excellent Guide acknowledges the difficulty of bringing the various community forces into concerted action to create the system. The importance of CES in the spectrum of child abuse and neglect issues must not be underrated. CES is a significant mechanism for insuring a coordinated team approach to intervention and initiation of treatment.

SAN FRANCISCO - A COMPLEX CITY

San Francisco is both a city and a county and has a population of 681,000 representing some 20 or more different ethnic groups. Fourteen percent of the population is below the poverty line. The Social Services Resource Directory lists more than 650 different social service and health delivery organizations, ranging from storefront operations to major bureaucracies. Fifteen languages are taught in the bilingual public school programs. Neighborhood divisions clearly define economic groups. Public participation in local government decisions is intensive and

dedicated. Advocacy groups are created as important issues emerge; women's rights, gay rights, handicapped rights, children's rights, housing for the poor, etc., all finding willing and competent advocates. In this heady and exciting climate, CES as a concept was introduced to San Francisco by an HEW conference on the Nashville plan in May, 1975.

THE "POLITICS" OF SOCIAL SERVICES

There was a ready market for adherents. The San Francisco social service system was bifurcated. The Probation Department provided detention and in-home services for court dependents, and the Welfare Department provided protective services and out-of-home supervision. Lines of authority and responsibility for the children shifted, often without a clear understanding of case needs. More than 800 dependant children were admitted each year to the Juvenile Detention Center. Nineteen hundred children were in out-of-home (many in out-of-county) placements. Children were being placed a rate 2½ times that of the rest of the State of California, at a cost 67% greater than the statewide average.[4] Prior to the HEW conference, many groups interested in child welfare had identified the problem of excess detention of dependent children and offered various systemic solutions to the Department of Social Services and the Juvenile Probation Department, but their suggestions had been referred to committees or ignored on the assumption that the overtaxed city could not pay for new social programming.

After the HEW conference, Coleman Children and Youth Services, a private non-profit organization, emerged as advocate for CES. Funded by a bequest from the estate of Mrs. Gertrude Coleman, the organization devoted itself to facilitating Comprehensive Emergency Services. The Board of Directors was formed in 1974, and an executive director was hired in May, 1975. We were not welcomed with enthusiasm. Community organizers and bureaucrats were suspicious of a third force, but we began operations, keeping lines of communication, however tenuous, open at all times.

The commuity organizers wanted a neighborhood-based, community controlled CES. The officials of the public agencies wanted CES, but developed at their own, slower pace, and under public control. The Probation Department did not want to relinquish control of dependent children to social services, and the Department of Social Services wanted a larger budget if they were to become the sole providers of services to dependents. The conflicts and tensions immobilized any progress toward reforming children's services.

FIVE STRATEGIES FOR CHANGE

Given this context, Coleman Children and Youth Services adopted five strategies for change:

1. Communication with the public and description of CES
2. Research and the development of a data base
3. Systems design
4. Education of public officials
5. Creation of a coalition of potential service providers.

These strategies and the history of the development of CES will be described in the following paragraphs:

COMMUNICATION WITH THE PUBLIC

Communication with the public was an important strategy simply because CES was not understood by the public. By continually informing the public, CES became a watchword for progress, and an expectation for the future of child welfare services.

We created a mailing list of 1,200 names of individuals and groups who had shown an interest in children. The list included commissioners, legislators, agency heads and members of their staffs, volunteers, advocacy groups, and others. It was important to include several copies of our mailing to each agency lest a single copy get hidden on an over-crowded bulletin board. Mailings were periodically sent as significant progress occurred; among the mailings were research results, description of CES systems, and acknowledgement of a lack of progress when this seemed appropriate.

The progress reports created tensions among the child welfare groups. Public agency people were resentful when lack-luster efforts were reported. Community groups felt that our agency should write the newsletters in the name of a grass-roots organization.

It was important to keep the newsletter short and factual. The goals of CES needed to be constantly restated and in language that could be comprehended by the layman.

RESEARCH AND THE DEVELOPMENT OF A DATA BASE

We were able to obtain permission of the local Probation Department to analyze the face sheets of the dependent children admitted to the detention center. Using a simple computerized two-way matrix system, we are able to point out the differences between the various categories of dependent children (abused, neglected, absent parents, etc.). The data were organized to answer the many questions of the potential critics of CES. The format included: demographic data by census tract, zip code, and mental health district; workload information, (i.e., day of the week, time of booking, etc.), and characteristics of the child and family, (age group, race, days in custody, etc.). A similar study was performed for children receiving referrals for protective services; this study was designed to identify case duplication, and, as it turned out, the two studies proved that the two agencies served different cases, but that the family circumstances were identical.

We also analyzed police arrest reports to determine how police policies were reflected in the social service system.

Our final major report was a detailed analysis of the characteristics of children in foster care. The two-way matrix system of displaying data and the three research reports began to give a clear picture of the incidence, location, and characteristics of children at risk. Face sheets and arrest reports were extraordinarily valuable and simple source documents for revealing planning data. Various myths were validated or destroyed by the facts. CES issues could no longer be delayed by referring the matter back for "further study". The "further studies" were complete and widely distributed.

The results of our studies are not important for the purpose of this publication, but it is essential to stress that base-line data is necessary as an advocacy tool. Each participant agency needs to know how its own data base will link to a total CES need. System change is often preceded by anxiety resulting from an information gap and it is important for the advocate to objectively fill the gaps with useful data.

SYSTEM DESIGN

Using the Nashville model, Coleman Children and Youth Services developed what we considered an ideal CES system. Our proposal included a detailed analysis of needs for interdisciplinary staff, working hours, shelter needs, and an inventory of existing funding sources. We submitted detailed budgets to the city fathers, and acknowledged that the major source of money would result from a reallocation of detention and out-of-home costs. The exact nature of our system did not differ markedly from the Nashville program. Reallocation of resources was a major element of our CES plan and became red flag for the agencies. "We'll-lose-jobs", "This-is-not-Nashville", "We-need-more-time", "Thank-you-but-no-thanks", "If-you-only-knew-what-we-know", etc., became familiar phrases.

EDUCATION OF PUBLIC OFFICIALS

We realized that our research reports and systems analysis would be to no avail unless the legislative and executive branches of local government were involved. We approached as many members of our Board of Supervisors and Commissioners as possible. We intensified our mailing efforts, always optimistic, always redescribing our plan.

A new mayor and a new general manager of social services soon became the fulcrum for change. In September of 1976, without acknowledging the Coleman CES plan, the Probation Department and Department of Social Services merged their intake teams, establishing several emergency foster homes, and called the system "CHILDREN'S EMERGENCY SERVICES." CES, however named, was on its way.

CREATION OF A COALITION OF POTENTIAL SERVICE PROVIDERS

The Coleman bequest permitted the awarding of small seed grants. We gave hundreds of hours of free technical assistance to any agency who would expand its services to dependent children, and encouraged support of the Coleman Plan. We developed a program budget and announced that we would award funds to private agencies that could develop program linkages to the fledgling CES. Money was set aside for family shelters, emergency foster homes, emergency child care, and public education. To date, funds have been appropriated primarily for family shelters and training programs. Traveler's Aid has been awarded a small grant to initiate an emergency foster home program in the downtown area. The presence of small seed grants heightened consciousness among the many private agencies about their potential role in CES. The governing

boards of the private agencies provided opportunities for Coleman to meet with their committees. The network of potential CES service providers thus was dramatically broadened.

A group of 46 people representing public and private agencies and the community has met regularly to discuss CES. However, with differing points of view and the absence of any kind of governing structure, the Committee of Agencies Concerned with CES never emerged as an advisory or governing body for CES, but functions as a forum for exchanging information.

CES IN SAN FRANCISCO — 1977

Positive change in the delivery of services is still happening for San Francisco children. The new General Manager of Social Services is a charismatic leader and a risk taker. It was his leadership that ultimately created the actual change; without new management energy, we doubt whether our efforts at system reform would have provided anything more than token programs. By the end of this year he has promised to provide 24-hour interdisciplinary crisis teams, a coordinated non-institutional shelter system that insures each child the least restrictive environment, 20 additional children's homemakers and a few caretakers. A Coleman newsletter publicized his proposed changes and there is an expectation of change. Negotiations for emergency child care are underway. The out-of-home population has been reduced by 24% in two years. Court petitions are down by 38%. Intake procedures have been simplified, and crisis teams generally respond within 24 hours. The detention center is closed.

Coleman Children and Youth Services views itself as an agency that advocates for improvement in the child welfare system. The complexity of child welfare is such that the actors have a difficult time creating change within their own systems. There are just too many self interests, and an outside agency is essential to act as researcher, facilitator, educator, and cheerleader.

THE ESSENTIALS OF CHANGE

We believe that an external advocacy agency with no financial interest in the service to be rendered is essential. It should have a paid staff who should examine and interpret data and be knowledgeable of all the facts. It should have a specific point of view and know what it wants. It should have a dedicated and influential board of directors. It should be tenacious and persistent and should maintain open communication with all the participants. It should maintain sole allegiance to children and their needs and should insist on quality professional services.

CES can be attained with a minimum expenditure of new money. Local government need only look at the career costs of out-of-home placement and detention center budgets. However, no miracles are crouching deep within the line items of the annual welfare budget. Some minimal new funding will be needed; however, we believe the intracacies of interagency agreements and system reform are more difficult to attain than any new tax dollars.

An independent citizen-based professional review advocacy service is essential if CES is to emerge from the confusion of eight or nine independent agencies serving the same child, the same family, and the same crisis.

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Child Abuse Treatment

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There are different ways of understanding and thinking about child abuse and neglect, and our view of this serious social problem influences our approach to treatment. We may see child abuse as occurring at the family, institution, or societal level, or any combination of these. Traditional treatment approaches have focused on the pathological model wherein the treatment is individual or family therapy. In fact, our social service agencies and staffs are trained and capable of providing little more in the way of service to abuse and neglect families, except in those agencies where advocacy becomes a part of treatment. In these agencies, treatment workers may educate/train/counsel their clients in methods of dealing with the social service system in order to help relieve the stress on the family.

Newer treatment approaches are developing which reflect a broader and more holistic perspective of child abuse and neglect. Gil (1970, 1973) suggests that our social policy systems are responsible for child abuse and holds that the solutions to this problem are political and not technical. This particular philosophy often leaves counselors and treatment workers feeling impotent and angry. The treatment approaches outlined here take into account the causal relationship of social policy systems with child abuse and neglect and further provides an action plan, a method of treatment in which counselors can participate with their clients.

The treatment philosophies upon which these two approaches are based include the following assumptions: that children have a right to their natural heritage; that all children are of equal worth—entitled by birth to fully develop their potential; that all children and families are entitled to participate in the total social and economic resources; that punishment serves no benefit for either children or parents; that the medical-pathological model serves no useful purpose with people in crisis and is limited in the treatment of abuse and neglect; that voluntary, rather than coercive, services are the treatment of choice; and finally, that no matter what the causal factors, people can change and, when given the opportunity, will make choices that reflect the value premises of optimal development and self-actualization.

The first treatment approach to be presented here reflects a comprehensive understanding of social and family dynamics and aims at balancing minimum disruption of the family with maximum protection to the child. This treatment approach is embodied in an HEW-funded demonstration project—The YMCA Family Stress Center (FSC). The facility is located in a community with easy access to public transportation as well as an outreach capability. The staff are highly trained in the multi-facted complexities and issues of abuse and neglect and are sensitive and able to suspend moral judgments.

The components of this project are tied together by a 24-hour, 7-days-per-week, on-call emergency response system. Treatment workers rotate on a beeper system and are available to go out in an emergency to homes of families already involved with the FSC or with police officers on emergency family crisis calls. All calls are logged and immediate services arranged on the spot or by the following morning. A major focus of the treatment approach is remedial and educative—with clients, other professionals, and the community. A subcontract was arranged with the county which allowed for assignment of county personnel to the FSC for 18-month periods of time with these same persons rotating back into their own agency and new personnel assigned.

A non-threatening, realistic public-awareness campaign was initiated, with television and radio spot announcements, open house, speaking engagements, and campaign buttons, all focusing on family stress and the difficulties of parenting. The response has been overwhelming throughout the community, with the FSC very soon operating at capacity with almost 60% of clients self-referred. Staff were assigned to work with other community groups, not to conduct programs, but to provide resources and information which enable the provision of services in other parts of the county by these groups and agencies.

The major treatment components utilized at the Center are in keeping with the above educative approach. They are:

Positive Parenting—A six to ten-week training program in which hundreds of parents have participated. The design of the training is a participation model which addresses parental styles, concepts of discipline, needs of parents and children, role reversal, the concept of empathy, parental openness, problem-solving models, and communication styles. Child care is provided for all participants.

Parent Aides—Well-trained volunteers available four to ten hours weekly to visit in the home, providing nurturance, support, skill training, friendship, and modeling for various family members.

Emergency Caretakers—Well-trained paraprofessionals on call 24 hours a day, 7 days per week to provide emergency and respite care to families in crisis. Also used as part-time homemaker/trainers to improve parental skills, protect children, and minimize the removal of children from their families.

Child Care Center—Designed to provide high-quality child care and permit a respite, or time out, for parents on an interim or longer-term basis.

Individual and Family Counseling—Provided for family members when indicated. The design of the treatment approach emphasizes the strengths of the individual family members and the dynamics of the family group in a growth and learning-oriented approach, rather than with a pathology/historical model.

Marriage Group Counseling—A couples group where relationship issues are dealt with and the curative, change-producing factors of group therapy—universality, altruism, cohesiveness (Yalom, 1970)—are developed.

Child Development Group—A training group for parents conducted by a pediatric nurse where information on child development is presented and discussed.

Mothers Group—A weekly social gathering for mothers to share and socialize. Child care is provided, there is no structural format, a staff member is made available, and supportive systems among the mothers often develop.

Advocacy—Provided by the primary treatment worker on behalf of parents and children with other social agencies, the courts, hospitals, and medical practitioners. This is a collaborative model where the treatment workers work with other involved agencies and make themselves available for court testimony, written reports, and case management and consultation. Every effort is made to have clients preview reports and records as part of the treatment process.

Transportation—Provided for family members when needed for appointments, child care, and other needs according to staff availability.

This first comprehensive treatment program is intended to serve as a model for the community. Extensive evaluation of its impact and effectiveness will be published in the future. The treatment approaches are designed in accord with the philosophy presented earlier and in an attempt to be realistic about the needs of families as well as the fragmentation of services in the abuse and neglect field. This treatment approach is just a first step in providing meaningful treatment to abuse and neglect families and shares with other demonstration projects the danger of deluding ourselves. This is treatment, not prevention, and should we decide to eradicate child abuse and neglect, we shall have to eliminate the causes, which lie in our concept of human differences, our institutions, our economic activities, and our political system.

The second treatment approach is a system of coordinated services designed to meet the emergency needs of children and families in crisis, providing options in care and treatment which protect children and reduce trauma. The Comprehensive Emergency Services (CES) system was developed as a demonstration model in Nashville, Tennessee, and provides a vehicle for cooperative program planning between agencies. It involves a concentrated effort to provide high-quality service to neglected, dependent, and abused children on a 24-hour basis, including weekends and holidays. However, CES is not limited to abused, neglected, or dependent children

and is, therefore, more than just a child protective service. It is an early intervention system which has elements of both protection and prevention and allows for a coordinated treatment approach for children and families with the family as the focus for the service impact. The preservation and strengthening of an intact family is the primary objective while providing a safe environment for the child with as much continuity as possible.

CES provides a wide range of options for children in crisis. It focuses on maintaining children in their own homes, but when removal is necessary, services are provided to children and the family which promote a more orderly, less damaging placement. The system consists of the following basic components:

24-Hour Emergency Intake—This component utilizes an answering service to respond to calls 24 hours a day, 7 days a week. Calls are screened and then referred to caseworkers who rotate for night, weekend, and holiday duty. Caseworkers are immediately available to handle emergency situations involving children in crisis.

Emergency Caretakers—Emergency Caretakers provide adult care and supervision to children whose parents are absent or incapacitated. The children remain in their own homes and a caretaker is assigned until the parents return or until an emergency homemaker is assigned to the family case. This component drastically reduces the number of children being removed from their homes and involved with the court system.

Emergency Homemakers—Emergency Homemakers provide 24-hour care to children in their own homes until parents are able to resume parenting or until an alternate decision is made. Homemakers are successful when parents are temporarily absent in abuse and severe neglect cases, and in cases where children have failed to thrive. This service is also used to improve parental functioning by teaching parents more effective ways of caring for children and maintaining their homes.

Emergency Shelter for Families—This service furnishes temporary shelter care for the entire family involved in crisis. Children remain with their parents and the family is assisted by a treatment worker in resolving the crisis while the family remains intact.

Emergency Foster Family Homes—The Emergency Foster Family Home cares for children who cannot remain in their own homes. This service, available on a 24-hour basis, provides up to 15 days of care and is designed to minimize the emotional shock of removal of a child from the family by providing a home environment as an alternative to institutional placement.

Emergency Shelter for Adolescents—Emergency Shelter for Adolescents meets the special needs of older children by providing emergency shelter or group care for a specified period, usually 2 or 3 weeks, while alternative plans are explored. This component is utilized for youth who are not able to function in their own homes or in a foster home setting.

Outreach and Follow-through—This component provides immediate casework assistance to children and families in crisis and continued, coordinated follow-through and supervision beyond the crisis stage to help families cope with immediate problems and to find longer-term solutions. This is a coordinated effort that goes beyond crisis intervention and involves a supportive relationship with the family while enhancing their coping abilities.

The development of CES requires the joint efforts of planning and restructuring of traditional agency roles and responsibilities on the part of the community, government agencies, and private agencies. No longer can communities ignore these problems that occur after working hours. This system revolves around the family to offer the best solution, rather than casting the child and family into a chain of events which is frequently more damaging than the original crisis.

Each component of this system must interrelate with all the other components in such a way that there are no gaps in service to the family; for example, the emergency intake worker should be able to utilize emergency homemakers, emergency food, and food stamps at the time of crisis. If it is to succeed, the system should be identified as a specialized service program

within an agency and not be rendered ineffective by the familiar "bureaucratic red tape." The system must have the capacity to monitor itself and detect gaps as they occur. Staff conferences, clinical assessments, and inter-agency agreements and communication should be planned and systematic.

The Nashville experience with CES demonstrated some dramatic results with this system:
—A reduction (56%) in the number of neglect and dependency (N&D) petitions filed.
—A reduction (54%) in the number of families with one or more children named on N&D petitions.
—An increase (180%) in the number of complaints and referrals where no petition was required.
—A decrease (51%) in the number of children placed in some type of substitute care.
—A reduction (87%) in the number of children placed at the shelter facility as a result of petitions filed.
—A reduction (100%) in the number of children under the age of six placed at the shelter facility.
—51% of the referrals to the emergency services unit of the Department of Human Services were after normal working hours.

Given the clear results of this second approach to child abuse treatment and the promise of the multi-faceted treatment of the Family Stress Center, it is apparent that traditional treatment approaches are far from adequate. The difficult problem of child abuse and neglect is a community and social issue which requires more creative, innovative, and collaborative efforts like those described here. And more, if we professionals are to take our tasks and responsibilities seriously, we must study these models and create more and better services, and examine our own roles as private practicioners and/or agency workers to determine if we, too, are part of the problem.

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A Comparative Evaluation of Two Community Protective Services Systems: Mechanisms for and Effectiveness of Intervention

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Apparently, in the not too distant past, the delivery of child protective services was a relatively simple process—investigating, rescuing children, and prosecuting or otherwise punishing parents. There were fewer complexities then than now with regard to appropriateness of service plan decisions, legal issues, societal consequences, and the like.

More recently, the general goal of protective services has changed from that of rescuing and prosecution to that of casework and other ameliorative services. In the broadest sense, treatment in protective services is for the primary purpose of protecting children and modifying the behavior of the abusing or neglecting parent.

This philosophical stance has been included in the "Child Abuse Prevention and Treatment Act." The proposed regulations suggest multi-discipline, multi-service resource channels to deal with the problems of child abuse and neglect "...in order to protect the child and help strengthen the family, help the parents in their child-rearing responsibilities, and if necessary, remove the child from a dangerous situation."[1]

Therefore, philosophically at least, protective service intervention becomes a complex process initiated officially by the "mandated" public agency. This involves the use of appropriate community resources toward the goal of protecting children and rehabilitating families.

Indeed, there are several problem areas in the delivery of protective services: legal issues, treatment modalities, and modes of intervention on behalf of children (placement and appropriateness of services). While the delivery of services cannot be problem free, criticisms concerning quality and effectiveness of services are beginning to mount.

With increasing frequency, newspapers are covering serious abuse and/or neglect of children who, at the time of the "expose" were or had previously been under "protective supervision" of or otherwise known to the mandated protective service agency or other community systems. Thus, in addition to concerns about the nature, effects, rising reported incidence, and causes of abuse and neglect, recidivism has become a major concern.

Hopefully, findings from this study, with primary focus on mechanisms for and the effectiveness of social intervention in child abuse and neglect cases, will offer administrators the kind of information needed to modify, if indicated, their systems' operations, while seeking improvements in their agency environments.

METHODOLOGY OF THE STUDY

This research project was officially launched in the fall of 1973. Data collection began in the spring of 1974. Its general objectives were to: (1) determine, at the local level, the organization and structure of protective service delivery systems; (2) determine and assess the nature and content of services delivered; (3) determine the effectiveness of the protective service delivery systems; and (4) develop models for training and service delivery systems based on insights gained from the findings.

RESEARCH DESIGN

This project was developed as evaluation research utilizing an exploratory-descriptive design. Evaluation research involves the collection of data for assessing the outcome of a program or a system's functioning. Given constraints imposed by limited staff, the nature of the system, time, and funding available for research efforts, many evaluation research efforts are limited in focus to one or possibly two of the major elements of a system, namely, inputs, operations, outputs, and/or outcomes. The present research was based on data relevant to all of the components.

DATA SOURCES AND RESEARCH PROCEDURES

Data for this study were collected in Nashville, (Davidson County) Tennessee and Savannah, (Chatham County) Georgia. In Nashville an emergency 24-hour reporting system, with a unique protective service program (CES-Comprehensive Emergency Services), had been in effect since 1971. During 1970-71, as a basis for planning for the program (funded as a demonstration project

by the Office of Child Development, DHEW), the Urban Institute (Washington, D.C.) conducted a study of neglected and dependent children in Metropolitan Nashville. In Savannah, the protective service system was a more traditional one, having no internal provision for 24-hour emergency reporting within the public welfare system.

This research project was conceptualized in two levels. The primary goal of Level I was the delineation of the systems' mechanisms for the identification and the handling of child abuse and neglect cases—program structure and organization. The major goal of Level II was to determine and evaluate the nature and effectiveness of the systems' intervention.

Level I data which served as the data source for the analysis of systems operations (or process issues) were obtained from several sources. In Nashville, these kinds of data were obtained from interviews with CES personnel, direct on-site observation, and two major reports: (1) one representing findings from an evaluation study of protective services in Nashville;[2] (2) an in-house survey of medical facilities.[3]

In Savannah interviews with instruments of structured and semistructured formats were conducted with administrative and service workers in the protective service unit of the Georgia Department of Human Resources (DHR), with similar level personnel in the police department, in four hospitals, in the public health department, and with court workers. Additionally, on-site observations of the systems' operations were used.

Thus, the data for the operations or process component of the two systems were not from entirely comparable sources. Actually, one of the values of the study is the comparisons we are able to make of two very dissimilar systems for the delivery of protective services to abused and neglected children. Beyond this, we do not feel that the efficacy of the findings is violated by this approach because the exploratory-descriptive design allows flexibility in the data collection process, and the systems flow charts—constructed as a result of the data collected and the on-site observations—were reviewed for accuracy by project personnel with systems' representatives at each site. Additionally, a draft copy of the monograph reporting systems operation was shared with representatives at each site for comments and/or corrections prior to the final printing.

Level II data, the data base for issues relevant to systems input, output, and outcome, were obtained at each site through structured interviews with protective service staff and a structured schedule to which case data were transferred from agency records by our research project staff.

Level II data relevant to the evaluation of the effectiveness of intervention were computer processed but manually analyzed. Succinctly, individual case data rather than aggregated data were analyzed to determine systems effectiveness.

The total caseload for this study was analyzed by decks of case data from each protective service system. Deck 1 refers to serial abuse cases for which there was a deck 3—a prior incident—and perhaps a deck 4—an even earlier incident. Deck 2 refers to cases on which only one incident had been investigated.

EVALUATION OF SYSTEMS OPERATIONS—LEVEL I

With respect to the goal of determining and assessing the mechanisms for the identification and the handling of child abuse and neglect cases in the two study sites, criteria presumed to be basic to the realization of a protective service system's delivery functions or activities were conceptualized. These activities and evaluation criteria, which were basic to Level I of the research project and reported on in detail in the first volume of this study, are outlined below.[4]

FUNCTIONS/ACTIVITIES

The major service delivery activities of a protective service system are: (1) coordination and cooperation with the environment, (2) intake, (3) screening, (4) investigation, (5) case assignment, (6) case handling, and (7) record keeping.

EVALUATION CRITERIA

The following set of criteria was used in evaluating how the systems operated in terms of the functions. The list is not inclusive, nor did every criterion relate to the evaluation of every function.

1. Expediency as a Criterion.
   This criterion refers to the immediacy with which the mandated protective service system responds to reports of abuse or neglect. The measure of expediency was determined by a consideration of the time between receipt of the report and of

official action; i.e., investigation. The data for these calculations were obtained from case records. Beyond this, a determination of expediency was based on the existence of intra and interagency linkages and coordination in the response process.

2. Compliance as a Criterion.
There are two aspects of this criterion. First, incidence coverage is defined as the extent to which cases identified by collateral systems are reported to the mandated protective service system. Secondly, investigatory coverage refers to the extent to which the recipient of reports investigates relevant cases. To determine incidence coverage, we considered the question of who may and who does report to the mandated protective service system. Similarly, respondents in the collateral systems were asked if, when, to whom, and under what circumstances they reported identified cases of abuse and neglect. To determine investigatory coverage, the responses to the question, "Are all cases investigated?" were considered. The question was asked in relation to neglect and abuse complaints.

3. Efficiency as a Criterion.
Efficiency, generally meaning productivity of action with minimum waste, was based on the extent of coordinated and cooperative efforts in internal operations and in relation to the parent agency and to the external environment. To determine the nature of such relationships, interviewees in the protective service system and in the collateral systems were asked to describe procedures of operating from the point of identification. Further, the respondents were asked if the outlined procedures were uniform/routine. In addition, a comparison of system's personnel performing functions was considered.

4. Operational Definition of Abuse and Neglect as a Criterion.
An operational definition of what constitutes abuse or neglect was considered to exist if the following conditions were present: (1) written policy describing conditions and priorities set for responding to reports, and (2) case handling predicated on a distinction between emergency intervention and long-term services. Beyond this, gross inconsistencies among respondents to the question, "If cases are confirmed as a result of investigation, what actions are then taken by your agency?" suggested a lack of definitional clarity. Interviewees were asked to consider a list of abusive and neglectful situations having serious and nonserious consequences for children.

EVALUATION OF EFFECTIVENESS—LEVEL II

The following set of criteria was utilized to evaluate the system's intervention; i.e., services rendered.

1. Recidivism as a Criterion.
The extent to which children did not return to the system (as measured by the absence of subsequent reports) was considered as an indication of the effectiveness of intervention. We acknowledge that the inability to control such relevant variables as family mobility, failures in the reporting system, and the occurrence of injuries not detected by potential reporters lessens the validity of recidivism as a criterion.

2. Length of Time Between Reported Incidents as a Criterion.
Longer periods of time between incidents was considered a measure of effectiveness. Here, too, the factors that tend to lessen the validity of recidivism as a criterion warrant that inferences be made with caution.

3. Severity of Subsequent Harm as a Criterion.
This criterion was predicated on the assumption that if services were effective, subsequent reported incidents would involve less serious harm than prior incidents.

4. Rehabilitation of Perpetrator as a Criterion.
To the extent that reported incidents did not involve the same perpetrator(s) and/or the same type(s) of harm to the children, we inferred that services were effective.

5. Disposition of Agency as a Criterion.
In utilizing agency disposition as a criterion, the assumption was made that subsequent dispositions would either remain the same or be less severe than earlier dispositions, e.g., services in the home as opposed to removal.

These criteria allowed us to make inferences about the services rendered by both systems. However, the limitations of the criteria as measures of effectiveness are acknowledged.

CASE SELECTION

As indicated earlier, data for Level II of the study were generated from two major sources: the staff of the protective service system (CES Unit) and case records.

At both sites the narrative accounts of reported incidents of abuse and neglect were maintained in family folders; the unit for record keeping was the family. For our research purposes, we studied records of all families in the child protective service caseload who were reported between August, 1971 and April, 1974 for abuse and neglect according to our predetermined definitions.

In terms of case selection, we excluded all cases which resulted from one or more of the following: (1) accidental injuries, (2) neglect due to family illness/hospitalization, (3) family crisis which could have negative consequences for familial stability, e.g., death, unemployment, and (4) personal report involving voluntary placement of children in the absence of abuse and neglect. The logic for the exclusion of the above types of cases is two-fold: such cases were not handled by Savannah's Protective Service Unit (PSU), and while the welfare of children and their families are at stake in such cases, the decisions made and the treatment required are basically different from that involved in cases generally defined as abuse and neglect.

One abused or neglected child per family was selected for inclusion in the study. If there was more than one abused and/or neglected child in the family, a schedule was completed for the child representing repeated abuse. If more than one child represented repeated abuse, the child reported most often was used. If none of the children represented repeats, a schedule was completed on the youngest child. If all of the children had been reported more than once but for the same number of times, a schedule was completed on the oldest child who was yet under the care of the parent or guardian.

Thus, our sample of cases represents the total population of families from each site that was reported during the period of study for abuse and neglect according to our definition. The number of cases included in our study does not represent incidence kinds of data.

SUMMARY OF LEVEL I FINDINGS

The efforts in Level I were directed toward a comparative evaluation of the two protective service delivery systems. Efforts were made to identify salient similarities and differences, and to pinpoint factors which impeded or enhanced the systems in their operations process.

Both systems were impeded in their internal cooperations as a result of the state of their relationship with collateral community systems. Operations were influenced negatively on two levels, one resulting from limited input from these collateral systems and the other from the ways these systems handled abuse and neglect cases. In addition, each system had particular strengths in their operations although neither system had all of the strengths that might be desirable in the delivery of protective services to children entering the service system.

SUMMARY OF LEVEL II FINDINGS

Utilizing the developed set of criteria for evaluating the effectiveness of intervention, the data suggest that neither system could be considered successful in dealing with abused and neglected children and their families.[5]

PRESENTATION OF THE EVIDENCE

Recidivism as a Criterion

Did the systems' intervention keep children from reentering the systems?

In both systems, a relatively high percent of the cases in the total caseload involved children who had been reported and investigated one or more times prior to the most current incident (44.8 percent of the CES total caseload and 24.4 percent of the PSU were serial abuse cases).

Among the serial abuse cases in the total caseload, slightly more than one-third of the CES cases and just under 30 percent of those in the PSU represented cases on which two or more prior incidents had been reported.

Of all cases which were investigated during the time frame for the evaluation of effectiveness—August 31, 1971 through April, 1974—slightly more than one-third of those

in the CES system and slightly more than one-fifth of those in the PSU were reported and investigated at least three times during that period.

Length of Time Between Reported Incidents as a Criterion

Did children remain out of the systems for a sufficient amount of time—more than one year—before their re-entry?

Fifty percent or more of the serial abuse cases in both systems' caseload (sample of cases for individual case analyses) involved the same children who were reported twice within a year's time.

A sizeable proportion of the children were reported twice within a six month period.

Severity of Subsequent Harm as a Criterion

Was harm suffered by children in subsequent reported incidents not serious if serious in earlier incidents, or not serious in either incident?

In both systems' sample of serial abuse cases, a relatively high percent of the cases involved children who were more seriously harmed in the current incident or seriously harmed in all of the reported incidents.

About half of the children who were more seriously harmed in the current incident, or seriously harmed in all of the reported incidents, were involved in two or more incidents within a period of one year or less.

Rehabilitation of Perpetrator as a Criterion

Were the same perpetrator and type abuse involved in subsequent reported incidents?

The same perpetrator(s) was involved in all reported incidents in approximately 80 percent of the cases in both systems' sample of serial abuse cases.

The type abuse remained the same in all incidents in approximately one-half of these cases. The perpetrator and type abuse were the same in about half of the cases.

Disposition of Agency as a Criterion

Did the dispositional stance in cases move in a direction which would appear to have less "severe" consequences for children and families?

There was a tendency for both systems to move toward more severe dispositions as cases progressed in terms of reported incidents.

In a relatively high percent of the cases, a petition was filed in the current incident only.

A sizeable proportion of the cases, involving a move toward more severe dispositions, involved children who reentered the systems in a short period of time.

CONTRIBUTING FACTORS

The findings from the data, and insights gained through the conduct of the study, suggest that factors contributing to the apparent lack of success (as measured by the aforementioned criteria) exist primarily in the problemmatic areas of the dispositional processes and the service delivery process.

As the ultimate goal of this study has been to provide possible insights for improvements in the delivery of child protective services, the following points are discussed without particular reference to either of the systems studied.

Dispositional Process: The Agency

Decision making, at each strategic point in the child protection process, was fraught with inconsistencies and a lack of consideration of client input.

There was an indiscriminate pattern in the investigation of cases; some cases requiring immediate intervention were not immediately investigated.

There was minimal observable difference between the dispositions made in cases involving serious and nonserious harm to children. Seriousness of harm appeared to serve only as a minor guide in the disposition to remove or not.

In spite of inadequacy of staff for the assessment-monitoring process, there was a tendency to allow the youngest age children who were seriously harmed to remain in the home.

Children were often returned to the home only to subsequently receive more serious harm.

The systems generally did not provide "treatment" services to parents during the placement of the children.

Dispositional Problems: The Court

There appeared to be a lack of criteria for guides in the court's dispositional process. Seriousness of harm did not appear to be a determining factor in the dispositions made: A more influencing factor seemed to be the fact of having been previously reported.

A relatively high percent of the children having child-related, personal problems were returned home by the court. This pattern causes a degree of concern inasmuch as our data indicate that children with problems have a good chance of being seriously harmed.

Case Handling: The Staff

Staff was generally ill prepared and lacked ongoing training in protective services. Beyond this, staff carried heavy caseloads which limited the ability to plan effectively and render intensive services as required.

In one system, all of the functions in the protective service process were carried out by one staff member. The case handling/management process functions were severely sacrificed.

On the other hand, ongoing services to children in the other system were not provided by staff trained in protective services.

Case Handling: The Service Delivery Process

Dispositions through time appeared to suggest a lack of in-depth assessment of the presenting problems, inadequacy of service plans to needs, and laxity in case planning.

There was limited utility of expertise in the wider community in the case diagnostic/problem definition processes.

From case data and responses to a set of case vignettes, we observed that service delivery often appeared not to follow a service plan which spoke of some of the most obvious needs of children and families.

There was insufficient monitoring due to inadequacies in staffing.

The delivery of services, from a community perspective, was fragmented and was not monitored by a single agency.

CONCLUSION

A host of interrelated factors contribute to the dilemmas evidenced by the data. Indeed, if these are agencies' problems, they are problems over which they have little control and little hope for instant resolution. In one degree or another, these problems typify child protective services.

This sad commentary is not intended as a sweeping criticism of the CES concept or as a negation of the value of implementing CES or any other "innovative" effort toward the goal of child protection. Instead, the findings from this study should serve as a reminder that "innovation" per se will not necessarily result in a cure-all package.

The success or lack of success accorded CES with abused and neglected children and families is confounded by the fact that data relating the success story result from a diverse population of neglected and dependent children. This conclusion is partially supported by the findings of Burt and Balyeat's evaluation of the demonstration program.[6] According to their data, the hospitalization and/or illness of mother accounted for 40 percent of the reasons for the assignment of a homemaker. Relief to foster parents accounted for an additional 25 percent.

While it is a credit to any community system that can deflect any child from the juvenile court system, and, where possible, maintain him/her in their own home, it is both illogical and dangerous to apply successes in this direction to children who are not abused and neglected in the "true" sense in order to make generalizable statements regarding probable success with the "truly" abused and neglected child.

Our data and other existing knowledge demonstrate the utility and feasibility of CES for crisis intervention oriented to short-term placement and crises resolutions. However, it is absolutely essential for communities to recognize that emergency intervention and ameliorative services can not be viewed as an end in themselves, merely a step toward the delivery of appropriate services. Regardless of the system type, the success in the delivery of services to abused and/or neglected children involves appropriate decisions, actions, and services, and at several junctures (the initial intervention being only one) in the total protective process.

The failure to rehabilitate parents is perhaps one of the most obvious indications (recidivism, seriousness in subsequent reports, short periods between reports, and agency tendency to move toward more severe dispositions are artifacts of the failure to rehabilitate parents and ameliorate familial circumstance) of failures in the service delivery process. A

variety of factors undoubtedly contribute to the failure to rehabilitate parents, among which are: (1) a lack of consistency, routine, and expertise in the diagnostic/problem definition process; (2) inadequately prepared and trained caseworkers; and (3) inadequacies in staffing of protective services which limit the intensity, consistency, and coordination in service provision as indicated by the service needs.

Data from the present study support the commonly held notion that children are often left in homes and/or returned where they continue to be maltreated—and in a sizeable proportion, more seriously in subsequent incidents—while child protection workers "work" with the family. Among the factors felt to contribute to this failure in the child protection process are: (1) inadequate criteria for determining the appropriate response and action in specific kinds of situations; (2) inadequacies in staffing which limit warranted case monitoring or surveillance; (3) agencies' philosophy of maintaining children in their own home and the emphasis upon rehabilitating parents (at times, children's immediate safety is jeopardized); and (4) the practice of returning children to the home after placement (short and long periods) with little or no interim services to the families.

The present target for training and specialization in service delivery is on staff who assume the responsibility for intake/investigation and emergency intervention. There is no doubt, however, that the failure to rehabilitate parents and, consequently, the failures depicted by other criteria are due primarily to efforts, or the lack thereof, in the assessment-monitoring cycle of the child protection process.

For protective service systems to fulfill their mandated responsibility, each suspected case must be conscientiously handled from start to finish; i.e., from the receipt of the report or complaint (input) to the investigation, to emergency action and court proceedings, if warranted, and to the strengthening of the family, if possible, through support services.

In order for this mandated responsibility to become a reality, a network of community interactions beyond the boundaries of single systems must be coordinated.

The previous description presents a generalized picture of a working protective service system. What is missing, however, is an explicit statement of the process "from start to finish," the agency organization for moving the process, and the community's responsibility in the process.

One of the outcomes of this study was the development of two models which, hopefully, will lend insight to directions toward a more specific picture of a working protective service system within the mandated agency: a process model for child protection cases and an organizational model.

FOOTNOTES

[1]Public Law 93-247, 93rd Congress, 5.1191 (January 31, 1974). Department of Health, Education, and Welfare, Office of Child Development. Proposed Rules for the Child Abuse Prevention and Treatment Program, *Federal Register*, Vol. 39, No. 168 (August 28, 1974), section 1340, 3-3(3) (ii).

[2]Burt, Marvin R. and Blair, Louis H. *Options for Improving the Care of Neglected and Dependent Children, Nashville-Davidson County, Tennessee.* Washington, D.C.: The Urban Institute, 1971.

[3]Drinnon, Donna J. *Survey of Twelve Hospitals, Nashville-Davidson County, Tennessee.* Tennessee Department of Public Health, October, 1973.

[4]Johnson, C. L. *Two Community Protective Service Systems.* Functions, criteria for evaluating systems operations, and contributory factors are discussed in Chapter 3.

[5]For the detailed case analyses on effectiveness of intervention, the serial abuse caseload in both systems was decreased significantly due to the deletion of all cases in which all incidents prior to the most current were reported prior to August, 1971—the implementation of the CES project.

[6]Burt, Marvin R. and Balyeat, Ralph. "A new system for improving the care of neglected and abused children." *Child Welfare*, 1974, LIII(3).

Developing a Crisis Nursery: Some Practical Considerations

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DEFINITION AND PURPOSES

In working with abusive families, one of the greatest breakthroughs occurs when parents begin to anticipate or recognize a personal or family crisis. However, recognition of such a crisis and of the factors that play into it is not a fool-proof safeguard that a child will not be severely affected or injured as a result. Good supportive services available to the parent and child in crisis should not only alleviate some of the stress but also provide safety and respite for the child. Families in crisis often need a few hours, or days, to cool off and work out some trouble spots before rejoining each other. A Crisis Nursery can provide this opportunity.

Definition

A Crisis Nursery is a residential care facility which provides short term, 24-hour care to a small group of children in a particular age group who are suspected of being abused and neglected or who are in danger of being abused or neglected.

Because this definition can be used very narrowly or broadly to include or exclude children, each Nursery will have to be more specific regarding its criteria. For example, neglect could include children who need care because parents are temporarily unavailable because of an accident. Another Nursery may prefer to limit usage to abusive families.

In summary, a Crisis Nursery is a child care facility that specializes in providing short-term crisis care to abused and neglected children. It is not to be confused with or incorporated into an existing child-care program, e.g., receiving home, day-care program, or preschool. It is a separate and highly specialized service to children and to their parents.

Purpose

A Crisis Nursery may begin with one or two purposes or goals and later expand to multiple purposes as facilities are more adequate, staff more competent, and families more comfortable with using the Nursery. It can be differentiated from a foster home, receiving home, day-care program, or preschool by the types of purposes.

The two major and initial purposes or goals of a Crisis Nursery are to provide:

1. A safe environment for the child and
2. A non-threatening resource for the parent.

   First, there must be a place in which there is respite for the child and second, the facility needs to be used by families in crisis. As basic as these two points may seem, they are the only essential goals for beginning a Crisis Nursery.

As the program develops, other goals should be added:

3. Therapeutic aid to the child.

   In times of duress and extreme confusion, children in crisis need help in sorting out the disturbing emotions which they are feeling. Generally, most of the children who will be seen in a Crisis Nursery come from abusive environments which are unpredictable and inconsistent. Therefore, the children may have severe developmental and emotional disturbances.

   Coupled with the tumult at home and the arrival at a Crisis Nursery, the child's emotional stability will be extremely fragile. A nurturing and knowledgeable staff member can play an important part in assisting the child to work out some of the perplexities.

*Excerpted from the manual *Crisis Nurseries: Practical Considerations*, available from the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado. $2.00.

4. Developmental screening and referral for the child.
Most children who are seen in a Crisis Nursery are noticeably delayed in some aspects of their development or are emotionally disturbed. This is more than frequently the case.

Observations and developmental screening can be done by Crisis Nursery Staff. Referrals to diagnostic clinics and evaluation centers can be facilitated by such efforts. Many children who have never been assessed may need immediate and intense help in reaching their developmental potentials. Often children who are seen in a Crisis Nursery have not been in any other setting where such concerns could be raised. They simply "slip through the system."

5. Referral to appropriate on-going programs.
Children seen in Crisis Nurseries are usually not enrolled in on-going child-care programs. For this reason, it is important that Crisis Nursery personnel be cognizant of appropriate day-care and preschool programs and other resources for children in the community. Oftentimes, after trust has been won on the part of the parents, suggestions can be made regarding referral to an appropriate child-care program or treatment resource. Information about the child that is gleaned during his/her stay at the Nursery can be utilized in order to provide him/her with an on-going program that is suited to his/her needs.

6. Medical screening and health care.
As with developmental delays and emotional problems, medical problems are frequently discovered in the Crisis Nursery setting. In addition to general childhood maladies, visual and hearing problems, seizure disorders, and motor deficits have been detected. Referral can again be effective to aid the child in his physical development by arranging consistent pediatric care and appropriate consultation.

7. Helping the parent to obtain some assistance.
While the parent and child are separated, the parent can address the issues that precipitated the incident. Seeking help through a social service agency, community service group or mental health facility is a major step. The Crisis Nursery staff should know about appropriate resources for the parent and help with referral.

8. Teaching the parent to use child care.
The parents need help in learning to use child-care facilities and staff. To view the Crisis Nursery as a supportive rather than a threatening service is not easy for them. However, this is essential to their using the Crisis Nursery again. It often is a first step toward utilizing other appropriate babysitters and early childhood educational programs in the community.

Finally, while developing a Crisis Nursery program, it is judicious to decide on the purposes of your program with realistic and obtainable goals. Decide what you are capable of providing and then go from there.

LICENSING AND LOCATIONS

All Crisis Nurseries need to be licensed. The type of license will depend on where the facility is located and what the state regulations are. Basically, there are three types of licenses:

1. Extended Care Facility of a Hospital
2. Receiving Home (Foster Home)
3. Residential Child Care Facility.

An extended care facility license is perhaps the easiest to obtain, but it is also the rarest because of the hospital affiliation. The Crisis Nursery at The National Center for the Prevention and Treatment of Child Abuse and Neglect (Denver) has this type of license because The Center is part of the Department of Pediatrics at Colorado General Hospital. There is no special red tape because the hospital standards are clear and usually quite practical. A Crisis Nursery which is affiliated with a hospital functions best if it is outside the hospital proper. The parents are less threatened and the children less fearful, yet medical services are readily available if needed.

A receiving foster home license is also rather easy to obtain. The home must meet the state's standards for foster care and become licensed for a certain number of children. Most rural areas will find this the most practical means of establishing a Nursery. However, there are some serious drawbacks. First of all, in order to truly be an efficient, short-term relief system

parents must have direct access. They must be able to bring their children, day or night, and to trust the caretakers. If access is only available through the Department of Social Services or a metropolitan crisis center, parents will be more hesitant to use the facility. They may be afraid of letting "authorities" know, and there may not be enough time for several phone calls and long explanations. Secondly, the boundaries between a Crisis Nursery in a receiving home and a receiving home can become fuzzy. It is all too easy for Social Services' caseworkers to use the Nursery as a holding facility when a foster home is not available. When this happens, there no longer may be room for children who only need a few hours of care before they can be returned to their parents.

In most states a license for a Crisis Nursery as a residential child care facility will be difficult to obtain. To put a Crisis Nursery in a preschool or day-care center and keep it open twenty-four hours a day implies residential care. Several years ago, when infants and toddlers were being institutionalized far too readily, many states adopted regulations preventing residential care for children under three years of age. Yet, many of the most seriously abused and neglected children are under three. State regulations may need to be rewritten to allow for short-term crisis care of these children.

Many day-care facilities and preschools opt to include children in crisis into the regular daily routine of the other children. We seriously question this practice as it negates the premise that children in crisis have special needs. This does not mean that preschools and day-care centers should not provide crisis care. It merely means that a specialized program within the facility needs to be developed.

This manual focuses on standards for Nurseries that are extended care and residential child-care facilities. However, many of the standards can also be applied to Nurseries within foster homes.

PERSONNEL

The most critical element in a successful Crisis Nursery program is the personnel. Selection of staff is a difficult task because it must involve consideration of academic skills and personal qualities.

The Crisis Nursery director or supervisor should have academic learning in the areas of child growth and development (a minimum of twelve semester or eighteen quarter hours); knowledge of the effects on children of abuse and separation; at least three years of verified full-time work experience or equivalent with children cared for away from their own homes; and skills in management, with ability to supervise child care workers. Personal qualities should include openness, warmth, empathy for abusive families, and a sense of humor. Because of the necessity for the supervisor to know child development theory and techniques in working with young children, social workers may not necessarily be qualified for such a position.

Child care workers should be at least twenty-one years old and have had two years full-time experience in working with young children, either as a parent, in paid employment, or in supervised volunteer work. Their personal qualities should be the same as for the Crisis Nursery supervisior. It is preferable for them to be willing to make a one or two-year work commitment.

The number of staff members caring for the children in the Crisis Nursery should be kept small and consistent. The use of volunteers should be considered only if they make commitments for large blocks of time on a regular basis and meet the same qualifications required of child care workers.

Each child care worker should participate in an initial orientation and on-going in-service activities. These should include policies of the Crisis Nursery, dynamics of child abuse and neglect, the effects of inadequate parenting and separation on children, principles of child development, and methods of child care and crisis intervention techniques with abusive parents and their children. The Crisis Nursery supervisor should continue his or her own learning through courses and conferences offered in the community.

Working with abusive and neglectful families is emotionally draining work, and staff morale can be low unless special precautions are taken. Best results occur when the Crisis Nursery is kept full and there is an adequate staff-child ratio. If the Nursery is consistently under-utilized, child care workers lose their enthusiasm. Efforts may need to be made to better publicize the Nursery or find alternative work for the staff to do when there are no children. If staff work overtime, they must be granted compensatory time off. They will need time to meet with each other and the supervisor to air their frustrations and share their ideas. To keep staff for many years, it is useful to be flexible in granting leaves of absence; a good worker may need a summer off to "recoup."

Medical, social work, and child development specialists are necessary consultants if the Crisis Nursery is to operate at a professional level. Particular children will need special evaluation, and the staff will need advice on how to work with these children. If the specialists are unable to see the children within the Nursery, a referral system can be utilized. It is essential that feedback be given to the Nursery staff because they are likely to see the children again. It is also necessary for the staff to have the phone numbers of doctors and social workers to call when there are emergencies, such as a child with bruises being brought to the Nursery.

POLICIES

Referrals

The Crisis Nursery should accept referrals from all private and public agencies and from parents themselves. Efforts should be made to publicize the Nursery as an alternative for parents under stress who are afraid they might injure their child(ren). Administrative paperwork should be kept to a minimum so that parents find the access relatively easy. The consent forms must be signed the first time the parents use the Nursery for their child(ren). If at all possible, parents should be encouraged to visit the Nursery with their child(ren) prior to a crisis situation.

Most Crisis Nurseries will choose to provide short-term care for children from infancy through twelve years of age who are abused, suspected of being abused, in danger of being abused, or who are in other immediate danger. Most communities have other kinds of facilities for children over twelve who need short-term care. Combining an age range from birth to twelve years is difficult. If a community is large enough to have two Nurseries, it is best to split the age groupings into birth to six and six through twelve, except in unusual circumstances involving sibling groups. If this is not possible, administrators should be aware of the problem with the name "Nursery." "Crisis Center" might be a more appropriate name for a facility which will be utilized by older children. Separate rooms and supplies should be available for the age groupings.

In general, any child who typically would be cared for at home can be admitted to the Nursery. If a child has any injuries or is suspected of having any, he should be seen immediately by a doctor. Without this precaution, it could happen that a child with a broken arm who does not cry could be kept in the Nursery overnight. Children with other complicated medical problems or severe emotional disturbances may not be appropriate for the Nursery, but it may be dangerous for them to remain at home with a distraught parent. Short-term care can be provided if there is professional consultation and a referral network.

Reporting

Most states require that a report to the Department of Social Services or Police Department be made immediately on all children who are suspected of being abused or neglected or who potentially may be abused or neglected. If this is so, the families must be informed prior to the report being made. It is essential that the reporting and investigation by Social Services be done in such a way that the parents view this as help, not an intrusion. After all, if the parents have chosen to use the Crisis Nursery on their own, they have already recognized they have a problem and are seeking help.

Length of Stay

Each child should return to his or her own home within seventy-two hours of admission to the Crisis Nursery. Most admissions will be for less than a day. Many communities will choose to lengthen this time; a stay of seven days should be the maximum limit. One danger is that the Nursery may become a convenient receiving home in counties where there are shortages of foster homes. A nursery used as a holding facility will soon no longer have room for short-term crisis care. Another danger is the harmful effect of multiple caretakers on a young child if he or she is kept in care over an extended period of time. If it is clear at the outset that foster care is necessary, a regular receiving home should be used rather than the Nursery. With other children, the decision may not be so easy. Parents may initially want to leave their child for only a day but later choose a voluntary foster placement. A guideline to use is: Who is having the crisis? Is it the parent, or is it primarily the caseworker because he or she cannot find a foster home for a child?

Living Units and Staff-Child Ratio:

Each child should be placed in a living unit within the Crisis Nursery which includes no more than eight children. If a Nursery wants to routinely provide crisis care for more than eight children, a

second living unit is required. The small clusters are necessary to provide individualized attention in a calm, consistent environment.

At least two staff members should be at the Crisis Nursery from 7:00 a.m. to 10:00 p.m. The staff-child ratio should be no more than four children to one staff person. During the day and early evening, it is not practical to have one staff person at the Nursery and another on-call. One minute it may be calm at the Nursery with only a couple of children in care; the next minute a distraught mother can arrive with several crying and screaming children. The mother wants to talk, and the children need to be fed. There is no time to call or wait for a back-up person.

From 10:00 p.m. to 7:00 a.m. one staff person at the Nursery is usually sufficient unless more than four of the children are staying overnight. Supper time and bedtime are crisis points in many families; few children are brought to the Nursery in the middle of the night. Therefore, usually there is sufficient time to arrange for a second staff person to stay overnight.

Record-Keeping

Each child should have his or her own chart which is easily accessible to Nursery personnel. Release forms, medical information, and any evaluation reports on the child should be filed. The staff should keep written records of their observations of the child's behavior while in the Nursery. Additional notes should be made regarding family circumstances and parent-child interactions.

Transportation

Abusive and neglectful parents frequently do not have transportation. Bus coupons and a taxi credit card help with this problem in the city. Parents often need help in knowing the "details" of riding the bus, that is, where to meet the bus, where to get off, and the cost. Rural areas may need to arrange for a Crisis Nursery staff member to provide transportation. There is no sense in providing crisis care if it takes hours to arrange a ride for a family to the Nursery.

THE NURSERY ENVIRONMENT

It is extremely important to obtain adequate and functional physical space for a Crisis Nursery facility. Space must be well-defined so that the children recognize particular functions in each designated area. These space allocations might include: bedrooms (maximum of three to four children per room, depending on square footage); bathroom facilities (with bathtub); play area (perhaps two areas—one for quiet activities, one for large-muscle activities); kitchen-eating area; living area (with television, soft chairs, and couch) and an office-work area for intake, parent conversations, and conferences.

Setting up the space to be child-oriented, attractive, and operable is of paramount importance. As we will point out in the next section, many abused children find it hard to make choices as to what materials to play with and are often scattered in their play, trying to do everything at once. It is, therefore, most critical to introduce the child to an environment that is not over-stimulating. A few materials can be made available to him or her; decor can be made of soothing colors and a few bold prints. A limited amount of equipment should be visible; the rest can be put away in storage cabinets.

The total space will fare well if it creates a comfortable, home-like environment. Lots of soft pillows, overstuffed chairs, and rocking chairs can enhance the soothing atmosphere. Places to hide and quiet areas where the child can be alone are equally critical. A child-size table with chairs, cribs, and twin beds should be provided.

Materials can be arranged in interest areas to enhance their appropriate use. A housekeeping/doll-play area often can aid the child in working out some of his familial conflicts. Book corners give the child a place to relax and listen to stories. Block play, puzzles, and games are important to promote cognitive and emotional skills. Gross motor equipment (tricycles, climber, slides, walking board, and rocking boat) and an adequate outside play area (with sandbox and grass yard) are crucial components. Art activities can often be used to help the child enter into some play. Initially, less emphasis should be placed on cognitive materials; however, they should be available to the child who is at ease enough to delve into a more structured activity.

As mentioned previously, the Crisis Nursery is most effective when it is a separate program in itself. If housed in a day-care center or other large program, the children will not benefit if incorporated into that larger program. They are far too delicate at the time of crisis to cope with such an arrangement. It may, however, be appropriate to refer the child to the program for later child care.

Quite obviously, proper nutrition is an integral part of any Crisis Nursery program. Nutritious snacks and hot meals should be served. Many children coming to the Crisis Nursery may have gone for many hours without any food and may need a hearty snack before they will be willing to interact with other children and adults. Eating is sometimes difficult for these children, with refusal of food or hoarding being common patterns.

The number of visitors to the Nursery must be limited because the constant intrusion of strangers distracts the children from the major focus of the child care program. Many people will request to observe your program; this can often be done with the use of one-way mirrors, visual aids, or workshops. Actual tours through the children's areas can be quite damaging to the children's feelings of privacy and safety. Interruptions should be avoided.

CHILDREN'S PROGRAM: ATTENTION TO SPECIAL NEEDS

Abused and neglected children have special needs. They can have speech and language deficits, gross motor delays, and cognitive, emotional, and social disturbances. Behaviors are often at extremes--either acting out in rage or excessive compliance. Many children are hypervigilant, alert to everything in their environment. They may be indiscriminate in their relationships with adults. Many of them become "stuck" in their play; they find something that is safe but are unable to expand the play.

Helping the children and providing consistency for them are the keys to an effective, therapeutic Crisis Nursery. For many children, this experience may be the first of its kind for them. As they continue to be seen in the Crisis Nursery, each staff member's attempts to aid expression will bring the child closer to working out some intense feelings for himself. The staff member's attempts to provide consistency will help the child believe there are such things as safety and predictability.

Children in this new setting will cope in many different ways. Some may be extremely angry and act out; some may withdraw and refuse to participate; others may fall apart and sob for minutes on end. Other children will act as if nothing is wrong, being compliant and oftentimes very adult-like and pleasing. All of this behavior *must* be acknowledged, respected, and dealt with by the staff. Specific guidelines to use in comforting children who arrive at a Crisis Nursery include: (1) Explaining the situation to the child in simple terms; for example, "Mommy and Daddy are upset and want us to take care of you for a while." (2) Assuring the child; for example, "You are all right; we will take good care of you." (3) Building up the child's integrity; for example, "Mommy and Daddy are mad, but it's not your fault."

Introduction of activities and involvement with other children and adults must be carefully handled after assessing the child's readiness to become active. The daily happenings for each child must be dictated by that child's needs. Initially, it may take a few hours or days to interest the child in play. Others may delve into activity vigorously. The staff member must be willing to give each child some time to adjust, key in on the child's particular interests, and then slowly introduce him/her to more stimulation. Many children will need to be shown how to play, how to use materials, and how to express themselves. Again, this whole process is dependent on the child's readiness.

Consistency and routines are the "Golden Rule." The activities and scheduling at a Crisis Nursery should be predictable and *consistent*. Transitions are characteristically difficult for young children, especially for children in crisis. This is often eased by "warning" them ahead of time. For example, "In a few minutes, we'll get ready to go outside."

Structure can be placed within the program by deciding what limits will be set and sticking with them. Care must be given not to "overstimulate" the child by barraging him with activities and materials. Every minute does not need to be planned for the child. He also should not be expected to pour out his feelings twenty-four hours a day; too much of anything can undo any progress made.

Appropriate activities and materials might include:

Art activities--painting, Play Dough (with utensils), colors, chalks, collages, pasting
Water play
Sand play (beans)
Puzzles, Tinker Toys, sorting box, nesting cups, and other manipulatives
Books
Blocks, trucks, cars
Doll houses (people, figures, animals)
Dramatic play--play kitchen, house, equipment, dress-up, babies, puppets

Doctor/nurse play
Gross-motor equipment—climber and slide, walking board, rocking boat
Pillows, bean bag chairs, things to hide in.

Again, any activity or material introduced to the child must suit his/her needs and not just be used to pass the time. This is a critical point in helping young children in crisis.

Helping the child to learn self-help skills gives him/her a great deal of support and reinforcement. For example, "See, you can do it by yourself!" Self-help skills can be emphasized around routines such as toileting, feeding, and dressing.

Bathing and bedtime are often extremely difficult times for children when they are in a strange, new setting away from their families. Again, routines are important, with support, comfort, and guidance given by the staff. Nighttime is confusing and frightening, requiring a great deal of empathy on the part of the night staff.

As is to be expected, management of behavior problems is often trying and exhausting for both adult and child. Staff interchange, consultation, and training are needed to discuss contingency management. Again, each child must be considered separately. One child may respond appropriately when a staff member stops a behavior and redirects him or her. Another child may need to be physically restrained or removed from the situation.

It should be remembered that many children have severe emotional disturbances and require careful and skillful intervention. Staff will need consultation and support in dealing with such children.

SERVICES FOR PARENTS

Services to parents must not be overlooked as a function of a Crisis Nursery program. The Nursery staff can provide a great deal of assistance by being warm, sympathetic, and supportive. A full cookie jar and a fresh pot of coffee can make a parent feel welcome; occasional visits and chats with staff result in a sense that "maybe this place is okay."

For many parents, a Crisis Nursery may be their first experience with utilizing child care. "Sharing" their children with a staff member is painful and revealing for most abusive parents. Generally, they are afraid that they will look like "bad parents" and that their children will "like someone else better" than themselves. A supportive staff can begin to break through this deep-seated fear. Gradually, the staff members become important role models for the parents and can begin to discuss the children's development. Through the use of a Crisis Nursery, parents can learn to use other resources. Referrals to Parents Anonymous, mental health clinics, or therapists in private practice can be made when the parent is ready. If at all possible, it is valuable to have a parents' therapy group offered directly through the Crisis Nursery.

A Crisis Nursery program can best be evaluated by its usage. If a parent learns to use it and uses it appropriately, then it has provided a very valuable service to children and their families.

FINANCES

Local monies for Crisis Nurseries are often available through United Way, Junior League, Lion's Club, church groups, and businesses. State legislatures are sometimes willing to increase the budgets of protective service departments so they can provide crisis care. At the present time, Federal monies are quite limited. Set-up and operating costs vary considerably depending on where the Nursery is located, how large the Nursery is, how it is staffed, and what materials are donated.

Connecticut's Emergency Coverage Protective Services System Concept

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During the past two years, Connecticut children's welfare services have undergone a major revolution; Legislation in 1974 mandated the Department of Children and Youth Services (DCYS) to expand its delinquency services base to include child welfare services and all children's mental health services. This mandate was based on the premise that coordinated comprehensive services to children would result in more thorough and higher quality children's services. The welfare department now contracts with DCYS to provide the mandated protective services as part of the child welfare services. During state office hours, five regional DCYS offices take direct protective services referrals.

CARE-LINE

Connecticut's 24-hour child abuse hotline is known as the Care-Line. Care-Line was created by one of the oldest and strongest private child advocacy groups in the United States, the Connecticut Child Welfare Association. It provides a well-publicized statewide toll-free phone number for citizens, including professionals, to call for information, referral, and often therapeutic support in regard to problems with children. During the 1975 program, most of Care-Line's 2,930 calls involved abuse or neglect problems.

Care-Line's trained intake telephone staff is backed at all times by professional clinical staff. When a call is received reporting abuse or suspected abuse, the intake answerer encourages the caller to telephone the local mandated agency office for protective services (DCYS). When the caller indicates that he will do so, the Care-Line staff asks permission to follow up (and does so, usually within one day) to determine if, in fact, the report was made. If the caller is hesitant, or refuses to call DCYS, and Care-Line is convinced that a neglect and/or abuse condition exists, it will submit such a report to the DCYS local office. When an abuse crisis is imminent outside of DCYS office hours, the professional Care-Line backup staff member (reached by telephone or pocket pager system) further screens and works with the family in crisis, taking responsibility when necessary to immediately contact the local DCYS stand-by emergency staff for appropriate services.

EMERGENCY COVERAGE NEED

This 24-hour link-up with DCYS is a very critical and separately contracted service of Care-Line. According to Care-Line's statistics from last year, most emergency protective services calls came between 4:30 p.m. and midnight. Therefore, Connecticut's state government, faced with the usual tight state budget that most states face, has opted to officially involve the private services of Care-Line with emergency public protective services. The rationale for this could be summarized as follows:

1. Care-Line was already in existence for two years and had established a well-known reputable, non-threatening statewide image to the public.
2. The state of Connecticut could not afford its own hotline plus office coverage for protective services evenings, weekends, and holidays. Yet the state (DCYS) is responsible for providing emergency protective services around the clock.
3. Public-private cooperation strengthens resources and has value in itself.
4. The child abuse state grant would cover a purchase of services contract (at a reasonable cost) with Care-Line that would link protective services workers across the state via a pocket pager system with a hotline entry point for emergencies. The grant would also cover small payments to the standby protective services workers for being on "standby". The state already pays a worker who goes out on emergency placements during non-office hours.

The current working design is not ideal. After eight months of operation, we already have design modifications for next year's state child abuse grant. I will indicate several of the problems and possible future modifications after I describe the current design.

BASIC DESIGN OF EMERGENCY COVERAGE

Connecticut's children's services are administered from five child welfare regional offices. Each region has sub-offices depending on its geographic size. Ten standby protective services workers, on a pocket pager system, give comprehensive geographic coverage between 4:30 p.m. and midnight on weeknights, and 10:00 a.m. to midnight on weekends and holidays. After midnight Care-Line emergency calls are screened and when necessary referred directly to the regional DCYS protective services supervisor, who can call a protective services worker to go out. Protective services workers volunteer to be on standby, and monthly each regional director selects those he will put on rotating emergency standby for one week at a time. Workers are chosen on the basis of capability to make emergency crisis decisions and placements. Protective services supervisors themselves can take a turn on standby and cover their own region. Standby workers are paid a flat rate to be "on call," regardless of whether or not any emergencies arise.

WHEN AN EMERGENCY CALL COMES IN

Step one: Caller reporting abuse emergency phones Care-Line; Care-Line trained intake worker screens call and takes caller's phone number; Care-Line pages professional back-up social worker;

Step two: Care-Line back-up person phones Care-Line intake worker to pick up call;

Step three: Care-Line professional then phones back to caller and further screens problem; Care-Line professional queries Central Registry for prior report (if time); Care-Line professional contacts protective services worker on standby in appropriate region if emergency needs immediate intervention;

Step four: Protective services worker phones caller. (He may also phone his supervisor if a special problem arises.)

TWO MAJOR PROBLEMS

1. The most obvious problem as this system now exists is that it is cumbersome, with several phone calls being made before a protective services worker actually calls back to the caller with the abuse emergency. In practice, this has not become a major problem. Everyone clearly knows his role, and the process goes quickly into action. In practice, this process usually takes ten to fifteen minutes to complete. In a literal crisis, the Care-Line intake worker can call the local police immediately to rescue the child(ren). Also if the problem that the caller presents can be competently handled by telephone, the Care-Line professional back-up will usually provide this service and report the case to DCYS the next working morning.
2. A second potential problem with this public-private linkage is the legality of having Care-Line staff make decisions for which the mandated protective services agency must be held accountable. Frequently, Care-Line staff works as a team with protective services staff in mobilizing resources during an emergency. Frequent communication and feedback have minimized this potential problem.

POSSIBLE DESIGN CHANGES IN FUTURE

Several possible suggestions are being considered for next year:

1. That the Care-Line intake worker be a professional social worker (this would greatly increase the expense);
2. That the standby pay be increased and official coverage be extended throughout every night;
3. That the state take over the hotline function and that shifts of protective services office staff provide direct coverage throughout the night.

SUMMARY

The full extent of Care-Line's telephone protective services casework was not elaborated for the purposes of this paper. However, Care-Line also provides short-term supportive counseling to potentially abusive parents as well as to parents who are calling in reaction to the trauma of having just abused a child. After almost one year of operation, the Department of Children and

Youth Services feels that this system has greatly increased its ability to respond immediately and professionally to crises. This emergency delivery system is working very smoothly, with good follow-up on the next working day.

One might ask why Connecticut is proceeding with an unperfected system for emergency coverage. We have as a state made a commitment to start with our existing public and private resources, to take some reasonable risks, and to foster a feeling that protecting children is everyone's responsibility.

Louisiana's Statewide Interdisciplinary Approach to Diagnostic, Protective and Treatment Services for Abused and Neglected Children and Their Families

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Louisiana is the only state in the United States with a legislative mandate to establish child protection centers. The state is ahead in the statewide services it provides to abused and neglected children such as 24-hour availability, university-supervised medical care, and use of the interdisciplinary team concept.

Protective services are delivered to children through two unique systems, the six child protection centers and 64 special protective service units. The centers are located at state supported university hospitals where private or indigent patients requiring hospitalization are admitted. The medical care is provided by the medical director, a Louisiana State or Tulane University Medical School faculty pediatrician.

The centers are staffed with social workers (MSW), pediatricians, homemakers (parent aides), lawyers, psychiatrists, and psychologists. Volunteers and community service organizations provide auxiliary services. Interdisciplinary dispositional conferences are held prior to discharge from the hospital or court hearings. During the conference, the situation is explored comprehensively to determine if abuse exists and to develop a plan of management for the child and his family. Close cooperation and coordination exist between foster care and the center. Law enforcement assists the social worker with night investigations.

The Louisiana Protective Services Director and Medical Director of Child Protection Programs provide the administrative supervision. Funding of the centers and protective service units is provided by the state with matched federal funds. The Baton Rouge Child Protection Center is funded for three years by a federal grant to develop a model center using the interdisciplinary team concept.

Emergency and community services provided by the centers and protective service units are: (1) 24 hour referral of suspected child abuse and neglect cases, (2) crisis counseling, (3) early protection of the abused child, (4) consultative services to other community professionals in abuse case management, (5) fulfilling mandated reporting procedures to the court, (6) long term follow-up and treatment programs for the child and his family, and (7) training programs for community professionals and paraprofessionals. The major goal of re-uniting the family is always kept in mind.

The social workers employ individual, group and/or "couples" counseling in providing rehabilitative services to the parents. Cases also are referred to mental health and family counseling clinics. A homemaker assists in providing "in-home" parenting.

LOUISIANA'S STATEWIDE CHILD PROTECTION PROGRAMS

Organization

The development and implementation of Louisiana's statewide child protection programs are coordinated by a state director of protective services and a medical director. Close cooperation exists in the interdisciplinary team approach (between the medical and protective services disciplines at the state and local levels) which provides diagnostic, protective, and treatment services to the abused and neglected child. The state medical director is a university-appointed pediatrician and is responsible for the medical component of the program. The protective services director (MSW) provides the administrative supervision of the program.

Medical Component

The responsibilities of the medical component are to: (1) provide diagnostic and treatment services to the child (inpatient or outpatient); (2) obtain and coordinate the necessary consultations from psychiatry, psychology, surgery, and others as needed; (3) provide frequent medical evaluation and treatment progress reports to the center caseworker; and (4) furnish

medical data and its interpretations at the interdisciplinary team dispositional conferences and court hearings. The child protection center's medical directors provide for the coordination and delivery of medical care to the abused child (and family) at the community level. The center medical directors are university pediatricians appointed by the state medical director. The university appointments are either with Louisiana State University School of Medicine, Pediatric Department or Tulane University School of Medicine, Pediatric Department.

Protective Services Component

Louisiana's organizational chart illustrates the administrative structure within the Office of Family Services for protective services, which is the legally-mandated agency to investigate reports of abuse/neglect. My responsibilities include direct supervision of the child protection centers as well as development, coordination, and maintenance of the statewide protective service program.

Although not directly under my supervision, the 64 parish protective service units are closely coordinated through state staff, in conjunction with the child protection centers. These parish units were designated and trained beginning in January, 1973. The number ranges from one in small parishes to 35 in Orleans Parish. Where there is no child protection center, these units receive, investigate, and treat suspected abuse and neglect cases. If medical examinations--pediatric, psychological, or psychiatric--are needed, they are purchased from local medical resources case by case. Louisiana is no different from other states in terms of lack of resources in rural areas. Of course, the most crucial inadequacy is that of private and public mental health resources. There is a health unit in each parish, with a physician available, and also a District Attorney available to the parish protective service units. Homemakers, available to the parish units, are used extensively in protective service cases. If social workers feel the need for guidance on cases, they may request it from an agency social service consultant or designee. If placement is indicated, arrangements are made with the foster care unit in the parish.

If court action is indicated, a letter or court report is written by the social worker to the District Attorney giving the circumstances and recommendations. If the District Attorney feels action is warranted, he sets the judicial process in motion by filing petitions, issuing subpoenas to witnesses, and docketing the case. All abuse-neglect cases are heard by a Juvenile Court Judge or, where there is none, by a City or District Judge sitting as a Juvenile Court Judge. The proceedings are confidential and closed to the general public. The investigative and judicial procedures are outlined in the state reporting law.

With final approval of money from Public Law 93-247, we plan to add 24-hour coverage and the multidisciplinary teams in three additional parishes. We also plan to extend the team aspect in another parish, which is rather small, but is at high risk per capita.

Statistical Data

As of 1 July 1976, Louisiana's master index of abuse-neglect cases showed 16,320 cases open and 18,477 closed. This number is four times higher than 1974.

As a participant state with the National Study on Child Neglect and Abuse Reporting, we recently analyzed data from 1975. Of the total reports on 3,314 families, 53% were valid and 47% invalid. The five highest groups reporting (ranked in order) were relatives, neighbors, public social agency, law enforcement, and school personnel. We are pleased with reporting from school personnel because, prior to 1975, this group was low in its reporting. Out of 693 children involved, 231 were classified as emotionally disturbed; 130 as mentally retarded; and six other characteristics with less than 75 children each. These characteristics are based on the social workers' impressions rather than test results, but, in view of the large numbers, it is safe to say these are prominent characteristics. Of the valid abuse cases, the most frequent injuries were contusions, abrasions, and lacerations. The most frequent types of neglect were physical, emotional, and educational. Neglect cases were more prevalent than abuse, by four to one.

Thirteen fatalities were reported in 1975. The stress factor most often leading to abuse was the child's disobedience. Out of 25 stress factors, the leading five (in order) were: insufficient income, heavy continuous child care responsibilities, marital stress, absence of essential family member, and unemployment.

Child Protection Centers

The six child protection centers are located in Baton Rouge, New Orleans, Alexandria, Lafayette, Shreveport, and Lake Charles. In these large cities, the centers are the agencies responsible for investigation of reports of child abuse and neglect. The centers are situated at state university

hospitals. Private and indigent referrals are accepted for investigation. The medical supervision is performed by a salaried, full-time, university-appointed pediatrician, while the inpatient and outpatient medical care is provided by state-supported university hospitals. The administrative supervision is delegated to an administrator (MSW) who is appointed by the Commissioner of Health.

Protective Service Units

In the 58 parishes (counties) of Louisiana without child protection centers, the agencies responsible for investigation of reports of child abuse and neglect are the parish protective service units. They are located in the parish family services offices. Private and indigent referrals are accepted for investigation. The staff includes social workers, homemakers, and consultants in the fields of pediatrics, psychology, and psychiatry. Medical care is provided by physicians and hospitals located in each community. The emergency and community services available are: 24 hour reporting of suspected child abuse and neglect cases; early protection of the abused child if the home is proven to be unsafe; medical/social services to the abused/neglected child and his or her family; and long-term follow-up for cases referred by the child protection centers and courts.

COMMUNITY CHILD PROTECTION CENTER

I will detail the scope and organization of one of the child protection centers, illustrating the interdisciplinary approach to providing diagnostic, protective, and treatment services. This will demonstrate the use of legal, psychology/psychiatry, foster care, homemaker, medical subspecialty consultants and other disciplines in the management of cases referred to the center.

Baton Rouge "Model" Child Protection Center

The center, in its third year of operation, is funded by an HEW grant for the purpose of developing a "model" child protection center. Hopefully, the innovative concepts being developed and implemented by the model center will be employed when additional centers are opened in other states. The other five centers are similar to the Baton Rouge Center in organization and function.

Staffing of the "Model" Center

The child protection center is staffed by: an administrator (MSW); a social worker supervisor; caseworkers (MSW); a pediatrician; a psychologist/psychiatrist; homemakers; an attorney; a public information officer; a public health nurse; and volunteers. Since all these disciplines are employed by the same agency, it provides for better understanding, by members of one discipline, of the objectives, standards and ethics of the others; more effective interdisciplinary communication; less disagreement about management responsibilities; improved institutional relationships (especially between the center and hospital staff); development of confidence and trust on the part of personnel from different disciplines; prevention of interdisciplinary detachment; and interdisciplinary cooperation and coordination in providing child protection and treatment services to families so that they can be kept together while becoming more nurturant and safer for the child.

The Center and the Community

The Baton Rouge Child Abuse Committee, responsible for the legislation and funding of the child protection center, also had a great impact on establishing close communication, coordination, and cooperation between the center and all community professionals and facilities including physicians, hospitals, schools, health department, mental health, law enforcement, courts and social agencies. The center's scope was readily accepted by the entire professional community, which was favorably impressed by the center's ability to manage difficult child abuse cases.

Educational programs, made available to physicians, school personnel, law enforcement, mental health clinics, public health clinics, and social agencies, acquainted them with current reporting laws pertaining to intervention. Information about investigation and intervention by the center is continually being disseminated to all community facilities.

The center and community-based child welfare agencies continue to develop reliable channels of communication by requesting that the community agency staff referring the case attend the interdisciplinary dispositional conference as well as the outcome of the case management and disposition.

The center's lawyer coordinates the legal aspects of the case with the parents' lawyers, law enforcement officials, and the courts. With this legal arrangement, very few of the child abuse/neglect cases ever reach the juvenile courtroom. Criminal prosecution of abusing parents has occurred in only two cases during the last five years.

In Baton Rouge, once the administrator was hired (through the Office of Family Services) and the pediatrician was located (by Dr. Hebert), the administrator then hired the center staff and contracted for the other professional services. The supervisor and social workers (all MSW's) were strongly committed to the demonstration project and this accounted for their longevity in the project. It soon became apparent that the Office of Family Services was not prepared for some of the problems, such as the dramatic increase in abuse referrals, compensation for on-call duty, lack of placement facilities, and methods for coping with the burnout.

A unique feature of the project is a full-time public information officer. This person is responsible for handling all publicity, while coordinating community education of professionals and lay people.

The center contracted with a local, private-practice psychologist and psychiatrist for consultation and evaluations. The characteristics sought in these disciplines were a sincere interest in child abuse, and a realistic approach to treatment. The specifics of their responsibilities were outlined while open communication was established. Firm agreements need to be established with contracted disciplines and gratis opportunities should be avoided. Quality service should be expected for fees.

The social work staff felt they needed additional training in working with groups, so a contract was initiated for training. Again, the project was fortunate in locating a competent trainer, skilled in group work.

The attorney selected has proved to be outstanding. We again suggest someone committed to the problem. Prior to 1975, Louisiana had little legal precedence in its reporting laws. During the last two years there have been several court decisions clarifying the law.

The project was fortunate in employing a homemaker who, in addition to previously being employed at the hospital, is a warm, giving person. The homemaker's contributions are one of the most successful services offered.

In addition to paid and contract staff, it was necessary for the center to initiate and establish strong liaisons with key community agencies. The identified critical links in the service system were the hospital, law enforcement, family court, foster care, mental health, and the school system. These groups were seen as case finders and service providers. Ironically, resistance initially came from within the center's own agency, because of having to give up turf, and increased demands for placement facilities. Although an agreement was worked out with the school system for reporting, teachers have been reluctant to report because either they believe the report will jeopardize their own relationship with the parents, or few believe the project will remove the child from the home. Although private physicians in Baton Rouge report few cases, the number reported by private physicians statewide has increased.

Just prior to initiation of the project, the sheriff's department had established an identified child abuse unit. These Juvenile officers became an integral part of the system. Wearing plainclothes, driving unmarked cars, and better trained than the other deputies, they had an interest in rehabilitation rather than punishment. The turnover rate in this unit almost equals that of the center, which is attributed to burnout. Although no statistics have been kept by the law enforcement unit on referrals to the District Attorney for prosecution, their overall belief is that far fewer cases are referred for criminal charges than prior to the establishment of the center.

THE SOCIAL WORKER AND THE ABUSED CHILD

Depending on the referral source, case processing varies. The center is currently able to respond to emergencies immediately and to less severe intakes within 48 hours. After-hours reports average 28 per month. During the project's first six months, the predominant referral source was law enforcement because they were the only after-hours resource. With community publicity about the center's 24-hour availability, the referral sources changed; during May, 1975-April, 1976, 42% of the referrals were from relatives, 32% from neighbors or acquaintances, 19% from law enforcement, 5% from the hospital, and the remaining 2% were from other agencies, school personnel, and private physicians.

When a case is identified at the hospital, a call is made to the center where the intake worker on call after hours responds. The social worker alerts the pediatrician; then the child is examined and admitted, if necessary. The social worker (as well as the pediatrician) interviews

the parents, and if the child is hospitalized, the social worker makes a home visit and schedules psychological testing if indicated. Before release, an assessment is made as to whether or not the child can be returned home. If hospitalization is not required, the interviewer assesses whether or not the child may go home with the parents (usually the case). Then an additional assessment as to services needed, is made.

When a case is identified by the school system, the social worker contacts the parents and arranges either a joint visit to the school that day or a home visit, depending on the severity of the complaint. Should the parents be unavailable and the report severe, the social worker and a juvenile officer will visit the child at school.

Reports from law officers have a high validity rate because the officer likely will have made a visit to see the child before calling the center from the place of contact. The officer then waits for the social worker to arrive and begin assessment. On some reports initially made to law enforcement, another procedure is that the officer calls the center and a joint visit is made.

Calls from lay people are investigated alone by the social worker unless it is a night call or there are indications of violent behavior. In those cases an officer will accompany the social worker. The 24-hour availability is provided after regular office hours through an answering service and beeper device.

Most referrals are not so urgent that the social worker does not have time to telephone for an appointment. This courtesy sets the stage. Visiting without an appointment casts the social worker as a "snooper." It is unrealistic to advise a worker never to make home visits without previously having made an appointment as there are situations where it is not always possible. Workers should talk in a slow, casual manner and get one's name across to the parent. Most parents, upon learning they have been reported, ask who made the report. Generally, a parent wants to focus on who made the report rather than on the contents of the report. In dealing with this situation, a worker should explain the responsibility of his agency and the need for the reporter's identity to remain confidential. Quickly moving away from the question of who made the report, the social worker can then begin compiling family data.

The need for the social worker to do a cursory examination of the child's injuries is another delicate part of the initial interview. If the child has no presenting injuries, the parent will usually initiate the discussion of injuries with the social worker in order to prove nothing is wrong. In those cases where the child has visible injuries, the worker must explain the need to examine the child. If the child requires a pediatric examination, this may add another barrier for the worker to overcome in establishing rapport with the parent.

Working with abusive parents is extremely demanding and frustrating. It requires social workers with some exceptional abilities, such as sensitivity; the capacity to accept hostility without needing to retaliate; the capacity to handle a parent's criticism, yet not be critical of parental behavior; considering the parent's needs rather than one's own; avoiding using parents to increase one's own self-esteem; the guts to continue in spite of overwhelming odds; and not mingind that the work offers few immediate gratifications. Perhaps a simple way to describe a protective service worker's personality is to say that he is a person who cares, is consistent, and most importantly, is honest.

Family Advocates: The Need

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Today's families are members of the first generation to be raised under the influence of television. We have witnessed the launching of the first man in space, the building of the Berlin Wall, the assassination of a president, and the resignation of another. We have seen and heard nearly every major political and religious leader of the world.

We have seen the other side of the moon, the redness of Mars, the funerals of prime ministers, and football games 3,000 miles away. We have also witnessed a racial revolution in America, the cries of protest as well as the cries for peace, and the wars in Vietnam, the Middle East, India, Pakistan, Cuba, and Angola. We have seen the cruelties of poverty and the corruptness of politics exposed. We have seen and heard the riots and cries that continue to shake the nation and the world.

In 1970, the White House conference on Children reported: "If the present trends continue, one out of every nine youngsters will appear before a juvenile court before age 18." The Senate Subcommittee on Juvenile Delinquency estimates that juvenile crime now costs about $4 billion each year. Although the human cost to children and society cannot be calculated, the price is too high to pay without protest.

Whether the focus is federal, state, or local, the central concern remains children. So does the central neglect! That children in this child-centered society are systematically neglected, mistreated, and abused is a disquieting irony. Society gets the system of justice it deserves.

The problem children face can only be solved from within the community. The solution is partly preventative, partly rehabilitative. Many times, parents are the real "delinquents," working cleverly to shun confrontation with their own problems and with those of the child. Spiritual and emotional abandonment of children is commonplace. It all too often emerges as an ulcer in the familial relationship.

We must, as a people, look to active community participation in building neighborhood awareness, and to regimes of help and surveillance that lean on people other than parents and police.

Institutions habitually grow in size and tenacity. Breaking free of their toils becomes nearly impossible. They tend to crush the individual. Ideally, our task should be to organize the neighborhood so that there is an identifiable group of responsive and responsible people whose aim is not living for themselves but for others. We will discover that this is the only path to self-fulfillment.

I want to start with the premise "a child is a child is a child"—and every child is normal. Some normal children have special needs. What are some of these needs? A child needs a family support system. A child needs nurturance and love. A child has a basic need of trust; therefore, these basic needs must be met. If a child has never been able to trust, where can that child get trust? How can a child recognize trust if he or she has never been exposed to it, much less experienced it?

As a child grows, he or she challenges the system and feels powerless against it, so the child learns to manipulate it. Most often he fails, and instead of building trust distrust is reborn. Each failure is living testimony that the system does not work.

We must learn to inculcate trust, love, and nurturance. A child must learn to trust and love himself. We must develop an attitude and systems to instill and teach trust and love from birth. We must more effectively use what is available now, and develop new methods. Why do we not take the present Parent Effectiveness Training (PET) model and use it as an essential for our day care centers? Why not make PET a must for parents with school-age children? The facilities are there, as are trained leaders. Why not disseminate more exemplary projects such as Child Care '76's "Middle Road Traveler" so that this already effective tool can become more effective?

We must work ourselves out of a job. Other areas can use our energy and talents. We should begin the task at hand. We must break the destructive cycles in which children get caught and try to survive. Children can never break the cycle. They can only flee from it—to another destructive cycle, the justice system—and so it goes.

Our focus returns to the family system. It seems that so much is preventative. In a crisis, it is too late for prevention. But what happens when there is no crisis? How do families, agencies, and services deal with that? As we have all experienced, professional agencies too often divide rather than support the family.

Human problems need human solutions. Human solutions must involve ordinary people as well as experts and professionals. The problems of America's young people are deep-seated and tough-hided, encrusted by decades of neglect. Yet, America's young people—delinquent as well as law-abiding—are precious, exciting, and brimming with human potential. A civilization that deserves to endure cherishes its young. A society that rigidly and shortsightedly relegates millions of children to jails and institutions may find it has lost more than a small percentage of its citizenry. It may also discard its claim to moral leadership in a troubled world.

In virtually every American community, groups of intelligent, concerned men and women meet regularly in clubs and associations based on economic, social, or sentimental ties. They enjoy good dinners or coffee hours, listen to "interesting speakers," become temporarily enthusiastic about a new idea—or angry about an old injustice—and then resume their patterned lives without considering how they can change the patterns. A terrible consequence of living in a complex, increasingly depersonalized society is that the media dramatically project social problems, but the institutionalized machinery affords no room for effective citizen participation.

One of John F. Kennedy's favorite Chinese proverbs was that even the longest journey begins with a single step. We must all decide to take that first step, again, on America's journey to a better future for all children.

A poem posted on the wall of a detention center read: "Nobody promised you tomorrow." Yet, we make that promise when we bring children into the world. Who will keep it?

Quality Foster Care—A Service to Children and Their Parents

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Can the abused child safely remain at home or be returned home following medical treatment if the parents respond to casework services? Can the neglected child safely remain at home while the parents receive services aimed at improving their parental functioning? Does the abused or neglected child need specialized treatment in a therapeutic setting? Such complex but crucial decisions (as to whether the healthy development and growth of the abused or neglected child can best be safeguarded in the child's home or in a foster home) must be based on multiple assessments.

Children may be viewed as abused or neglected when they suffer serious unexplained or repeated injuries; their normal development is seriously blocked or retarded; or their opportunities for a healthy, satisfying, and productive life are drastically reduced. Henry Kempe and Ray Helfer in their excellent book, *Helping the Battered Child and His Family* (1972), have given specific criteria for diagnosing child abuse. The writer has attached similar criteria for diagnosing child neglect. Once the diagnosis of neglect or abuse has been substantiated, at least five additional assessments are essential to determine whether the child can remain at home while the parents are provided casework services and supplementary aids or whether placement is indicated.

The first assessment is an evaluation of the effects of abuse or neglect on the child's physical, mental, emotional, and social development. Interdisciplinary collaboration may be needed in making this evaluation, both in terms of the child's present condition and his chances for healthy growth and personality development.

Second, we must assess the relationships between parents and children and the positives and negatives in family living. For example, what meaning do the children have for the parents and what is the quality and consistency of parental caring and concern? To what degree are the basic needs met for the children and other family members with particular attention to the members' needs for security and individualization? How serious and pervasive are parental limitations in fulfilling parental and marital roles? Does the family give evidence of any family unity, group cohesiveness, and responsibility? What is the child's response to parents—withdrawn, fearful, hostile, highly ambivalent, clinging?

The third assessment relates to the parents' motivation and capacity to use help to improve parental functioning. Are the parents interested in any change and if so, what change? How much discomfort do they feel in the present situation and how much hope of improvement? Can the parents be engaged in a therapeutic alliance? Are they able to relate to family or friends who might be available and willing to help in crises? How realistic are the parents in viewing their current situation and behavior and how ready and able to participate in working toward change? Or will parental efforts be directed toward sabotaging services or outward compliance without significant change? How do the parents characteristically react to stress? Do they seem interested and able to learn new ways of child management and of coping with problems? How rigid are their perceptions of responsibilities to the child?

Parental behavior toward the child is assumed to be the maladaptive outcome of parents' unsuccessful efforts to cope with stress. On this basis the fourth assessment examines the adequacy of extended families, friends, and community resources needed to supplement family functioning. To illustrate, can serious financial strain be reduced through public assistance? Are homemaker services or day-care facilities available if these would ease parental stresses and provide a safer environment for the child? Is there someone close to the abusing family who has sufficient capacity to recognize impending crises and to help the family meet these crises without a child becoming abused?

Last, and most important, is the summarizing assessment as to whether the combined efforts of parents, worker, and other resources will be sufficient in amount and continuity to insure the welfare of the child. What will be the outcome if the child remains at home? If the child is placed, how will the separation affect the child and family? Are the desired placement facilities available? What will be the ultimate goals?

Difficult as these assessments are, they are essential to developing a realistic plan for strengthening family functioning while serving the child's best interests. In some situations the positive assessments will favor the child's remaining in the home while the parents use available services to improve family relationships and patterns of child care. Unfortunately, there will be situations in which it is desirable to place the child while seeking to involve the parents in rehabilitation of the family unit. In too many situations when children have been placed, we forget that foster care should be only an interim plan while we work with the parents toward the goal of restoring the family unit. The desired constructive change in family functioning depends on engagement of the parents in a working alliance with the professional helper. This engagement cannot be secured unless the worker can develop accepting, nonjudgmental attitudes toward the parents. But can we accept abusive and neglectful parents? In our anger at their behavior toward their children, can we be nonjudgmental when we feel so deeply the children's pain, hurt, and rejection? Unless we honestly deal with our angry, impatient feelings toward the parents and unless the parents experience our concern for them as troubled individuals and our wish to help, a therapeutic alliance is not possible. It may help the worker to be less critical if the parent can be perceived as a somewhat larger child, often as needy, insecure, frightened, and as hopeless as the child who is being placed. As we explore the stresses the parents experience and as we learn of their deprivations and hurts, we can begin to appreciate that their behavior toward their children represents their efforts to cope with stresses threatening to overwhelm them. We can begin to identify with the parents as troubled, insecure individuals who usually suffered deprivations in their own childhood which limit their capacity for parenthood.

Engagement of the parents also necessitates that the worker explore the parents' feelings about the referral; their attitudes toward the worker, the court, and the agency; and their perceptions of what will be involved in their encounters with the agency. Misperceptions and erroneous expectations must be discussed and clarified. The parents must be informed clearly and specifically of the reasons why placement seems indicated. They need to express their anger, shame, guilt, loss, and anxiety about the future. They need to experience expression of these feelings without retaliation or criticism before defensive maneuvers can be laid aside and the motivation to change can be stimulated. Often these families have had no hope of change and the worker's belief in their potential for growth and change can be a potent leavening force in enlisting their participation.

Another ingredient in engaging parental participation is the clarification of the changes that must be made before the child is returned. The tasks to achieve these changes must be specified. There should be clear agreement as to the particular obligations and responsibilities of both the family and the worker. Unless the parents know what steps must be taken to achieve a goal, they are likely to move in a random, purposeless way and ultimately may lose sight of the goal. With specification of shared responsibilities, the parents may feel less helpless and alone. The worker offers a new perspective, hope, and support in reaching toward needed and desired changes. Simultaneously, the worker emphasizes that parents are the ones in control of their lives. They, and only they, can bring about change. The worker can offer direction, guidance, information, and support. The worker can be the family's advocate in securing needed services. But changes in behavior, attitudes, and performance of role responsibilities must result from parental investment in making these changes. Actually, such conviction on the part of the worker can serve as an incentive to parental participation in both planning and goal-directed action. The worker's insistence that the parents are in control of their lives and are the only ones who can bring about change in their situation emphasizes that the parents are not helpless or hopeless. A realistic time limit should be established as to when the home situation will be reevaluated as to its adequacy in meeting the child's needs.

Engagement of parents in planning is furthered when the worker helps parents face and cope with their feelings about separation from the child. Experience has demonstrated repeatedly that children are limited in ability to use placement unless they have been helped to deal with the pain, guilt, and anger over separation from the parents. The child is better able to cope with these feelings if he has the help of the parents in the separation process. Often, however, the anger and guilt of abusive and neglectful parents make it impossible for them to ease the child's feelings about separation. In these instances the worker's efforts in helping the child can be supplemented by the foster parents, provided they have been helped by the agency to understand the child's feelings about placement and separation from his family.

Ongoing engagement of the parents focuses on strengthening their capacities for constructive parenthood and on rehabilitation of the family unit. This focus requires the parents to participate in ongoing planning and decisions relating to the child in foster care. The degree of

their participation initially may depend on their interests and capabilities. The agency's conviction that their participation is needed will quicken interest and stimulate growth in assuming parental responsibilities. Regular visits with the children should be supported by both the agency and the foster parents. Parental visits are often difficult for foster parents to tolerate, especially when the children seem disturbed by these visits, reacting later with depressed feelings, upset stomachs, or rebellious behavior. A further problem is the criticism many natural parents express toward the foster parents, voicing their criticisms not only to the foster parents but also to the child and the agency worker. These criticisms are particularly difficult to face when they come from parents who were unable to give adequate care to the children. For the parents, "there lies the rub." The natural parents often experience pain and shame when they see their child responding affectionately to the foster parents or turning to foster parents for permission. And many natural parents deal with their pain, shame, and rivalrous feelings by unrealistic and unfounded criticism of the foster parents. Foster parents at such times need the help and support of the worker in understanding the problems of the parents. If the foster parents can be helped to identify with the natural parents as somewhat larger children than the foster children but just as needy, the foster parents can deal with the natural parents' competitive reactions. The foster parents then can offer a significant contribution through serving as models to the natural parents. If the natural parents are welcomed in the foster home, their observations of the foster parents' interactions with the child may help the natural parents develop more constructive patterns of child rearing. The parents' transactions with both the child and the foster parents will provide helpful clues as to the quality of parent-child relationships and the parents' capabilities in meeting their child's needs. Meanwhile, the child's response to the specialized services needed and provided during placement will be crucial in determining his readiness to return home and the additional help he may need at that time.

Unfortunately, there has been considerable evidence that many children have been permitted to "drift in foster care" for an indefinite period, uncertain and insecure as to their identity and their future (Sherman et al, 1973). To avoid such unplanned drifting, the worker should involve the parents in evaluating the current situation when the agreed-upon time period ends. If the parents have been unable to make the changes specified despite their sustained and positive efforts, a new contract can be renegotiated, redefining the desired goals, the tasks to achieve these goals, and a new time limit. Time-phased, purposeful planning requires, however, that the parents clearly understand that a decision as to the child's future must be made preferably in six months, but definitely by the end of the year. The child's best interests must be given due weight and not be subordinated to the rights of the parent or to the goal of restoring the family unit, if the latter is unrealistic. Simultaneously, every precaution must be taken not to delay decisions unnecessarily so that the child is not left in limbo, hesitant to develop meaningful relationships which may be interrupted at any time.

Planned long-term foster care is proposed as a viable alternative when the child cannot return home and relinquishment for adoption is not feasible. Planned long-term foster care or permanent foster care provides the child the opportunity to develop security, a healthy sense of identity, capacity for positive and meaningful relationships, and desirable models for identification. The agency selects a foster home which can provide continuity of care for an indefinite period and often until the child at 18 can plan for himself. The acceptance that placement is for a lengthy period permits the child to experience a sense of security and stability and enables him to "settle into" the foster home. Hopefully, the foster parents can accept the limitations of the natural parents while valuing their strengths. The acceptance of the natural parents relieves the child of the necessity to defend his own parents and frees him to adopt the foster parents as surrogate parents. He need not cling to the natural parents out of guilt over abandoning them. His hostility toward the parents who neglected or abused him is abated by his recognition of their problems and by the love and security he finds within the foster family.

Sustained emphasis throughout this paper has been given to time-phased, goal-directed planning, continuous evaluation of movement toward goals, and active engagement of the natural parents. These emphases lead naturally to the position that termination of placement should be carefully planned. If there are evidences of the readiness of both parents and child to restore the family unit, the child's return home will be planned gradually. Periodic visits home, increasing in length, will provide a smooth transition for all members. Close contacts with parents and child will enable the worker to help the family members make necessary adjustments. The worker will also involve the foster parents in the process so that with the worker's assistance, they can support the child in separating from them without being torn by conflicting loyalties. The foster parents' pain over separation is eased by their recognition of the contributions they have made and by their current support to the child as he leaves for his natural family.

Should restoration of the family unit be possible, casework services should continue for a reasonable period. The child's return home will necessitate new adjustments for parents, child, and other family members. The family may need help in undertaking these adjustments and in communicating effectively with each other. The worker can help the family through this adjustment period with guidance and support so that they can sustain the newly established gains in family functioning and the child's development. Such follow-up services can also involve anticipatory guidance in preparing the family to deal constructively with possible problems that may arise. Crises often can be prevented in this way and the family strengthened by successful experiences in coping with stresses.

Parental participation in a working alliance has been stressed as essential to the child's effective use of foster care as well as improvement of family functioning. This alliance between natural parents and worker is enhanced when foster parents enter the partnership. At several points we have emphasized the significant contributions foster parents may make to the child and to the natural parents. We ask a great deal of foster parents over and beyond the daily care of the foster child. For example, we ask that they give the child affection but not become so attached to him that they cannot relinquish him when he returns home. We ask that they accept and love a child who may have difficulty in fitting into their family. We ask that they be tolerant when the entry of a foster child into the home upsets family life and established patterns. We not only ask that they accept parents whose visits may disturb the child but also that they understand why the worker is not immediately available when a problem arises. As an experienced foster care worker phrased it, foster parents come for a child but find it is "bargain day," getting not just a child but also the natural parents, the agency, and sometimes nosey neighbors.

Foster parents can fulfill such expectations only if the agency is clear as to the objectives of foster care and the contributions and shared responsibilities of the foster parents in achieving these objectives. Furthermore, the foster parents' understanding of their role responsibilities will be congruent with the agency's expectations and perceptions only if agency expectations are communicated clearly to them. This communication of expectations begins at the time of the foster home study but must be supplemented by periodic group sessions as well as by regular individual conferences with the children's workers. Obviously, the foster parents should be given a copy of the signed agreement or contract between the agency and the foster parents when a child is placed in the home. This contract should specify clearly the foster parents' obligations to the child, the natural parents, and the agency. A handbook for both foster parents and agency staff is useful for delineating agency policies and the responsibilities of the foster family and agency. Written material is available for ready reference and is a useful tool against which memory of discussions can be checked and misconceptions clarified. While many agencies do not share such material with the natural parents as well, this action might help them better understand the responsibilities of the foster parents and their relationship with the agency. Clearer understanding of obligations and relationships might lead to more positive and congenial interaction between natural and foster parents. Agency and foster parents share responsibility for the child with the natural parents, but such sharing demands basic trust in the goodwill of team members, open communication, and respect for differing viewpoints. The worker has primary responsibility for developing this climate of trust and mutual respect.

The knowledge we acquire about living systems can help us better serve foster families. We need to understand the foster family as an open system whose members interact with each other and also with other systems of which they are a part—the neighborhood, the school, work organizations, social groups, etc. Any addition to the foster family leads to a change in family balance, family relationships, and transactions. The worker must help the foster family anticipate the inevitable changes in family functioning and in reciprocal role relationships when a foster child joins the family group. Awareness of such changes can lead to preparation and reduce anxieties and tensions in making necessary adjustments. It is not sufficient to prepare only the foster mother. All members of the foster family should be involved in considering the adjustments that will be needed with the entry of a foster child into the home. All members of the foster family must be willing to adapt to the changed situation if the placement is to be satisfying for both child and foster family.

Foster families often find it difficult to understand the child's ambivalent feelings toward rejecting parents. The worker needs to share with foster parents specific information about the child and the home situation to aid them in understanding and empathizing with the child's confusion and anxieties. Another aspect of foster parenting that is often difficult for foster parents is helping the child express his conflicting and sad feelings. It is a human tendency to

want to ease a child's pain and sweep away his troubles. But troubles cannot be swept under the carpet. The foster parents may need the worker's help and support in understanding the child's need to express his feelings rather than repress them. Only as the child is in touch with his painful feelings will he be able to ventilate them and ease their pressure so that he can experience and respond to the foster family's affection.

The worker also needs to support the foster family when the child's improvement is slow and his gains very small or when the well-intended efforts of the foster parents are rebuffed by the child's hostile, rebellious manner. Often, the worker can use family sessions to help the foster family and child share their feelings and reactions and gain fuller understanding and acceptance of each other. Misunderstandings and projections could be more quickly clarified in this way. Such sessions could serve as models for the foster family's deliberations and decision making, even when the worker is not present. Sometimes natural parents might be included in family sessions so that participation in decision making may lead to more consistent efforts by all to implement these decisions rather than resorting to sabotage or passive resistance.

Today, many foster families request greater participation in decision making that concerns the child in care. Certainly, the foster parents' intimate knowledge of the child is an asset in planning for his future. The worker who respects the thinking and contributions of foster parents can provide information that may be needed to enlarge the foster parents' perspective of the total situation. All points of view should be heard and assessed. The final decision must rest on the best-informed, carefully considered assessment of the child's needs and capabilities.

Constructive use of placement by all concerned depends upon effective working alliances between parents, worker, foster parents, and child. Each team member has rights and responsibilities but the central concern is the child's best interests, and whenever possible, rehabilitation of the family unit. Throughout all phases of planning and treatment, parental engagement is essential to insure goal-focused movement. Foster parents can be the worker's ally in serving both the foster child and the natural parents.

Appendix: Criteria Determining Child Neglect

Children are neglected when their normal development is seriously retarded and/or their chances for a healthy, productive life are drastically reduced.

Physical Development

Do the children lack a reasonably decent home which provides protection from gross danger? Are there unsanitary home conditions?
Is there insufficient nourishing food? Inadequate clothing?
Do the children lack adequate medical care?

Mental Development

Are there frequent or prolonged absences from school?
Do the parents give no encouragement to their children to learn?
Are parental attitudes toward school or teachers hostile or indifferent?

Emotional Development

Do the children lack a sense of belonging to the family?
Are there deficiencies in quality and continuity of affection?
Do parents lack acceptance of the children's individual needs and differences?
Is there irregularity and/or inconsistency and/or undependability of care?
Do the children lack help in learning to control their impulses?

Social Development

Do the children lack experience in learning to give and take within a group?
Are guidance and discipline inadequate, inconsistent, or unduly harsh in regard to social norms?
Is supervision of the children inadequate or inappropriate?
Do the children lack contact with other adults and peers? Do the parents evidence hostile, distrustful, and suspicious attitudes toward community persons?

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Permanent Homes for All Children

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Over the last eight years I have been involved in a variety of efforts, all directed toward improving the life of dependent children. These special projects have involved: describing ways to recruit adoptive families for black children; using an adoption subsidy to place black, older, and/or hard-to-place children; developing an advocacy program for foster children; working with minority agencies and some public agencies to develop and improve approaches for placing handicapped children in adoption; and, most recently, freeing children for permanent placement.

These projects have had different strategies. Some attempted to improve the system simply by making more information available. Others were more direct, trying to apply pressures from without, or from within by infiltrating and establishing new procedures.

All efforts were initially successful, but most failed in the long run.

Early on, we believed the lack of response, particularly the failure of the foster care system to identify children who could be placed for adoption, was largely a matter of discrimination, and that states simply did not care about their minority children. Gradually, we discovered the states knew little about any of their children. There were no summary records that even listed age, sex, handicaps if any, or why children were in foster care. In general, there were no plans apart from continued foster care, and this lack of planning was endemic to the system. Parents' as well as children's rights were ignored.

The main difficulty is that foster care is a system, but not one which is related to its other aspects in ways which facilitate the movement of children out of it. The conditions of accepting a child into the system greatly influence whether the child returns home. Activity to involve the parents in treatment and visitation will facilitate a return home, but parental refusal to become involved may result in termination of parental rights. However, if these activities with parents are not carried out, and the real, though unstated, goal of the agency is to maintain the child in foster care, then that is the only goal which will be achieved.

The only projects which seem successful in dealing with this system are those which address the way the system works. The 24-hour emergency services project in Nashville, which is being duplicated in twenty to thirty other cities, has its effect at the point of entry. By organizing public and private agencies into a smoothly functioning whole, able to respond to family emergencies at any time, even with a baby sitter at 3 a.m., children are prevented from having to enter the system. This approach not only helps the family, it also saves states money.

The second special effort, which also appears to succeed, involved identifying children who seem lodged in the system, and systematically planning and implementing a program to arrange for a permanent living arrangement for the child. This could include return home, relative adoption, foster parent adoption, adoption by newly recruited families, or permanent contract foster care. Implementation of this effort requires systematic followup and work with the parents, coordination with the courts, the training of workers as permanent planning specialists, and the use of lawyers as child advocates. Once implemented, this program affects all parts of the foster care system and appears to change the system. Therefore, it is easier to maintain as an ongoing effort after the special project is finished. Also, like emergency services, it actually saves money in addition to improving the child's life.

Briefly, these are the points which seem important to me. An agency must define the goal of its foster care program and then relate the efforts of its several parts in order to focus on that goal. If short-term, essential substitute care is the goal, then intake and a system for case planning, along with technical resources to carry out the plan must be available. Good information, good planning, and good management are essential.

Services to Special Populations

Services to Multiproblem Families

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The first family I saw when I was beginning student social work could be called, I suppose, a multiproblem family. I do not remember all of the family's problems, because I only had one of them to deal with—the placement of a six-year-old. He had been hospitalized with rheumatic fever and needed foster placement because the family was too disorganized to provide him care while he recuperated. I arranged placement and was the liaison between the foster home and the family, since parents were not encouraged to visit foster homes in those days. This family had seen many social workers before I entered the picture, and they knew how to keep our interviews going when I floundered.

The foster mother I was supposed to be counseling provided me with wise counsel. My contribution was lots of enthusiasm. For reasons that may or may not be obvious to you, and that I will discuss later, the case had a successful outcome. But sometimes even very good services do not work, and I think it is because the requirements of the clients we serve are not properly considered.

Before discussing what we need to understand as we plan services for child abuse and neglect clients, I want to give my definition of "high risk" and "multiproblem," because both of these terms were used to describe this panel's subject when I was asked to participate. "High risk" in child abuse and neglect cases describes children whose parents are not well prepared emotionally to care for them and might even harm them physically. The high risk concept is being used in developing tools of prevention, such as delivery room observations of mother-infant relations, and questionnaires that identify potentially dangerous parental attitudes toward their young. There are a couple of problems with the concept. One is that identifying a family as "high risk" can set them up to be just that—the "self-fulfilling prophecy." And, as with all terms used to describe problems, "high risk" could develop connotations which would doom such families to being viewed negatively.

On the positive side, when these identified families are given appropriate services they will become low-risk families. Furthermore, the term "high risk" has an air of excitement about it that attracts interest; it is not as depressing as the term "multiproblem." "Multiproblem" implies, to me at least, that the family has more problems than they or anyone else can handle. The term was specifically used in the '50's to draw attention to families who lived marginally, frequently needed interventions from publicly supported professionals such as social workers and police, and in the long run did not seem to benefit from any kind of intervention. It was believed at the time that with an all-out barrage of services for these families, things could change. One of the changes hoped for was that the family would have a more satisfying, more productive, less crisis-ridden life. The other change wanted was that public intervention into the lives of these families would no longer be necessary. However, for the most part, the concentration of services did not work.

Two decades later, we find ourselves talking about all-out services again—this time for families of abused and neglected children. Can we make services work better this time? What do we need to do to make services beneficial so that children can go on living in their own homes safely?

I believe that services, whatever they are, will have a much better chance of success if we take into account what our clients are like, and what is and is not acceptable to them. You may think that goes without saying, but does it?

I am going to propose four ways clients' needs have been overlooked, how the oversight has affected services, and what we should try to do about it.

Treatment services start with the very first contact we make with a reported family. The people we deal with do not trust most other people. They are abnormally frightened of strangers, and they cannot relate to a complicated agency system. Yet most of the time we fail to respect their fears. In many cases parents are interviewed by one professional after another—a doctor, a policeman, a medical social worker, a probation officer, a protective service worker. Some agencies have tried to handle this duplication by having two or more professionals make home calls together, but that is a compromise with obvious drawbacks.

While building a system to encourage identification and reporting, while setting up a structure to deal with investigations and what follows, we can so easily overlook the effect on the people we are supposed to serve. A system that forces parents to make adaptations that they are poorly equipped to make victimizes them. The worker and the family alike are being set up for failure. Workers are frequently frantic to find treatment techniques which deal with clients in a system that is countertherapeutic. Those in charge of the system, the administrators, need to know what they can expect from the clients of their agency and what they cannot expect—and make appropriate changes.

The second point I want to make involves the negative effect of name-calling. "Abuser" and "neglector" top the list for negation. These words are closely followed by some of our diagnostic labels. Even the word "neurotic" has turned into someting unflattering to say about someone you do not like. Diagnoses like "inadequate personality" and "impulse-ridden character" are used by very competent caseworkers, but these terms describe clients in ways that make positive worker identification with the client most difficult. Some of these terms express thinly-veiled hostility toward our clients. They are also dead ends; they do not tell us where to go. For example, rather than describing the client as infantile or an inadequate personality, we can use the term "overwhelmed" to describe their distressing condition. This word leads to questions for which we can find answers. Overwhelmed by what? If we say to a client "You're overwhelmed," they are likely to say "You bet." If we were to call them infantile, they would probably feel like punching us in the nose. If what we say about clients behind their backs can be written in their records for them to read—if they read their records and feel understood—then more than half the battle, perhaps even the whole battle, is won.

My third point has to do with anonymous calls. Most communities respect anonymous calls and although these calls are a valuable source of referral, they do have built-in hazards:

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

Anonymous calls are useful, so it is hard to say "don't take them." We are trying to encourage anonymous reporters to allow use of their names in a positive way, but they are not always convinced.

Before going on to my fourth point, I want to talk about the worker who goes out to discuss a report. The worker (for this example, let us say a female) begins by trying to involve herself in a friendly or useful way with her client. The client does not see the worker as friendly or useful and does not wish to be involved. Whether or not the client verbalizes his reaction (let us say a male client), the worker feels rejected, but she tries to be friendly and understanding anyway. She says some form of the stock phrase, "I want to help you." The client thinks "she has got to be kidding," and reacts with glum silence or, worse, he pretends to go along with her hoping to get rid of her. Either way, the worker is faced with the necessity of approaching the subject of the client's child rearing practices in a critical way.

Of course, there are techniques to deal with negative reactions. The worker is usually aware of the anger her visit can cause. She helps the client say what he feels, or if he can not talk, says for him what she thinks he might feel. The interviews, however, are by their very nature anxiety provoking for both the client and the worker. Workers are most anxious to establish themselves in a positive way, as a potential source of support. In their anxiety workers will sometimes list services they can offer before the client understands what they are talking about, or they will say something they think is sympathetic, which turns out to be the opposite. For example, in a recent training film, an investigating worker who was trying to display a caring attitude suggested that the mother spend some time away from her child. When parents are already fearful about the possibility of losing their children, separation messages of any kind are not reassuring.

The worker is dealing with parents who are difficult to understand, and very different from the worker in their ways of dealing with life. Rapport is hard to achieve. The client tends

to make the worker feel unwanted and inadequate. Furthermore, he arouses anger that the worker must contend with in one way or another, without clobbering him.

When any of our parents who had abused their children had to be placed in Colorado Psychopathic Hospital, there would be a ward meeting sooner or later that resulted in "limits" being set to help the patient. These "limits" turned out to be restrictions which did not make our patients feel at all helped, but they did make the ward personnel feel better.

One such patient, Liza, had been hospitalized at Colorado Psychopathic Hospital with her 5 month old son, and we felt very lucky that the hospital would take him. However, all hell broke loose when Liza not only refused to feed her baby, but threw fits when the nurses tried to feed him. For the good of everyone concerned, the staff was prepared to send the child from the hospital, when I asked if I could try something. I fed the baby while maintaining eye contact with Liza. That is a terrible way to feed a baby, but it did make a connection for Liza and she could feed the baby too. All I did was recognize that Liza was so desperate for attention herself that she could not tolerate complete attention directed toward the baby.

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

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

In my student days I had learned by accident that supporting clients meant giving them a sense of power, importance, and superiority. It meant helping them gain a feeling of self-worth which in turn fostered mental health and an ability to control their own lives. My clients, in the example I gave, actually helped me with their experience. Since I appreciated their help, they felt important and were able to improve and advance their position. You do not have to be as inexperienced as I was to find ways clients can help you. They are the consultants, the authorities on their own life experience. If we deal with them as sources of information, rather than as downtrodden receivers of guidance, a different relationship will bring about the different results I am describing. This, in my opinion, is essential to the success of service.

Engaging and Maintaining Parents from High-Risk Families in Treatment

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Skillful work with parents from high-risk families is necessary for providing effective services to improve their children's mental health. Each year, in outpatient clinics serving children, many children in need of treatment are not given service because their parents are unwilling to accept it. Of the 399,000 children seen in outpatient clinics in 1966, two-thirds did not receive treatment. Non-treatment is sometimes the result of referral or of treatment not being recommended. However, it is also often the result of treatment recommendations not being accepted (Seder-Jacobson, 1973). This author's clinical experience includes much work with parents who reject services for their children. Child abuse and neglect was occurring in many of these families. The nationwide figures, combined with this author's impressionistic clinical data, suggest that many children at severe risk, who are known to children's mental health agencies, do not receive treatment because their parents are unmotivated to accept treatment recommendations. It is important therefore to determine more effective ways to work with these parents.

Several articles have been written about work with resistive parents from high-risk families. Some of these articles discuss worker counter-transference toward this population of parents. Henry's description of an experimental outreach program to high-risk families discusses the workers' initial anxious feelings about intruding upon families. The workers' unrealistic expectations of anger and resentment from their potential clients reflected their own feelings of being threatened (Henry, 1958). Fantl describes an outreach program similar to the one described by Henry. Many workers, on arrival at the lower-class neighborhood served by her program, asked to be transferred to a better neighborhood. Some workers viewed the clients as "lazy", "dumb" and "bad" (Fantl, 1961). Stewart et al (1972) statistically document this kind of worker counter-transference in their citation of a 1970 study of attitudes of health care professionals. Use of services was limited by the "limited goals" of the poor, according to 93% of their sample, and by their ignorance of available services and facilities, according to 91%.

Workers' negative counter-transference toward parents from high-risk families can lead to poor work being done with these parents. Eiduson (1968) states that if the therapist sees the patient as a poor risk, he may devote little or no effort to stimulating the patients' interest in continuing. Wiltse (1958) writes polemically about workers who allow their counter-transference to interfere with their working effectively with difficult cases when he says, "There is no such thing as hopeless cases, only hopeless...workers."

Several other important ideas with practice implications can be drawn from the literature. Overton (1953) discusses the need to look for both strengths and weaknesses in family functioning when developing treatment plans, and suggests working with families to modify conscious negative attitudes toward authority. Henry discusses: (1) the importance of directness with this client population, (2) the need to develop short-term, achievable goals within one's treatment plan, (3) the need to continuously discuss with the patient his progress in relation to treatment goals, and (4) the concept of the "opening wedge", a point at which the parent and worker can come together to work on a mutually defined goal, no matter how small (Henry, pp. 132-134). Davoren (1974), in her article on work with abusive parents, talks about the cultivation of a genuine liking for the patient, resisting the desire to dominate the patient, giving total interest to the patient, and creatively using home visitation. She also states that the removal of a child from the home can be a motivating factor for a parent entering therapy. Finally, Davoren states that collateral work with other agencies can be very helpful in working with this population. Stewart et al, cite studies which show that organizational factors like outreach workers, more flexible clinic hours, use of indigenous workers, and participation by consumers in program planning and implementation can increase use of services. Eiduson looks at effects of education, clinician-patient relationship, referral source and other variables on therapy continuance. She raises an interesting point on the effect on socio-economic class on therapy continuance when she states that dropping out of therapy is not limited to the lower socio-economic class. If a therapeutic relationship is established, the lower-class patient is more likely to cling to a therapeutic contact.

> His degree of distress is thought to be keener than that of the middle class. Although he usually needs tangible evidence that treatment will work before he gets involved, once he makes contact he feels compelled to take advantage of it. He does not recognize possible alternative resources; if he does they seem too distant (Eiduson, p. 913).

By contrast, the middle-class patient, with his psychological sophistication, tends to know about alternative resources to which he might turn, and therefore has a greater tendency to be mobile in his psychiatric contacts.

These ideas from the literature have been helpful in working with parents from high-risk families in the Early Childhood Services Clinic at the Texas Research Institute of Mental Sciences (TRIMS) in Houston, Texas. The Early Childhood Services Clinic provides services to emotionally disturbed children under six and their families. The children served represent the total range of emotional disturbance, from the mildest to the most severe. It is usually recommended that the parent(s) be seen in weekly individual, group, or couples counseling. Much training is done in the clinic, including a two-year full time post-baccalaureate training program in child therapy. The clinic also trains social work students, pastoral counseling residents, senior nursing students, and medical students.

The case material which follows: (1) illustrates the usefulness of some of the concepts from the literature; (2) indicates additional concepts related to effective practice, and (3) presents some commonalities in treatment approach and family structure between parents with intellectual limitations and those with emotional limitations. The three cases to be presented are actually compilations of aspects of several different cases being seen in the clinic. The presentation is brief to protect confidentiality. The chart below presents a summary of the presenting problems of these families:

	Family A	Family B	Family C
Child	Three years old Congenital disorders Severe developmental delays; depression Maternal deprivation syndrome	Three years old Neurotic-like symptoms; pan anxiety reaction Victim of child abuse	Three years old Reactive disorder with anxiety and depression
Mother	Depressed Educably mentally retarded Supported largely by Public assistance payments	Explosive personality Intelligent Works to financially support family; child abuser	Actively psychotic Cared for and supported by her mother
Grandmother	In her 40's Depressed	In her 60's Obsessive-compulsive neurosis Adjustment reaction to old age	In her 50's Obsessive-compulsive neurosis

Each mother is in her 20's and is unmarried. Also it should be noted that, at the time of the initial intake, the mother and child lived with the grandmother in each of these families. Finally, in each family, the grandmother works to support herself.

In each of these families, the grandmother-mother relationship can be characterized using Bateson's typology of the "double-bind" situation. Bateson (1972) states that the double-bind situation requires (1) a "victim" (in each of these instances, the mother), (2) repeated experience of the double-bind situation, (3) a primary negative injunction (e.g., "Do not do so-and-so, or I will punish you"), (4) A secondary negative injunction conflicting with the first at a more abstract level (e.g., "Do not see me as the punishing agent" or "Do not submit to my prohibitions") and (5) a third negative injunction forbidding the victim to leave the field.

These families have several similarities. In each family, the pathology in the mother-grandmother relationship was subtly evident in the initial consultation interview, and the mother/grandmother relationship was one of the causal factors in the development of the child's difficulties. In all of these families, persistent outreach over a period of several months was needed to maintain the families in treatment, as was collateral work with other agencies.

In order to be sure that the other agencies were providing effective, needed services to our patients, we found that it was necessary to continue communicating periodically with them over time. Initially, much of our effort focused on maintenance of the family's therapeutic involvement. Maintenance of each of these families in treatment involved separating the mother's and grandmother's treatment as much as possible, preferably with each being seen by a different worker. Immediate changes in family dynamics were initiated by the therapists before these mothers could enter treatment. In the two families which have been most regular in their participation in parental treatment, work with the mothers has focused on specific concrete issues regarding parenting and on the mothers' psychodynamic issues. Work with each grandmother has focused on the grandmother's psychodynamic issues and on helping the grandmother to move the mother out of the scapegoat role in the family. Though all of these families have made significant progress, it is interesting that Family A, with retardation in the mother and a child at biogenic risk, has shown the most improvement. The case material presented above might raise questions about the beliefs held by some therapists that work with the intellectually limited parent is quite different from and more "hopeless" than work with the emotionally limited parent.

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The Mentally Retarded Parent

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We have known for years that a professional's attitude toward his client greatly influences the progress of that client, that a therapist who thinks his patient is incapable of change is unlikely to help that patient get well. Is there a client population that is seen in a more negative light by professionals and potential support groups than abusive parents? Yes: retarded parents. Their mental retardation causes them to be excluded by some service providers and is not taken into consideration by others. Is it the limited skills and negative perceptions of the therapist or characteristics of the retarded themselves which cause therapy with retarded parents to be so noticeably absent from our communities and our literature?

The potential of the mentally retarded has traditionally been assessed by standardized intellectual tests such as the Stanford Binet and Wechsler, with the retardation categorized as mild (69-55), moderate (54-40), severe (39-25), and profound (24 and below). Although effective parenting requires a certain degree of intellectual function, it requires even more that a parent perform at the highest adaptive behavior level of which he is capable. Adaptive behavior is defined as the effectiveness with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. The American Association on Mental Deficiency and most state educational agencies require that both intellectual and adaptive levels be significantly subaverage for an individual to be classified as mentally retarded and to be eligible for services to the mentally retarded. The AAMD Adaptive Behavior Scale, which has both an institutional and a public school version, is perhaps the most widely utilized adaptive behavior scale at this time. Its component scales reflect level of skill in independent functioning, physical mobility, communication, social and economic activity, occupation, and self direction.

A profoundly retarded fifteen-year-old or adult will, at best, demonstrate levels of adaptive behavior similar to those of a severely retarded twelve-year-old, a moderately retarded nine-year-old, a mildly retarded six-year-old, or a normal four-year-old. For example, he may still need some assistance in bathing, or may have rare toileting accidents. He may use and understand only simple verbal communications such as "put it on the shelf". He may recognize advertising words and signs such as "STOP", "MEN", "EXIT". He interacts with others in simple play, playing "store", "house", enjoying expressive activities such as art and dance. Fortunately, it is rare for profoundly retarded adults to become parents, as they would need constant supervision for themselves, as well as for their offspring. Likewise, the severely retarded adult is not likely to become a parent. Severely retarded adults may, however, function adaptively at the level of a normal six-year-old, making an effort to be dependable, realizing money has value, but not knowing how to use it except for coin machines. They may prepare simple foods (sandwiches), help with simple household tasks, and set and clear the table. They may participate in group activities, engage in simple games, and have friendships which last over weeks or months. This individual would require optimal support in a sheltered community living situation.

The moderately retarded adult, like a normal eight-year-old, can select daily clothing, read simple materials, interact cooperatively, shop, add coins to a dollar, and do simple routine household chores, including preparation of simple foods requiring mixing. The mildly retarded adult functions at the level of a ten-year-old and frequently is not known to be retarded or noticed as being "different" as he or she functions in the community. He or she can go about the community with ease, and can carry on everyday conversation but not discuss abstract or philosophical concepts. He uses the telephone and communicates in simple writing, interacts cooperatively or competitively with others, initiates some group activities for social or recreational activities, and may belong to a recreation or church group but usually not to civic or skill-related organizations. The mildly retarded adult enjoys recreation such as bowling, dancing, television or checkers, but is rarely competent at tennis, sailing, bridge, piano playing, or other activities requiring rapid, involved, or complex planning and implementation. He can go to several shops for a series of purchases and make change, but does not use banking facilities; he

may earn a living in a semi-skilled or simple skilled job but has difficulty handling money without guidance. The mildly retarded adult can prepare simple meals and do household tasks; he initiates most of his own activity, pays attention to a task 15-20 minutes, may be conscientious and assume responsibility for major tasks such as health care, care of others, or complicated occupational activity.

Having reviewed the adaptive level or potential best performance of the mildly or moderately retarded adult, how do these descriptions assist us in working with mentally retarded parents?

In order for anyone to perform at the highest adaptive level of which his intellect is capable, he must have cognitive input in the area of skills to be learned and the emotional support necessary to handle whatever total life stress arises while attending to learning the task.

Applying this principle to the study of child abuse, we can consider three major clusters of contributing factors to child abuse and neglect. The first has to do with training input. Many retarded parents either have not been presented skill information at all, or have had access to it only in a form far above their level of comprehension. A couple, for example, who met at a state residential facility for the retarded, married after they had both been discharged. They had no parenting skills and the mildly retarded maternal grandmother was of little help. Their two children were frequently left in bed or in a playpen for prolonged periods of time. The initial suggestion was to remove the children and send the parents back to the state school. The father was working at the time as a mechanic's aide and the mother had been trained in food service at the Harris County Center for the Retarded. She was moved to an MR classroom as an aide trainee and learned child care techniques under close supervision. The grandmother and the father, who became rough with the children when both cried at the same time, were brought in for sessions so that they might understand and support the parenting skills of the mother. The younger preschool child is now doing well developmentally and attends a day care center and the other is functioning well in a public school class for the retarded. Both parents work. The family is doing well but requires followup both to offer support and to identify needs for additional skill or therapeutic input.

While in the state school, these parents had been out of the community and truly had had no opportunity to learn parenting skills. The father's mental retardation was from brain damage, which led him to be extremely vulnerable to the stress of having simultaneous demands and crying from both children; he reacted with explosive outbursts. As he began to learn more alternatives, his outbursts rapidly declined. He did not require medication to limit his explosiveness.

One of two teenage retarded siblings was seen with her infant, who was developmentally within normal limits. The mother provided nurturing and the maternal grandmother, who worked as a domestic, provided emotional support for mother and baby. The grandmother had more stress than she could productively handle, for when her retarded teenage boy needed medication for his behavior problems, she gave him more than the amount prescribed. Additional emotional support and skill training for the young retarded mother was recommended in the form of the Infant and Teenage Mother project of the Mental Health-Mental Retardation Authority of Harris County. With increased skill training and associated emotional support for the retarded mother, the grandmother was able to devote a more feasible (i.e., smaller) portion of her energy to her retarded daughter, allowing sufficient time for better management of her son's behavior problems.

Another young unmarried retarded mother was working in a sheltered workshop. She had few resources and excessively punished her retarded preschool child when he continuously snacked, depleting the family food supply from the refrigerator. The child was enrolled in a school program. The mother was transferred to a classroom aide training program and she was given additional counseling and home visits in which described situations were role-played and alternative responses explored. Through counseling work with a special education graduate, she began to buy and store uncooked foods rather than prepared foods and the child began to eat at regular meal and snack times when foods were prepared and offered.

The above case reports are, comparatively speaking, success stories in which a gap in skills was filled by providing parenting training to retarded parents, utilizing the methods found most useful in preparing the retarded for other jobs: showing, helping, and supervising, with much repetition and positive reinforcement for gains. Training and employing them as "teacher aides" makes learning interesting and reinforcing to retarded parents. During working and school hours, the child is in an appropriate pre-academic or day care program, benefiting from developmentally appropriate cognitive and emotional stimulation.

A second cluster of factors is illustrated by the young mildly retarded mother whose first baby was deprived to the point of being removed from the family. The mother seemed at first as unaware of the requirements of a child as the others—offering a newborn only three meals per day, for example. A community early childhood program sent a counselor into her home at least weekly to work with her around specific parenting skills. She expressed an apparently excessive concern that her baby might not live and with her husband was admitted to a weekly therapy group. Only in the therapy group did it become clear that she had been sexually abused as a child. When she had told her parents, they had not only refused to believe her but had punished her severely. Her unresolved anger at both the male offender and her mother prevented her from developing a satisfactory relationship with either her husband or authority figures. Her husband was expected to meet all her unmet needs from childhood, as was, at times, her newborn son. At other times she reacted to them as if to her feared assailant. A modified, much more directive, gestalt therapy was used in which she played the roles of herself in the past as well as of her mother and significant others. Initially, the therapist gave her phrases "to try" when stuck in the gestalt of early scenes, having her accepting those which fit and rejecting those which did not. It became clear to her in therapy that from an early age her parents had encouraged her not to think, which probably contributed to her not profiting from our initial input of parenting skills. Once she had decided to think and through therapy had identified those responses to her baby which were really responses to the past, she was able to utilize both therapy and parent skill training more effectively.

Therapy was slow, as with many abusive parents. She had a second child. When she decided in therapy to take responsibility for herself and her children, her husband dropped out of therapy, refused to return and made many efforts, some successful, to sabotage her therapeutic gains. She had a gastrointestinal illness requiring hospitalization and surgery. Later, she moved. These events represent the third cluster of factors contributing to ineffective parenting—stress. The mentally retarded parent has less finely developed coping skills than his intellectually normal counterpart and requires more emotional support, even therapy, to handle a given amount of stress.

The mother slowly improved again, divorced her husband and re-decided to care for herself and her baby. Her infant is now developing normally; the mother no longer requires the child to meet her unmet emotional needs from the past. She has developed some close relationships with other adults, is engaged to be married, and is now utilizing both genuine relationships and community resources more effectively to meet both her own and her child's needs.

In summary, working with parents who have intellectual limitations can be effective and rewarding to both client and therapist. Efforts must be clear, repetitious, and experiential, and more directive than other therapeutic approaches. The therapist must be sure he is meeting the client at his or her level, with each intervention, whether therapy, skill training, or case management, being interpreted in the light of the retarded parent's own major concerns at the time. Once a crisis is over or a skill learned, it is necessary to insure continued goal attainment, for the vulnerability of the retarded client does not cease when the crisis is over—it only becomes less apparent to the unskilled observer. Working with the retarded requires not only a broad range of skills, but also a well-developed sensitivity to where the retarded client is, an ability to empathize with him at his level, and a real sense of whether the next step should be taken for him, by him, or with him.

Innovative Aspects of Child Advocacy in the Military: Research and Administration

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Few would dispute the assertion that both civilian and military communities do indeed have a problem of child maltreatment in their respective midsts. However, upon closer examination, attempts to measure the magnitude of the problem become clouded as a result of several factors. First of all, there exists no unanimity in social welfare, political, or legal circles as to exactly what constitutes child abuse or neglect. Questions remain as to the age range of victims, legitimate corporal punishment meted out by adults in fulfilling their parental roles, and the elements of emotional neglect. Even within the Armed Services, the Air Force and Navy use age 21 as the upper age limit for victims while the Army uses 18. Second, the whole reporting procedure reflects wide variability. Third, the low social visibility of much child abuse and neglect is well recognized. Considering only these three major definitional, reporting, or assessment issues, it is not surprising that conducting research in the field of child maltreatment today proves a Herculean task. One is obliged to qualify a study to such an extent as to make generalizations problematic. If it were possible to agree on exactly what child abuse and neglect are, much more research into etiological factors would certainly be possible. This point was articulated by Srinika Jayaratne in a January, 1977, article in *Social Work*, where the author cautioned against operating on some of the widely accepted assumptions about the etiology of child abuse and neglect. Among other things, Jayaratne was calling for good, scientifically-sound research into the whole problem of child maltreatment. No longer can we afford to accept retrospectively-derived "truths" such as "Today's abused children are tomorrow's abusive parents."

If we may oversimplify for a moment, there are basically three general types of research on child maltreatment which could prove fruitful if conducted by either the civilian or military sectors: (1) Research into incidence and epidemiology; (2) Research into causal/etiological factors; (3) Research into effective intervention and treatment strategies. Very frankly, research in the final two areas is to a large extent lacking or confusing, as pointed out by Jayaratne. Prior to 1975 any official attempt to deal with child abuse and neglect in the military was within medical rather than command channels. In addition there were no service-wide directives (i.e., regulations) concerning child maltreatment. Considering our very recent entry into the child abuse arena, we in the military have very little to offer with respect to research into etiology or treatment effectiveness.

We do, however, have some preliminary data concerning the incidence of child abuse and neglect in the Armed Services. One of the real advantages we have within the Department of Defense establishment is that we are "total institutions" as conceptualized by Erving Goffman. As such we have an inordinate control over what goes on within our institutional structure. The hierarchy of the military is widely known, and while some persons like to point out its disadvantages, it certainly permits addressing a problem with much more completeness than is possible for our civilian brethren.

While the military services have until recently shared with the civilian sector the general benign neglect concerning child maltreatment, there have been notable programs worth mentioning. Within the Army, Navy, and Air Force many programs under medical auspices were in effect prior to 1974. Certain of these were reflected or reported in the literature. Some of these include programs reported by Casimer R. Wichlacz et al at U. S. Army General Hospital, Frankfurt, Germany, and Lt. Col. John K. Miller at William Beaumont Army Medical Center, El Paso, Texas. Miller undoubtedly emerged as the best known and most articulate spokesman for child abuse programs within the U. S. Army during the formative years of the military's efforts in the field. In the Air Force and the Navy, as in the Army, various medical centers and hospitals developed local programs to facilitate case management of child maltreatment at their facilities. The prime Air Force leader in the field probably was Wilford Hall USAF Medical Center at Lackland AFB, Texas, although several other programs have been established at medical facilities including our medical centers at Keesler AFB, Mississippi, and Travis AFB, California. It was clear to all three services that without command attention and service-wide regulations, child abuse and neglect programs would lack the support required to achieve effectiveness.

What was it then that led to the ultimate development of child advocacy programs within the Army, Navy, and Air Force? I think the Air Force's experience was paralleled by that of our sister services. The key milestones in this process can be seen in Table 1.

Table 1

Historical Milestones in Development of Military Child Advocacy Programs

13 Mar 73	S.1191 (and H.R. 6380), Child Abuse Prevention and Treatment Act, introduced in Congress.
Mar - Jun 73	Congressional hearings: Senate Committee on Labor and Public Welfare, Subcommittee on Children and Youth; House Committee on Education and Labor, Select Subcommittee on Education.
21 Jul 73	Tri-Service and OASD/H&E meeting with Dr. Kempe.
Oct 73	SAF directs AFOSI study.
31 Jan 74	P.L. 93-247, Child Abuse Prevention and Treatment Act, passed in Congress.
Jan 75	Tri-Service Child Advocacy Working Group formed.
25 Apr 75	Air Force Child Advocacy Program, AER 160-38, effective.
1 Feb 76	Army Child Advocacy Program, AR 600-48, effective.
4 Feb 76	Navy Child Advocacy Program, BUMEDINST 6320.53, effective.

The Army Child Advocacy Program (ACAP) became operational 1 February 1976 and the Navy Child Advocacy Program on 4 February 1976. In spite of nearly identical program goals the three military programs are organized, managed, and administered somewhat differently. Table 2 shows some of these differences.

Table 2

Military Child Advocacy Programs

ELEMENT	AIR FORCE	ARMY	NAVY
Directive	AFR 160-38	AR 600-48	BUMEDINST 6320.53
OPR/Proponent	SG	TAG	SG (BUMED)
HQ Committee	HQ USAF/CAC	- - -	CCAC
Where Local Programs	All Bases	Posts W/2,000 Dependents	Medical Facilities Where Treat Children
Local Manager	Child Advocacy Officer	ACAP Officer	CAR
Local Committee	CAC	CPCMT*	CAPC
Cases Forwarded	Established**	Established	Suspected & Established
Report Forms	AF Form 120 CAC Report	DA Form 4416-R: Child Maltreatment Summary	NAVMED 7320/15 CA/N Report
Central Registry	SGO, Wash DC	HSC, Ft. Sam Houston, Texas	BUMED, Wash DC

*Note: Child Advocacy/Human Resources Council also on post
**Note: Suspected cases are sent thru AFOSI channels to DCII

AIR FORCE CHILD ADVOCACY PROGRAM

The Air Force Child Advocacy Program (AFCAP) is the responsibility of the Social Work Program Manager, Clinical Medicine Division, Office of the Surgeon General. At Major Air Command level the program is managed by a coordinator in the Surgeon's office. At base level AFCAP is the responsibility of the base commander. A Child Advocacy Committee (CAC), with line and medical membership, is established and chaired by the hospital commander or chief of hospital services. The CAC, which meets at least quarterly, reviews all cases of suspected child abuse and neglect and renders a decision as to whether a case is substantiated or not. The central figure in the AFCAP is the base child advocacy officer, who maintains all the records, serves as a member of the CAC, and is responsible for primary prevention efforts, in-service training of medical staff, etc. Of the 130 child advocacy officers well over half are professional social work officers. Child protection teams may be established at a medical facility, and each medical center and regional hospital has a senior social work officer serving as area or regional child advocacy consultant. Established (confirmed) cases of child maltreatment are forwarded by the local CAC to the Central Register at the Office of the Surgeon General in Washington. Suspected cases are reported to AFOSI and transmitted through their closed investigative channels. These records can not be accessed by outside agencies.

ARMY CHILD ADVOCACY PROGRAM (ACAP)

The Army Child Advocacy Program (ACAP) is directed by the Adjutant General, Community Services Division. At installation level the Post Commander is responsible for establishing an ACAP at installations where 2,000 or more dependents are present. The post Child Advocacy/Human Resources Council is responsible for assisting the commander in administering the local ACAP by mobilizing all possible resources for the program, engaging in preventive efforts, and basically coordinating the local program. The central figure in the local program is the ACAP officer who is usually a personnel staff officer or social work officer with the installation Army Community Services Program. The Medical Treatment Facility (MTF) commander is responsible for establishing a Child Protection and Case Management Team (CPCMT) to assist in evaluation, diagnosis, treatment, and making case recommendations on all suspected cases. A social worker or community health nurse generally serves as the MTF contact point. If the CPCMT judges a case to be "established" child abuse or neglect, the case record is completed and sent to the commander, U. S. Army Health Services Command, Fort Sam Houston, Texas, for filing in the Central Register.

NAVY CHILD ADVOCACY PROGRAM

The Navy Child Advocacy Program is organized differently than those in the Army or the Air Force. The Navy program is the responsibility of the Navy Surgeon General. At the present time this program impacts directly only upon Navy medical facilities since it is governed by a "BUMED" instruction rather than a "SECNAV" or "BUPERS" instruction, i.e., Line Navy. The program manager in BUMED is the Surgeon General's consultant in clinical psychology. There is also a Central Child Advocacy Committee (CCAC) comprised of three clinical members and representatives from BUPERS, the Chief of Chaplains, JAG, and HQ U. S. Marine Corps. A Child Advocacy Program Committee (CAPC) is established at each Navy medical facility which treats a significant number of dependent children. The CAPC, which meets at least bi-monthly, is composed of Medical Service and line personnel. The medical facility commanding officer will appoint a Child Advocacy Representative (CAR) to serve as the liaison between the command and the CAPC in matters relating to child advocacy. When a case of suspected child abuse or neglect occurs, it is reviewed by the local CAPC, and a report forwarded to BUMED for placement in their Central Register.

INCIDENCE OF CHILD MALTREATMENT IN THE MILITARY

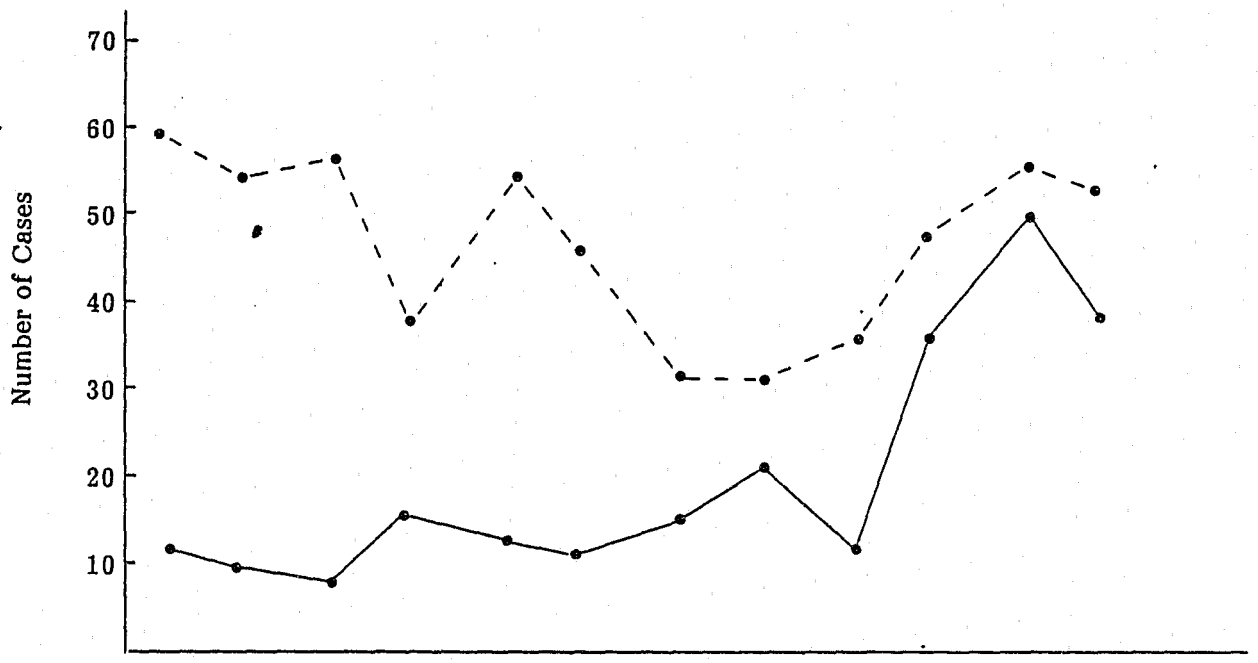
As alluded to earlier, national estimates of the extent of child abuse and neglect vary widely, ranging from 665,000 to 4,070,000 cases per year. NCCAN estimates that if all cases were reported there would be 1,000,000 incidents annually involving 2,000,000 children. The National Study of the Incidence and Severity of Child Abuse and Neglect is using estimates of 5 cases of physical abuse and 20 cases of neglect per 1,000 children per year.

In light of the current general imprecision concerning the extent of child abuse and neglect, we in the military should not be apologetic. After all, the Air Force's program, the first in the Department of Defense, has been in effect for just under two years. Due to the varied reporting procedures among the three child advocacy programs, at this point in time the Air

Force data may provide a better indication of the military incidence of child maltreatment. Latest available figures place the total Air Force community at 1,580,463 individuals of whom 611,087 are children. Figures depicting the incidence of reported cases of child maltreatment during CYs '75 and '76 are portrayed in Tables 3 and 4.

Table 3

Reports of Suspected Child Abuse and Neglect Incidents (By Month)*



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
——1975	11	10	9	15	13	12	15	21	12	37	50	40	245
----1976	59	54	55	37	54	44	30	30	37	48	55	53	556

* Source--AFOSI/IVGSF

Table 4

Reports of Suspected Child Abuse and Neglect Cases (2 Years)*

Type of Case	Number & % Reported - CY 75		Number & % Reported - CY 76	
Death	16	6%	10	2%
Physical Abuse	159	66%	342	62%
Neglect	35	14%	111	19%
Sexual Abuse	35	14%	93	17%
Total	245	100%	556	100%

* Source--AFOSI/IVGSF

Descriptive data concerning abusers/neglecters and victims is shown in Table 5.

Table 5

Child Abuse and Neglect - CY 76*

	Mean Age of Abuser	Mean Age of Victim	Modal Grade and Sex of Abuser	Modal Sex of Victim	Modal Abuser-Victim Relationship
Death	23.2	1.9	E1-E4/Male	Male/Female	Natural Parent
Neglect	25.7	4.3	Dependent Female	Male	Natural Parent
Physical	26.4	5.0	E1-E4/Male	Male	Natural Parent
Sexual	26.4	11.3	E5-E9/Male	Female	Natural Parent

* Source of Data--AFOSI/IVGSF

These data translate out to the following for CY 76:

1. A mortality rate of 2%.
2. A morbidity rate of 1.42 cases per 1,000 families.
3. 352 cases of suspected child abuse and neglect per 1,000,000 population.

The Air Force Central Register was established in April, 1975. As of 1 April 1977 there had been 576 cases of established child maltreatment reported. During this same period there were 866 suspected cases reported through AFOSI channels. This suggests that 64% of the suspected cases are confirmed, slightly more than the 60% figure estimated by NCCAN.

FUTURE DIRECTIONS

The three military departments have recognized that child maltreatment is a problem which must be dealt with effectively, if not for humanitarian reasons, then at least for its impact upon mission accomplishment. Army, Navy, and Air Force programs stressing child protection rather than abuser punishment are now organized and operating. While some administrative and managerial problems are yet to be solved, we are able by virtue of our closed system to work for the resolution of child abuse and neglect in a comprehensive and effective way unavailable to the civilian community. Our local program managers are initiating preventive strategies as well as perfecting identification, treatment, case-management, and follow-up procedures. Because of the nature of military life and the allegedly "authoritarian" individuals who choose military careers, one might conjecture that the Armed Services might reflect a higher incidence of child maltreatment than is true nationally. Initial Air Force data does not bear this out, and unless there emerge wide variations as Army and Navy reporting procedures are smoothed out, there is every reason to believe that child maltreatment in the military is no more or less a problem than elsewhere. In any event we will continue our combined efforts in dealing with this important problem in the months and years ahead.

Management and Supervisory Issues of Military Child Abuse Programs

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In November of 1975 the Department of the Army published a regulation entitled "Army Child Advocacy Program". While this was not the first time that the military had decided to do something about child abuse, it was the initial step towards providing policy and guidance to Commanders and health care providers regarding the coordination of human services, specifically towards preventing, controlling, and treating child abuse and neglect. This regulation was based on programs in existence for several years at various Army posts and took into account many of the very positive aspects of child abuse and neglect programs as well as many of the lessons learned and the mistakes made regarding the management of such programs.

The objectives of the Army Child Advocacy Program revolve around developing a community base program; coordinating services impacting on children's growth and development; identifying, using, and strengthening existing community resources to enhance the welfare of children; preventing and controlling child abuse and neglect through education; training the individuals who provide health and welfare services to military families; and identifying, reporting, and managing cases of child abuse and neglect among Army families.

In contrast to the Air Force's hospital based program, the Army's is community based. It incorporates staff members besides those assigned to the hospitals, such as lawyers, military police, and various commanders. There are problems with this type of program, both in providing services and in coordination and supervision. I will discuss these problems as well as the favorable aspects of the program, and also mention various guidelines and principles for developing and managing a successful program.

Brooke Army Medical Center, where I am presently stationed, is a 650 bed training hospital located in San Antonio. It not only incorporates the usual services and clinics found within most hospitals, but also maintains a child guidance clinic, Adolescent Medicine Service, community mental health activity, community health nurse section, and interfaces with other military agencies such as Army Emergency Relief where financial assistance is located, the American Red Cross, who also have social workers on their staff, and Army Community Services.

The Post Commander, who is almost never the Hospital Commander or the Director of Health Services, is responsible for appointing a child protection case management team. This CPCMT is composed generally of a pediatrician, psychiatrist, social worker, psychologist, community health nurse, legal representative, community service social worker, chaplain, department of public welfare child welfare worker, military police representative, and any other members of the health care team and military and civilian communities deemed appropriate, many of whom attend on a case-by-case basis. Coordination of this type of council requires an extensive amount of time, interest, and good management. Many military posts have established a position of Coordinator, sometimes identified as the Child Advocacy Officer, to run the program. He usually is a social worker by profession, but not, in most instances, the social work services provider.

This coordinator has many responsibilities, including (1) planning and coordinating the meetings, (2) maintaining liaison with the hospital to ensure its support for the CPCMT, (3) ensuring that reported instances of child maltreatment receive immediate attention and action, (4) keeping a constant check on current cases to determine if appropriate follow-up and evaluation are taking place, (5) developing an agenda for the CPCMT meetings, (6) maintaining minutes and records on cases, (7) informing appropriate members of the staff when new cases are to be presented, (8) handling requests from community agencies, physicians, school personnel, and public health nurses for assistance, (9) arranging for referral of suspected child abuse cases to the Medical Center, and (10) coordinating educational programs, not only for military personnel and their dependents, but also for the civilian community and the various agencies with which the military interacts. Finally, there are a number of other minor mechanical and logistical tasks which are required of this coordinator. As one can see, this is almost a full time job, but rarely is it defined as such.

Child protection has, within the past few years, been fully recognized as a military responsibility. Within the social work and health care fields, we consider this to be a tremendous step forward in the concern for human rights and human services. The Army has thus accepted the responsibility to protect its dependents as well as take care of its active duty personnel. Few, if any, additional staff have been added for this task, however.

Army social workers are educated in civilian universities and upon entering active duty receive substantial administrative training which helps them in case management and program management. Most of them have also worked in civilian agencies at one time or another. This gives them an appreciation and understanding of the need for good interaction with the civilian community and agencies. The military program, whether it be Air Force or Army, is highly dependent upon the department of public welfare, the judicial system, and in practically every instance, the foster care programs which are managed and operated by our civilian counterparts. Without an effective liaison, extensive cooperation, and good coordination between the military and civilian agencies, most military child protection and management team programs will fail or be mediocre at best.

There are a number of problems which are directly related to cases and reflect on program management. One of these is difficulty in stabilizing tours of duty. People in the military move very frequently. Occasionally, moves have been granted for less than justifiable reasons. I have personally been involved with several families who were able to move while the CPCMT was evaluating the family for alleged abuse and neglect. This requires a case referral to the post where the military family is reassigned. Fortunately, military members do not just drop out of sight. A world-wide locator service is available and orders are always cut when people move, which helps one CPCMT refer to another CPCMT.

A second problem is that coordination with the civilian community is not as easily developed and maintained as it might be. Private agencies, while not involved in the investigatory aspects of child abuse and neglect, are many times involved in treatment, particularly because CHAMPUS will pay for the treatment programs. Departments of public welfare provide foster care programs as well as the investigations. Jurisdictional boundaries of federal reservations and states, counties, and cities occasionally become problematic. The department of public welfare, city police, and other agencies have to be invited onto a Federal reservation. Occasionally, post commanders resist cooperating fully with these civilian authorities.

Being located in the Medical Center, we provide something identified as regional support for other medical activities, often located in different states. For example, Brooke Army Medical Center is located in Texas and the medical activities from which we receive severely injured, maltreated, and complicated medical patients are located in Oklahoma, Texas, and Louisiana. We thus need extensive knowledge of the guidelines and procedures of the various states and county welfare departments.

Another problem area, in part an extension of the second problem, is that the military can not provide total care for its families. This complicates coordination and management. Yet, I, as a social worker, personally welcome this "forced interaction". The Army judicial system is limited as are its long term treatment facilities.

A fifth problem is that military families occasionally do not want to receive social work services or treatment from military mental health clinics for fear that this information will be discussed with their commanders, and have a damaging effect on their career and promotional possibilities.

Sufficient money and manpower have recently become bigger problems for Air Force and Army child abuse and neglect programs. Money and staff have been increasingly channeled away from supportive services. This means child protection service providers have other job requirements, resulting in less case coordination and often losing the family as the focal point of treatment.

There are, nonetheless, many positive aspects and benefits to being in a military environment which help in the management of a child protection program. Being in a medical center, the regional support of other medical activities is clearly defined. When the medical activities feed into the medical center, they become familiar with the staff and procedures. Patients and families achieve some semblance of continuity and care. The Army Child Advocacy Program regulation does provide some uniform policies and procedures and clarification of terms. Referrals become less complicated and programs do not require rebuilding every two or three years as key staff members move.

The availability of multidisciplinary teams is most definitely an asset. Everyone is essentially on the same staff. Similarity in purpose and orientation, despite different jobs and functions, is quite helpful in the management of a child protection program.

A big advantage is case reporting. The pediatrician, the emergency room personnel, the social work service, and the other health care team members can work quickly and effectively in producing coordinated services to each family in need. Duplication is minimized and roles are more clearly defined.

In the area of education, which was cited previously as a function of the coordinator, the chain of command, the military structure, and the regulations actually become a vehicle to education active duty personnel and their dependents. For example, an emergency crisis line requires publicity and the chain of command is one way to publicize this. Video tape documentaries, brochures, and other training aids are readily available as well as easily distributed.

In many respects the management of a child protection program is similar to running a business. One of the basic requirements of a successful business is accessibility. An example of accessibility within a child protection management program would be having a crisis "hot-line" established, having personnel identified as having responsibility to provide services, and having these services available without respect to time of day or geographical distance.

A second requirement is visibility, identifying and advertising the location where services are provided. The CPCMT must be visible and recognized as a viable operating group within the community and the medical center.

Success is also based on mobility. Sometimes the services have to go to the family and the individual at school, in the home, or even on the job. If the child management team is restricted to operating in the emergency room, the wards, or a specific clinic, the program cannot develop effective impact.

Success in business or in a child protection program also requires continuity, clearly defined roles, established policies and procedures, and delineation of the various responsibilities, as well as training and education of the staff on a continuing basis.

A final factor in any successful business or child protection program is control. Evaluation, measurement, and quality assurance are control elements. Restraints and parameters need to be developed as guidelines for service delivery and program management. Controls also facilitate structure, help define roles, and provide tools to measure results. Duplication of services will thus be avoided and an increased efficiency of time and money should occur.

Before we leave this discussion on success some attention needs to be focused on the role of the social worker. Within the Army there is presently an adequate number of social workers available to work in child protection and case management programs. Most social workers have a greater knowledge of the administrative procedures involved in managing a program and are more aware of the command structure and the community agencies involved than other personnel involved in the management teams. It is not felt, however, that the social worker who manages and coordinates the child protection program should be the same individual who provides the services. The manager might logically be the service provider's supervisor. The supervisor is aware of what is being done to identify, investigate, and treat the families and would be able to help develop and implement child management policy. As a supervisor, he or she would probably have the opportunity to be involved in the planning of Medical Center policy.

Developing and negotiating different strategies is very complicated and time consuming. Much of this paper has dealt with the need for coordination, liaison activities, and collaboration with members of a vast array of multidisciplinary team members. The social worker who is providing the services will not have sufficient time and energy available to develop and negotiate the various programs' strategies. He also will not have the opportunity to extensively evaluate the program's effectiveness. The supervisor would be the logical person to handle this task.

An additional responsibility of the program manager is to evaluate and supervise the service delivery. I have occasionally heard that child beating often leads to increased abuse or tragedy in part due to the slackness on the part of social workers or their supervisors. Other factors are bad judgment on the part of the social worker who feels it will not happen again, poor understanding of the general public regarding child abuse and neglect, and inadequate termination rights leading judges to rule in favor of abusive parents rather than to decide what is best for the entire family. Good management and good supervision of the service delivery system are highly essential for an effective program.

In conclusion, the family must be the focal point of treatment, the multidisciplinary diagnostic and treatment team must be a central force in case management, there must be an emphasis on public education, and professionals must be trained to identify and report child abuse and neglect. These are all key measures which have to be present to effectively identify, treat, and prevent child abuse and neglect.

Profile of a Prototype Adolescent Medicine Clinic in the Military

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Dr. J. Roswell Gallagher conceived the first significant comprehensive adolescent service in this country at Boston Children's Hospital in 1951. The concept of caring for this previously neglected age group (13-21) in age-related clinic settings has since spread to other parts of the United States, Canada, South America, Europe, and Turkey. A Society for Adolescent Medicine has been established to develop guidelines and certification for this new specialty and to provide a forum for exchange of information between health professionals caring for teenagers.

The first adolescent medicine service in the Armed Forces was established by Dr. F. C. Biehusen at Letterman General Hospital in 1958. There are now 16 medical centers in the military with some level of specialized medical care for young adult dependents. Fitzsimons Army Medical Center has the only military adolescent fellowship available in the Armed Forces. A recent survey by Drs. Schydlower and Patterson from Tripler Army Medical Center confirmed the suspicision that teenagers continue to have difficulty in obtaining quality medical care, but that, fortunately, pediatrics departments in the Armed Forces are assuming responsibility for this age group.

The Frankfurt Youth Health Center (FYHC) was established in April, 1973, as a joint project of the White House Special Action Office for Drug Abuse Prevention and the Department of Defense. Its purpose was two-fold: (1) to treat and prevent adolescent drug abuse and (2) to provide a comprehensive medical and counseling service for adolescents living in an overseas military environment.

Adolescents aged 13-18 are seen without the necessity of parental consent in a clinic which is physically separate from other military facilities. The FYHC is composed of three extensively interacting units: (1) an out-patient medical clinic, (2) an individual and family counseling service, and (3) the Open Door, a non-structured environment providing recreation and experiential education.

Since its inception, the FYHC has experienced an adolescent out-patient medical load of approximately five times that seen previously in the dispensary pediatric clinic. Counseling visits have increased twelve-fold over those seen previously in the hospital-based adolescent psychiatric clinic. In addition to offering constructive outlets in a community with limited options for adolescent Americans, the Open Door has provided many intakes into both counseling and medical units. These facts support the contention that the FYHC provides a useful and effective model for comprehensive care of the adolescent.

The American Academy of Pediatrics now requires provision of formal training in the care of the adolescent patient for accreditation of residency programs. In 1971, the Army Surgeon General directed that all Army pediatric teaching departments would develop adolescent programs. An Adolescent Medicine Service was established at Brooke Army Medical Center in the fall of 1972 by the Department of Pediatrics to fulfill these requirements.

Prior to development of the clinic, approximately 200-250 patients were being seen in various clinics and the emergency room. Patients over the age of 13 were not eligible for care in the pediatric clinic, and pediatric residents were not trained in the care of 13-21 year old patients.

Essential discussions with the Departments of Psychiatry, Obstetrics and Gynecology, Social Work, Internal Medicine, and other physicians and health professionals caring for teenagers were held and coordination was initiated. It was concluded that unique problems of teenagers would be better handled in an age-related clinic, separate from adult and pediatric clinic settings. It was predicted that the adolescent service would provide more efficient and coordinated care with decreasing numbers of teenagers seen in the emergency room. Better quality of care and resultant improved patient compliance were other goals of the program.

Typical medical problems seen in the adolescent clinic included obesity, orthopedic problems, endocrine dysfunction, pregnancy, sexual and physical abuse, adjustment problems (with associated symptoms of alcohol and other drug abuse) and a surprisingly high number of other organic medical problems. The multiplicity and complexity of the patient problems encountered required the coordination and cooperation of a team of health professionals to adequately deal with them.

A nurse-clinician, physician, and MSW social worker formed the initial nucleus of the team and were soon joined by a clinical psychologist. Intake procedures and service policies were finalized through frequent staffings and trial and error over a five-year period.

The standard operating procedures used in the clinic are attached as an appendix. The nurse clinician and social worker worked full time and the physician worked three-quarters time during the first two years of clinic operation. Table 1 reflects the patients seen during the first six months of 1974.

TABLE 1

Actual workload of outpatients and inpatients seen by Adolescent Medical Service during first six months, 1974.

	OUTPATIENTS	INPATIENTS
January	11	2
February	17	3
March	36	2
April	42	3
May	50	2
June	201	4

The duties of the adolescent physician included team staff meetings two to three times per week with pediatric residents, medical students, psychologists, nurses, social workers, physician assistants, and other personnel rotating through the clinic. Outreach was provided by activities as school physician for Cole High School, where parent effectiveness classes included lectures on topics ranging from drug abuse to venereal disease.

Teenage child abuse cases were medically evaluated and treatment programs initiated in coordination with Project CARE, Bexar County Child Welfare, and Fort Sam Houston Child Advocacy Program Council. Workers from Project CARE were directly involved in long-term followup and treatment programs of the clinic patients, with very beneficial results. Clinic staff were required to testify in court for several difficult cases with some positive impact on disposition.

Other activities included Brooke Army Medical Center pediatric teaching rounds, service as U.S. Modern Pentathalon physician, and clinical instructor at University of Texas at San Antonio Health Sciences Center.

Coordination of patient care with other departments and services required close communication to ensure better followup and consultation results. The Department of Pediatrics decided to concentrate on the out-patient phase of adolescent care with no attempt to establish an in-patient unit initially. Inpatients referred from adolescent clinic to other services were followed in conjunction with the admitting specialty service.

Mrs. Helen Burt, the head nurse of the adolescent unit, planned, administered, and evaluated nursing care in the clinic and also functioned as the unit manager. She screened new patients and worked as a nurse-clinician in ordering laboratory tests indicated by her judgment. Additionally, she provided counseling for obese teenagers and other adolescents requiring supportive care. Volunteer school nurses as well as physician assistants and nursing students worked under her supervision while on the service. The nurse soon became conversant with psychosocial aspects of disease through daily contact with the psychologist and social worker on the service and was most effective in initiating counseling and positive reinforcement for teenagers.

The entire clinic staff received instruction in parent effectiveness training to prepare for their various roles in therapy, especially for abused teenagers. Both parents and adolescents required extensive counseling and guidance in the area of parenting skills.

Extreme caution was exercised to safeguard privacy of information obtained in the clinic. Informed consent was obtained from the patient prior to treatment.

The Adolescent Medicine social worker serves adolescent dependents of the military and their families who are experiencing behavioral, educational, drug, family, and medical problems. It is incumbent upon the social worker to assess the individual, family, and environmental life-styles as they may relate to the presenting medical problem. Further exploration of psychosocial dynamics is also made in order to provide appropriate therapeutic programs in conjunction with medical treatment.

Extensive consultation with community resources, school officials, and other military agencies is necessary in providing and implementing treatment to dependents and their families. Pertinent medical-social issues are examined as a means of providing and reinforcing positive adaptive patterns of supportive programs so necessary in treating the adolescent and his family.

An example of the outreach activities of the clinic is described as follows:

A PILOT PARENTING EDUCATION CLASS FOR ADOLESCENTS

In the spring of 1976, Marie Thurston, Project CARE, approached the administration of Cole High School at Fort Sam Houston with a proposal to pilot-test a class in parenting education for adolescents. The overall goals of the class were:

1. To prepare students to become good parents.
2. To introduce them to careers involving children.
3. To help them develop into good citizens.
4. To serve as a tool for primary prevention of child abuse and neglect.

In order to achieve these goals the following objectives were developed:

1. To provide an educational framework for increased awareness and understanding of the responsibilities of parenthood.
2. To learn basic information about child growth and development.
3. To learn how to observe children and who they experience their world.
4. To foster an awareness of responsible sexual behavior.
5. To observe child care attendants and kindergarten teachers working with children.

Program development and implementation were coordinated with the school principal and class teacher. Following consideration of age, sex, and grade level, an existing homemaking class of twenty-eight eighth grade boys and girls was selected as ideal for the pilot class. Eight weeks were allocated for the class.

A high priority was given to direct experience with children. Therefore, student involvement at the child care center during the class period was planned, negotiated, and implemented. Although some students had previous experience interacting with young children in their own families, the laboratory setting served as a valuable teaching tool, providing students with a structured learning situation to augment past experiences and prepare for the future. The pilot class was planned to allow the maximum amount of field experience with children.

Written materials were selected for classroom use from a variety of sources. Although a considerable amount of parenting material was available for adults, most resources were not considered appropriate for adolescents. The resource file of the Parenting Materials Information Center in Austin, Texas, was utilized. Materials were selected from the Exploring Childhood Series which was specifically designed for adolescents by the U.S. Office of Education in 1973. Included in the series are: Doing Things, Looking at Development, What About Discipline, and Getting Involved.

A high degree of coordination was required during the planning and implementation of the project. An assistant professor at the University of Texas at San Antonio School of Nursing was invited to give lectures on child growth and development. Several sex education films were located and previewed; one film, "Teen Sexuality", was selected because it was considered most appropriate for eighth graders. The day care center director was approached regarding use of the center for field experiences. Transportation from the school to the child care center was arranged through the junior high school. Tasks such as these consumed many staff hours in planning and coordination.

IMPLEMENTATION

The class met twice weekly for eight weeks beginning in September, 1976. The sixteen 55-minute sessions were divided into the following topics: pre-test, post-test (2 sessions), child growth and development (2), child abuse/neglect (1), planning and discussion (2), sex education (1), and visits to child care center and kindergarten class (8).

Students were evaluated on the basis of their journals, which provided an ongoing record of student impressions and experiences. Students were also given a quiz on child abuse and child growth and development.

Several methods were used to evaluate the parenting curriculum. The first method—a pre-post test of student attitudes and knowledge—was administered during the first and last class sessions. The test was also administered to a control group of 16 students in an English class. This questionnaire was a valuable aid to planning by assessing student attitudes and knowledge; however, control group comparisons were of minimal value because of the small number of students and the significantly greater number of male controls. Pre-post test results showed relatively little change, probably due to the short duration of the course and the fact that basic attitudes and opinions are difficult to change after a short training period.

An additional evaluative tool was administered at the end of the eight week course. Students were asked to rate the individual parenting class activities.

RECOMMENDATIONS

1. Incorporate the class into the school curriculum and make it available to all students. Students at higher secondary school levels might find a parenting class more meaningful because they are closer to actually becoming parents.

2. Extend the class beyond eight weeks. Additional time would be valuable for in-depth study of each topic, particularly child growth and development.

3. Utilize a longer block of time than one hour. Time limitations were a continuing constraint, particularly at the field setting where additional time was required for transportation and setting up and putting away materials and supplies. Time actually spent in the learning project at the field setting was minimal, and the projects were sometimes incomplete at the end of the time period.

4. Plan regular conferences between the parenting class teacher and the field setting (kindergarten) teacher. A more productive use of both classes' time would result from joint planning and matching of class objectives.

5. Consider use of English, social studies, or health education classes for future parenting education programs. These classes reach virtually the whole student body and a parenting education program could be incorporated into them just as effectively as in the homemaking class. In addition, the greater number of male students enrolled in these three areas would benefit from this program.

A PROGRAM OF PARENTING EDUCATION FOR ADOLESCENTS IS MORE LIKELY TO BE SUCCESSFUL IF YOU—

In Planning

1. Identify goals and objectives of the class.
2. Obtain support from school principal and coordinate program implementation with him.
3. Obtain commitment from principal regarding what technical support school will provide, e.g., transportation to field setting.
4. Obtain support from classroom teacher and field setting teacher and coordinate program development with them through a series of joint planning sessions.
5. Keep principal informed of each step to facilitate continuing support.
6. Allow sufficient time for planning, 3-4 months if possible. Location and selection of resources is a time-consuming process.
7. Develop a program of combined classroom instruction and field experiences.
8. Select a field setting with a structured program of activities.
9. Integrate class objectives of parenting class with class activities and objectives planned by field experience teacher.
10. Assess traveling time to field setting, and reduce it by selecting field setting close to school.
11. Delineate roles and responsibilities of parenting instructor (if outside consultant), classroom teacher, and field experience teacher.
12. Identify legal liability for accidents involving members of parenting class and children in field setting.

In Implementing

1. Utilize instructional materials geared to the level of adolescents, not adults.
2. Allow sufficient time for group discussion and exchange of experiences.
3. Allow for time spent in field setting getting out materials and putting them away.
4. Have a full period of activities prepared, with alternate activities to allow for change of student interest.
5. Determine rules and regulations of the field setting and see that students adhere to them (e.g., gum-chewing).
6. Have students keep a journal of notes and impressions during field experiences.

In Evaluating

1. Determine class grade on basis of journals, other assignments, and quizzes.
2. Utilize structured pre-test and post-test to assess change in student attitudes and level of knowledge.
3. Obtain a complete course evaluation on the final day of class. Utilize anonymous questionnaires for overall evaluation of course, field experience, written materials, and instructor.
4. Request input from field experience teacher.
5. Provide school principal, classroom teacher, and field teacher with a written report on the class.

The parenting skills education efforts, both in the adolescent clinic and the Project CARE program described above, represent the type of preventive educative efforts needed for appropriate care for the adolescent client. The cycle of child abuse can be interrupted more appropriately and cost-effectively by improving the skills of the twenty-two million potential teenage parents than by caring for their abused, unwanted children.

This non-threatening contact with the adult world also provides easier access into an effective, sensitive health care system and more opportunities for personal growth and physical well-being. These programs can serve as guides to help develop culturally appropriate systems in other localities.

What does the future hold for adolescent medicine programs? This question was addressed at the spring meeting of the Society for Adolescent Medicine (SAM) chaired by Drs. Adele Hoffman and Verdaine Barnes. The SAM Education Committee, represented by Drs. John Edlin and Fred Chisholm, reported a need for uniformity of criteria for training programs and recognition of the specialty of adolescent medicine by traditional certifying bodies. (The American Medical Association proposed recognition of the specialty of adolescent medicine at the annual convention in August 1977). Several members of the society have been asked to develop specific areas of model training programs to produce appropriate curricula for various levels of adolescent specialty training.

SAM feels that "post-graduate education in the field of adolescent medicine should be a continuing and a graduated process directed to meet the needs of physicians and other health professionals with varied levels of skills in treating adolescents."

Several programs in the military as well as their civilian counterparts are providing prototype programs involving units of health professional teams sharing expertise and interfacing with various agencies caring for teenagers. Valuable training in the techniques of providing care for the adolescent is available also. Our experience has been that teenagers will come to a military hospital for health maintenance and crisis intervention once credibility has been established. It is significant that in the program at Brooke Army Medical Center, there have been zero suicides among the clinic population since 1972 at a time when suicide is the fourth leading cause of death among teenagers.

Our team has matured over the past five years and is now better able to recognize limitations of the staff and appropriate levels of intervention relative to the needs of the patient. The flexibility so necessary in coordinating with other agencies, such as Project CARE, social services, and others, will prove invaluable in working with new systems now being implemented. Problems such as child abuse can be better dealt with in this compatible matrix of cross-trained, sharing health professionals.

In summary, we have described a military adolescent program and team approach designed specifically for teenagers and their problems. The decisions and processes involved are shared with you in the hope that much needed time might be saved in developing your own unique adolescent health care systems.

APPENDIX A

SOP ADOLESCENT MEDICINE SERVICE

BROOKE ARMY MEDICAL CENTER, FORT SAM HOUSTON, TEXAS, 78234

I. PURPOSE. The Adolescent Medicine Service, Department of Pediatrics, BAMC, will provide the adolescent patient from age 13 thru 21 with medical care, guidance and support uniquely necessary for the patient. The Adolescent Service will be divided into two major components:

a. Adolescent Medicine Outpatient Clinic—This clinic will provide outpatient medical care to all military dependents between the ages of 13-21.
b. Adolescent Medicine Inpatient Service—Will provide consultative inpatient service for ages 13-21 on any ward or service of BAMC.

II. PROCEDURE FOR REFERRAL TO OUTPATIENT ADOLESCENT SERVICE.
The Adolescent Medicine Clnic will be designed to provide as many specialty services as possible within the service but will also coordinate referrals of adolescents to appropriate specialties within BAMC. Many adolescents are already being followed in various clinics, such as internal medicine, allergy, dermatology, OB-GYN, child guidance, diet therapy, and others. These patients will remain in these various clinics and the Adolescent Service will be available on a consultative basis. Appropriate referral will consist of:

1. Referral by consultation sheet, Form 513, which will be submitted to the Adolescent Service, BAMC along with completed form FL 445a NS, 1 November 1972, which is the Parents Medical Information Sheet.
2. The patient will be given an appointment upon receipt of the completed Parents Medical Information Sheet. Any parent or patient desiring an appointment may obtain this form from the Adolescent Medicine Service, the Department of Pediatrics, or the Main Hospital Clinic. This form will be forwarded to the Chief, Adolescent Service, and appointment time and date will be sent to the patient.
3. Parent and patient will be interviewed together initially and the patient will be encouraged to come along on subsequent visits.
4. Information obtained during interviews between the patient and the adolescent medicine physician will be treated with strict confidence and parents will be encouraged to get results from such interviews from the adolescent or from the physician in the presence of the adolescent.
5. Consultations will be returned to the referring physician as soon as possible.
6. The initial interview will include evaluation by a 91G social work technician in attendance with the adolescent physician.
7. Emergency referrals will be given top priority as indicated and direct telephone notification of the adolescent medicine physician is preferred. Appointments will be available every Monday and Thursday afternoon between 1300 and 1630 with a maximum of 6 patients. New patients will be scheduled Tuesday, Thursday and Friday mornings with 2 new patients at 1000 and 1100 hours on those days.
8. Any questions concerning the procedure may be directed to (512) 221-6735 or 221-4024.

Types of problems that are anticipated in the Adolescent Clinic are:

1. Endocrine problems, such as thyroid dysfunction, diabetes, ovarian dysfunction.
2. Variations of normal growth and development such as obesity, short stature, and delayed puberty.
3. Common medical problems such as infectious diseases, allergies, acne.
4. Problems of social significance, which include drug use, venereal disease, family conflict, behavior disorders, and adolescent adjustment reactions, which include depression, school problems, and specific language disability. A clinical social worker will be closely involved in these areas.

III. ADOLESCENT INPATIENT SERVICE. This service will provide consultative service to all inpatient departments of Brooke Army Medical Center on all hospitalized patients between the ages of 13 and 21 as indicated. Specifically, the service will provide medical support and coordination of medical care.

Top priority will be given to the training of interns, residents social workers, nurses, and paramedical staff, to familiarize them with the concept of the care of physical, social, and emotional problems which commonly affect the adolescent age group.

IV. RESEARCH PROGRAMS. The Adolescent Service will initiate and develop research programs and multi-disciplinary treatment approaches directed towards the medical care and investigation and physiological, social and psychological problems of adolescents thereby improving methods of prevention, diagnosis and treatment for the adolescent age group.

Establishing Rural Child Abuse and Neglect Treatment Programs

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That children are abused, neglected, and sexually exploited in rural areas as well as in cities is a fact that has been documented, recognized, and accepted by all researchers into the phenomenon of child abuse and neglect. Individual agencies, professionals, and laymen in the non-urban community are also aware of local instances of child maltreatment, and yet child abuse prevention and treatment programs historically have been extremely difficult to organize, fund, and implement in the rural setting. Let's examine some of the factors that may be responsible for this difficulty.

Rural community attitudes, based largely on misconceptions about child abuse/neglect and maltreating parents, are a significant factor. A lack of awareness and education as to incidence and the impact of child abuse/neglect and its "spin-off" problems on the community (truancy, juvenile delinquency, crime, etc.) contributes to a lack of concern and, therefore, a lack of involvement and support. Small town conservatism, the perceived threat to parental rights and family privacy, fear of becoming involved and identified by reporting, lack of knowledge regarding the law and reporting procedures, small town politics and power structures, the geographic scattering of the population, and scarce or inaccessible resources all play a part in impeding the development of a rural child protection program.

Common to both rural and urban areas is the existence of a combination of "turfism" and "tunnel-vision" among professionals which interferes with the communication, cooperation, and professional respect necessary for a multidisciplinary approach to the problem. The lack of funding necessary for a coordinated program is also a vital factor and one which is usually dependent upon community attitudes and priorities.

As we describe the development of Project Children, we will relate the methods we employed in addressing these various issues. However, the underlying and most significant factor contributing to the progress of this program was our learning to work with people, professional and lay, in a manner that was non-threatening to the small community.

Project Children is a rural child abuse/neglect program serving a five-county area located in the south central portion of the state of Indiana. This region has a population of 142,000 people (approx.), with the population center of Columbus having 37,000 people (approx.). According to 1970 census data, this region is 61.6% rural.

The program was conceived in Columbus in the fall of 1971, arising from the involvement of a volunteer with an abused child and her family. The involvement and concern for this family developed over the following months, and exposed the lack of child abuse and neglect services in the area. After a period of becoming knowledgeable in the area of child abuse, speaking to organizations and groups, and creating community concern, this volunteer organized a group of professionals, who, in March, 1974, met to form what is now the Bartholomew County Child Abuse Council. This initial effort fostered additional child abuse councils in Brown, Decatur, Jackson, and Jennings Counties. Because of the regional scope that the program was developing, Quinco Consulting Center assumed responsibility for the coordination and funding of the child abuse program by inserting the position of program coordinator into a children's services federal grant application. (Quinco Consulting Center is a comprehensive mental health facility which serves the previously mentioned five counties.) The selection of the coordinator was a five-county cooperative effort, and was achieved in November, 1974.

The cooperative selection process was a very important factor. By involving various representatives of "the system", particularly the Directors of the five county departments of public welfare, we ensured, to a degree, their acceptance of and cooperation with the program coordinator. "Foreigners" are not always readily accepted by small town citizenry, particularly when they are professionals whose jobs may necessitate exposing faults within local agencies. Other appropriate disciplines were to be involved with the coordinator through the child abuse councils that had been established in each county. These councils are the linkages between the

local communities and Project Children. They are composed of professionals oriented towards the remediation and prevention of child abuse and neglect. The councils serve as a forum to discuss problems within the "system" and future program needs and direction. They also serve as vehicles for bringing together the "system" representatives, allowing for improved relationships, communication, and cooperation. Through the councils, the coordinator quickly became visible to each county.

Coordination of a program, whether in a rural or urban area, is essentially an effort to develop a more effective network or system for identifying and serving families where abuse and neglect occurs. Its purpose is (1) to develop a service network in which the various agencies' roles and relationships are clear, and (2) to provide the best system for helping families by avoiding overlapping functions and ensuring that essential services are available in the community.

The initial focus of a child abuse program should be a needs assessment. Questions that should be asked are: Is there a need for a child abuse program?; a coordinator?; should it be a new program?; could some alteration in an existing program achieve the required results? In our case, the initial needs assessment was conducted by individuals in the five counties, and the conclusion was that a program and coordinator were necessary.

In the initial stages of setting up our child abuse program, the goals were (1) to become visible in the community, (2) to become acquainted with those influential persons within the community, that is, the "community power structure", who might be later "recruited" for some service with regard to the program, and (3) to determine the community attitudes with respect to child abuse and neglect, program innovation, and reporting responsibility.

Determining community attitudes deserves additional consideration. It is very easy for professionals and so-called "experts" in child abuse to be "trapped" into telling a community what is needed. Forcing programs upon communities results in very little payoff and usually failure. Groundwork such as community awareness becomes a necessity. It is imperative for the community to want and support the various parts of the program.

A community education and awareness campaign in the rural area must be designed with a sensitivity to prevailing local norms and attitudes regarding child abuse/neglect. In our region, we encountered both complacency and an initial reluctance on the part of both lay and professional people to even acknowledge the existence of the problem. Therefore, an organized outreach effort was begun to inform and educate citizens regarding child abuse/neglect: etiology, identification, Indiana child abuse law and reporting procedures, child and family advocacy, etc. Letters offering a program on child abuse/neglect were sent to appropriate organizations throughout the five county area. Requests for programs came in slowly at first, but within a year had increased tremendously. Since December 1, 1974, 285 presentations have been made to various civic and community groups, plus junior and senior high school classes. Pamphlets and posters were developed and distributed to increase the public's awareness of child abuse/neglect, Indiana laws, and reporting procedures. Audio-visual materials were researched and acquired to aid in education. At the appropriate time in program development, the news media was contacted and involved on a supportive basis, by providing sensitive reporting regarding the problem of child abuse/neglect and local efforts to combat it.

Concurrent with education for the lay community, training for professionals began in anticipation of an increase in reports of child abuse/neglect. This was important in guaranteeing an appropriate response to the reporter and effective service delivery to the child and family. Failure to have the service system ready generally results in "turning off" the reporting public, particularly the professional, i.e., doctor, nurse, teacher.

Additional preliminary steps in establishing our program were to meet with representatives of the five county child abuse councils and also with the directors of the five county departments of public welfare to discuss their needs and also to identify problems.

The initial result of these meetings was a 2-day training session for D.P.W. child protection service staff. This took place two months after the hiring of the coordinator. The training areas included: investigation, use of authority, problem identification, developing a service/treatment plan, and the use of community resources.

There was a two-fold purpose for this training: (1) to bring these professionals to a certain level of expertise with regard to the various aspects of child abuse, and (2) to determine the various approaches that were currently being used in the five counties.

From this training, individual county child abuse case consultation contracts were developed. Presently, Project Children is providing up to 56 hours of child protective service consultation monthly to the five county departments of public welfare.

CHILD PROTECTION TEAM

After the January, 1975, training of child protective service staff and the initiation of a consultation service, an effort was made to develop a multi-disciplinary approach to child abuse. The rationale of this approach was that the individual child protection worker could not be an expert in medicine, psychology, and social work, but could be an expert in his own area, namely, child welfare. So the development of a child protection team began in February, 1975.

The essential member of the child protection team is a physician, preferably a pediatrician. The physician lends credibility to the team with other members of the medical community. He acts as a liaison between the team, the medical staff, and the hospital, and also adds his medical expertise to the abuse investigation.

Other members of the team may include professionals from the welfare department, mental health center (psychologist and social worker), police department, public health department, and, finally, an attorney.

Reasons for the inclusion of most of the members of the team are apparent, but why an attorney? The function of the attorney is to counsel the team with respect to ensuring both parents' and children's legal rights, and also to give guidance to the team with regard to the legal practicality of a recommended treatment plan.

After reaching the conclusion that a child protection team was needed in the community, the development, and then formal passage of, a hospital protocol for reporting suspected child abuse cases took place. Because of the nature of this protocol, the approval of various committees within the hospital, namely, emergency room, pediatrics and medical staff, was required. Again, the team physician was invaluable in expediting the protocol through the hospital committees.

As the protocol was being discussed by the hospital committees, a new focus was set for the team, that is, the development of a team procedure for handling child abuse cases. The child protection team is authorized by the county welfare department to investigate hospital-referred cases of child abuse/neglect. In conducting an investigation, the following evaluations are completed: a family study/social history; a medical evaluation of the hospitalized child; and a psychological evaluation of the parents/child. These evaluations are usually the responsibility of four people and are completed within 2-3 days after admission of the child.

The conclusion of the team process is the team meeting. At this meeting, after a discussion of the information that was obtained in the interview sessions, there are four questions that must be answered: (1) Was this child abuse/neglect? (2) Is wardship/guardianship necessary to protect the child? (3) Does the child need to be removed from the home? (4) What is the treatment plan, i.e., What services need to be provided and by whom? The most important question after abuse/neglect is confirmed is the treatment plan. What is essentially being asked is, "How do we try to help the family?"

After a treatment plan is formulated, these recommendations are forwarded to the welfare department, the case is assigned a coordinator, who is usually on DPW staff. The team meets periodically, every 6-8 weeks, to review the status of the case.

The Bartholomew County Child Protection Team was formed in March, 1975, and staffs approximately 30 hospital cases per year. Of the 60 or more cases that have been seen by this team, on only five occasions did the team recommend temporary removal of the child from the home.

Since March, 1975, two additional teams have been formed in other hospitals within the five counties.

Policies and accompanying guidelines were also developed for and adopted by the rest of the professional community (schools, law enforcement agencies, etc.) to assist them in handling suspected cases of abuse/neglect. Policy development was a cooperative effort involving representatives from each agency or discipline. Policy statements in themselves can do little to insure an appropriate response from a person or agency. It is the implementation of that policy by the agency that provides for a standardized and effective approach to carrying out individual and collective responsibilities. Implementation is achieved through a firm directive from the agency head and also specialized training to all staff. Training designs specific to each profession were developed for use in the various training programs.

PARENT AIDE PROGRAM

Following the development of the child protection team, an additional program area was developed, that of the parent aide. The parent aide volunteer program evolved because of a need. In our rural area, as is also true in many other areas, the lack of available staff, the lack of time to devote to the abusive family when much time is needed, and the threat that is imposed

by the DPW with regard to the removal of a child all indicated the need for an alternate method of servicing the abusive parent.

The parent aide volunteers are individuals who work with an abusing parent on a one-to-one basis. Their responsibility is to give these parents, who may be hurt, suspicious, isolated, and damaged, what is possibly their first experience in having a supportive, non-judgmental friend. The focus of the parent aide is to "nurture" the parent, not provide substitute mothering for the child (Parent Surrogate Program).

Where do you obtain volunteers? How are they recruited? The easiest way to obtain volunteers is with a community awareness program. In speaking to various groups, clubs, and organizations, members of the audience will inevitably ask what they could do to help. A newspaper article is also invaluable in the recruitment of volunteers. The first parent aide training began in July, 1975, with 17 volunteers.

There is a variety of ways to train volunteers. The volunteer could receive extensive training over a period of months, with the possible effect being an over-abundance of information and little experience. Extensive training may be beneficial, but also may result in volunteers losing interest and possibly dropping out of the program. On the other hand, a very brief training may not prepare the volunteer for his role. Our preference is to give a five-session training program.

After being periodically revised over the past two years, the parent aide training program includes the following areas: role of the parent aide; dynamics of child abuse; high risk indicators; crisis intervention; child abuse from the child's perspective; working with the parent; legal aspects; and confidentiality.

Following case assignment, periodic group meetings are held with the volunteers. During these group sessions, the volunteers have an opportunity to discuss the progress of their families/parents and also to talk about some of the problems they are encountering, with the possibility of obtaining a solution from another group member.

Included in these group meetings is an on-going training session. Speakers are brought in to discuss Goal Attainment Scaling, (a research method used to evaluate the progress of the client), the "helping relationship", child management approaches, Parent Effectiveness Training, and communication skills.

Parent aides are assigned cases from the welfare department, mental health center, Head Start program, and Family Service Agency. In each case, the volunteer is supervised by the referring caseworker. Additional supervision and coordination are provided by the program's coordinator of volunteers.

There have been 42 parent aide volunteers trained since July, 1975, and they have worked with 78 families. The average length of involvement with each family is 14.6 hours per month for 5.9 months. There has been noticeable positive change in the majority of the families involved with this program.

PREVENTION

In the area of prevention, we initially focused on two identified needs: (1) a child care facility that would serve children 0-6 years of age,since existing programs accepted only the children 3-6 years of age, and (2) an education for parenthood course as part of junior and senior high school curriculum. We were instrumental in mobilizing community support for the development of a comprehensive child care facility (Columbus Child Care Center, Inc.), which is scheduled to open in the autumn of 1978. The center will accommodate 240 children, 0-6 years of age, has the capability of providing 24 hour (crisis) and drop-in (respite) care. The development of programs designed to strengthen, improve, and enrich family life will also be a part of the center's services.

An education for parenthood course (Exploring Childhood) was added to the curriculum of one junior high school in 1976 and is now in the planning stages in three additional junior and senior high schools in the region. Our role in this effort was to document the need for education for parenthood, assist the schools in obtaining information and materials, and promote the addition of the course as a requirement for all students.

EFFECTIVE PARENTING

Another area of prevention is an effective parenting program. The program that is being used is Systematic Training for Effective Parenting, (S.T.E.P.) produced by American Guidance Service (Dinkemeyer and McKay).

The S.T.E.P. program is a nine-session program that meets weekly and discusses the following topics: the child's goals in misbehavior; encouragement; effective listening; exploring alternatives; natural and logical consequences; I-messages; reflective listening; and the family meeting. The program has been slightly altered to better fit the needs of our clients.

This program was initiated in January, 1977, with a group of families having difficulties in the areas of abuse, neglect, and child management. All members of the initial group were clients of the county welfare department.

Although there was some difficulty in adapting this program to the "lower functioning" client, present plans include additional effective parenting programs to include the parent aides and their clients, and also a group open to the general public.

SUMMARY AND CONCLUSION

In conclusion, we have tried to explain how a rural child abuse program was established, specifically, Project Children. We do not make any claims that Project Children is an ideal program, by any means, but we feel that our effort has been worthwhile, has had a positive effect upon the community, and has had a significant impact upon the problem of child abuse and neglect within our region.

The purpose of Project Children is to help families learn to deal with their problems in a way that results in non-abusive behavior toward their children and improved family functioning, with the result being an intact, healthier, happier family unit.

Project Children has been in operation since November, 1974. In that period of time, 10 new programs have been initiated within the five counties. Although this program may not be unique for an urban area, it may well be unique for a rural area.

We, like most rural areas, have limited resources, but we have endeavored to put these resources to their best use. We are fortunate to have a group of professionals and lay people who, while being active in other areas, are dedicated to a cause—the prevention of child abuse and neglect.

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Organizational and Research Strategies for Families of Abused and Neglected Children in Large Cities

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This paper will proceed on the assumption that large cities require specialized strategies to effectively bring community resources to bear on problems of child abuse and neglect. The large urban institutions with responsibility in this area are like most formal organizations in these times, experiencing an increasingly turbulent environment. The focus of the discussion will be organizational and research strategies employed primarily in Cook County, Illinois (pop. 6 million plus), with some observations from a parallel study in Los Angeles County. Perspectives presented here represent mid-stream data from organizational and research activities currently underway, but not as yet concluded.

These perspectives emphasize strategies applicable to development of program innovations and/or conducting research in the complex systems that exist in large cities. Where appropriate, literature from inter-organizational field and evaluative research will be drawn upon to provide a conceptual framework for a model to improve services to families of abused and neglected children.

THE ENVIRONMENTS OF ORGANIZATIONS

Traditionally, formal organizations in urban areas are organized along sectoral lines such as the educational system, the health system, the legal system, and the welfare system. Primary communication and interactions of organizations tend to be with organizations within their own sector. Emery and Tryst (1965), in discussing types of organizational environments, refer, to this traditional pattern as a "disturbed reactive" environment where "similar organizations are important factors in the organization's field...and choices are based on calculated actions of others and counteractions". An example of this phenomenon in the field of child abuse can be observed in the responses of some children's hospitals to Kempe's (1962) research and publications relating to the "battered-child syndrome". Children's hospitals in Boston, Chicago, Los Angeles, Oakland, and Pittsburgh all have well-established programs for detection and follow-up of child abuse cases. Along with Denver, these organizations are providing significant leadership in the field.

However, Emery and Trist further suggest that an evolution of environments is taking place, affecting formal organizations. They describe an evolving turbulent environment in which "dynamic processes arise from the field itself". Shirley Terreberry (1968), expanding on this idea of a turbulent environment, suggests that contemporary changes have "increased the ratio of externally induced change to internally induced change...and that other formal organizations are increasingly important components in the environment of any focal organization (p. 582)...Turbulent environments require relationships between dissimilar organizations whose fates are independent (p. 600)."

Recent developments in the field of child abuse and neglect suggest that organizations are experiencing a turbulent environment in which dynamic processes occur as the result of interaction and interdependence with other formal organizations. Child abuse and neglect reporting mandates specific professions to make reports. Agencies are designated to receive reports and conduct investigations. Still other agencies may have to assume costs incurred, e.g., public welfare paying hospital costs for children remaining in the hospital to permit investigation of potential child abuse or neglect by the child protective services and/or the police.

Within the framework of this analysis, these externally induced changes contribute to the turbulent environment of the organizations affected. The organizations then become, without intending to do so, more interdependent upon each other. Each organization finds it increasingly difficult to "control the compounding consequences of its own actions...increasing the complexity and the acceleration of the rate of change in the organization's environment" (Terreberry, p. 21). If, for example, a protective services agency or volunteer community group undertakes a vigorous media campaign to develop awareness and encourage reporting of child abuse and neglect (Sussman and Cohen, 1975) the agency itself, as well as other agencies, can experience overwhelming demands for service, as was seen in the Florida media campaign in 1976.

EXPLORATORY STUDIES REVEAL MAJOR PROBLEMS

Two exploratory studies of child protective services in Cook County in 1975 and 1976 revealed serious deficits in the provision of services to families of abused and neglected children. The American Humane Association study found that 60-75% of children being reported for abuse and neglect were being removed from their homes, and up to 80% of cases reported involved referral to juvenile court (American Humane Association, 1976). Initial findings of the current research project by the University of Illinois showed heavy reliance on foster placements and also an inordinate length of foster placements (Brown et al, 1976).

Both of these studies made recommendations for reorganization of emergency protective services and identified specific program and staff training needs. These studies, while focusing on the problems in one agency, also identified major factors in the environment of the organization that influenced its performance capability. The American Humane Association study observed that "too frequently the function of child protective services is pre-empted by actions of police and hospital personnel" (p. 16) resulting in high placement rate of abused and neglected children.

The agency undertook recommended internal reorganization and conducted intensive staff training to overcome these identified problems. However, major problems persisted. It became clear that the wider array of organizations that shared responsibility in the area of child abuse and neglect would need to become involved. It was also determined that there was little objective information about the extent of the service demand and the nature of actions of the various agencies.

The question was raised as to how research efforts could be undertaken to provide information that would identify the system dysfunctions, and provide factual data for decision making. Illinois, along with many other states, had recently enacted broadened child abuse and neglect reporting legislation. The environment selected for research was the justice system in Cook County, involving both adults and juveniles. The policy focus selected for the study was to "establish the impact of child abuse and neglect reporting laws on the justice system in Cook County, identify critical issues in handling this type of case, and develop recommendations for program innovations."

Given the fluid and undefined development of inter-organizational relations and programs, a formative evaluation approach was taken. This approach requires a great variety of instruments, with considerable reliance on observation and informal data collection, and a "sense of curiosity" that looks for explanations of problems and potential solutions from rather unorthodox sources, e.g., bureaucratic legends, anecdotes, and value preferences (Gifford, 1973). These are obtained in the process of becoming acquainted with the various systems and the individuals occupying key positions at various levels of each organization.

PATTERNS OF INTER-ORGANIZATIONAL COMMUNICATION AND INTERACTION

Anticipated resistance of practitioners to participation in the research project simply has not materialized. Although professional staff in the agencies were operating under heavy work-load pressures, they seemed to welcome the opportunity to be interviewed. The interviews immediately suggested certain prevailing conditions in the inter-agency relationships, including:

- fragmentation of effort
- multiple investigations with multiple consequences
- minimal contact of direct service personnel across agency boundaries
- confusion among agencies over each other's functions
- absence of mutually acceptable criteria for shared decision making
- communication among agency administrators primarily on a complaint basis
- minimal sharing of information and absence of feedback on actions taken on referrals.

In interviews, agency personnel were often extremely critical of what they perceived as arbitrary actions by other agencies. This sense of hostility seems to be based partially on the professional's own frustration at being unable to realize his own objectives for the children and families involved. Another less obvious source of tension was goal conflict, e.g., the conscientious youth officer, having observed the family in crisis and the injury or neglect of the child, tended to consider removal of the child as the only option to ensure his safety. There was tension when protective services staff, pursuing the objective of keeping the child in the home, would not concur that placement was necessary. In some cases the youth officer would arrest

the parents, thus forcing placement. Other types of conflictual issues were apparent between the court and protective services.

Administrators gave verbal support to inter-agency cooperation but were frequently pressed by their own staff to press complaints with other agencies. Their frustration seemed to be that agreements could be made at the administrative level, but problems in the field continued to persist.

STRATEGY NOTIONS FOR EFFECTING INTER-ORGANIZATIONAL COLLABORATIVE EFFORTS

PROPOSITION 1:

> Formal organizations engaging in collaborative efforts with other organizations on critical problems and evaluation of service delivery will more readily maintain participation under conditions of low visibility and absence of public controversy.

This proposition suggests that organizations can engage in mutual problem solving, including dealing with evaluative data documenting problems in their agency, if certain conditions are met, including:

1. That mass media does not have ready access to potentially embarrassing data;
2. That all participating organizations are mutually vulnerable to potential negative findings in collaborative discussions;
3. That organizational elites in each system acquiesce to participation of organizational representatives.

Bernard Gifford suggests that "bureaucratic inertia is often the most rational response to a controversial issue" (p. 29). Since the project was designed to provide on-going feedback of data to have impact on agency operations, a deliberate tactic to avoid the hazard of public controversy was established. An interim report circulated among the agencies in the fall of 1976 contained findings that might have been exploited, and therefore was not circulated to the media. This interim report provided a factual basis for a mutual frame of reference for subsequent policy deliberations and clarification of research questions.

This tactic places a considerable burden on the researcher who is collecting data that may reflect poorly on an agency. It is sometimes difficult but necessary to challenge preconceptions and ask hard questions without insulting or alienating those involved. There is the delicate balance of creating unrest with the status quo without "shattering the fragile psychological membrane separating resentment and reassessment" (Gifford, p. 30). If evaluation data is provided to agencies at regular intervals in the process, the potential negative impact is minimized.

PROPOSITION 2:

> In turbulent inter-organizational environments a third agency can often facilitate creation of an organizational structure which can address common problems emerging from divergent policies of participating organizations.

The prevalent practice in large organizations of using technical consultants has the advantage that these consultants, as third parties, have greater access to all levels of the hierarchies. This process can facilitate communications and gain information from all levels.

The researcher who engages in policy research in an inter-organizational setting also occupies a third party role among the participating formal organizations. The researcher, without power to change or control policy of the organizations, can serve as a non-threatening third party and take initiatives which participating organizations are reluctant to assume. In the Cook County project there is no hierarchy of organizational participants due to independent authority structures. All organizations have equal power, which provides a feasible basis for mutual problem solving (Bennis, 1962).

An innovative feature in the research design called for a "policy panel" to review procedures and findings of the research at periodic intervals. Jerald Hage (1974) observes that a "large number of evaluation studies have absolutely no impact on organizational networks" (p. 2). Delbecq (1976) suggests that "continuous involvement of some representatives from the institutional level...be built into the organization of the research effort...A policy committee overseeing the evaluation effort is often a structural mechanism to facilitate this involvement."

The policy panel became a functional part of the research project, making it more likely that the research findings would have an impact on programs and policies dealing with abuse and neglect. The policy panel is composed of decision makers in the courts, protective services, the prosecuter's office and the police. The panel is seen as providing:

1. Access to key decision makers with intimate knowledge of the system involved;
2. Feedback on staff's perceptions of researchers and interpretations of data being developed;
3. Legitimacy and sanction to the research effort;
4. A vehicle with shared membership across agency boundaries which facilitates communication among the agencies in a non-threatening setting.

In preliminary contacts with organizational elites, the policy panel idea was accepted. In fact, given the traditional paranoia about outside researchers, the institutions perceived the policy panel in an "overseer's role."

The policy panel formally recommended the creation of an Interagency Council on Child Abuse and Neglect, and specifically requested the researcher to issue (on project stationery) invitations to participate to the top administrators in their agencies. As a result, many of the panel members who had administrative responsibility for handling child abuse and neglect cases in their agencies were named to the Council.

As mentioned earlier, serious conflicts in policy were becoming evident. The Council was perceived as an opportunity to deal with these critical issues. In this way, the agencies acknowledged their own organization's increasing interdependence on the policies and procedures of other agencies. This suggests an empirical validation of Terreberry's thesis mentioned earlier. It seems further to replicate a process observed by Maniha and Perrow (1965) where "a city youth commission...was seized upon as a valuable weapon by other organizations for pursuit of their own goals."

PROPOSITION 3:

Formal organizations participating in inter-organizational structures more readily participate in mutual problem solving when presented a range of alternative potential solutions.

The model being described here differs from the traditional rational planning for human services. It seems that the rapidity and complexity of change precludes effective long-range planning. "Increasingly, the rational strategies of...long-range planning are being undermined by unpredictable changes...Rational decision making gives way to disjointed incrementalism...If the environment is predictably unstable then the process must be short-run adaptive measures" (Terreberry, p. 595).

The researchers in this project have been involved in research in Cook County in the area of child abuse and neglect for a period of four years. It has become clear that there will be no grand plan devised to deal with the complexities and serious issues in handling child abuse and neglect cases in Cook County. A strategy has been adopted which partializes specific problems while identifying the multiple sources of system dysfunctions, e.g., the high placement rate of abused and neglected children in Cook County has been identified as a problem of several different agency procedures. The research has allowed the recognition of the problem without any single organization being seen as the culprit. Incorporated in this mutual acceptance that a problem exists is that solutions will require adjustments among all the participating agencies.

It was foreseen that since the research does document the existence of critical problems, this might coalesce defensive responses from participating organizations, and a deliberate tactic was adopted to avoid this. In addition to identifying multiple sources for problems that exist, potential alternative solutions were presented alongside the problem statements. This tactic used with the policy panel tended to avoid the assessment of blame for problems and shifted attention to each organization's potential interest in the alternative solutions presented.

PROPOSITION 4:

Formal organizations participating in inter-organizational activities will be more likely to maintain their participation if benefits accrue for their own organization.

Up to this point the discussion has dealt with the extent to which it is in the self-interest of formal organizations to participate in mutual problem solving with other formal organizations in their environment. Conceivably, a formal organization may extend substantial resources in this direction without being able to demonstrate how this activity maintains and promotes its own specific goals. There must be demonstrable pay-offs for each organization in order for this commitment to participation to continue. Rothman, Erlich and Teresa (1976) suggest that practitioners (in this case researchers) should provide or increase appropriate benefits in order to foster participation.

A combination of events within the project has enabled the research project to engage in specific activities which both enhance the formative evaluation nature of the research and provide visible benefits to the individual organizations involved. One of the project's objectives was to assist the organizations to develop recommendations for program innovation to meet the problems identified. In the early fall of 1976, the project, in submitting its application for continued funding, committed itself to provide professional consultation for developing the series of program innovations recommended by the project's policy panel. Several of the recommendations provided for innovative programs to be developed within individual organizations, e.g., the panel recommended the creation of a police child abuse unit within the Youth Division of the Chicago Police Department. The endorsement of a child abuse unit by other major agencies strengthened the Youth Division requests for budget allocations for this purpose. The project, through its own funds, brought in a consultant from the Los Angeles Police Department's Child Abuse Unit to meet with police officials and conduct a workshop for police officers on handling child abuse and neglect. Providing this kind of support of police participation has enhanced the research project's access to police officers and records and has assured on-going participation of police in the inter-organizational structures of the Council and the project's policy panel.

CONCLUSION

In conclusion, it can be said that large cities do present significantly different challenges to effecting improved services to abused and neglected children. One associate referred to Cook County as "Chaos County" after having worked for changes among the large social agencies. It does not appear that a complexity of problems is unique to Cook County, however. Every major city has experienced this kind of fragmentation and system dysfunction. This paper has suggested some focused organizational and research strategies supported by current and ongoing observations.

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Workshop participants

The workshop on management techniques:
Walter Deines and David Chaves

Workshop leader

The workshop on Parents Anonymous

Alternative Approaches

What Kind of Alternative Delivery Systems Do We Need?

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In discussing the role that volunteer or community-based programs can play in the child abuse and neglect service delivery system, I rely on experience as founder and director of SCAN Volunteer Service, Inc., founded in 1972 out of a community's need to provide more intensive service to families with a child abuse problem. SCAN is a private agency, contracted through Arkansas Social Services on Title XX monies, with an additional HEW demonstration grant. SCAN is presently operating in 9 counties with a staff of 40 professionals and approximately 200 trained lay-therapists. In the year 1976-77 SCAN provided service to approximately 7,000 clients.

SCAN's treatment modality utilizes lay therapists who provide direct services to families referred to SCAN. The second component of SCAN Volunteer Service, Inc., involves investigation of all reports of child abuse. The third component is to establish a multidisciplinary team in each hospital. The fourth component is to support and sometimes sponsor Parents Anonymous groups. Each of these components exists in counties with a SCAN unit.

Included in the professional staff is an agency attorney and a clinical therapist, who provides group and individual therapy to clients as well as being available to SCAN personnel. Matching monies for Title XX were provided by community resources such as Quorum Court, Junior League, city government, and private donations.

All lay therapists and staff members are required to take the SCAN training, which involves an initial three-day, twenty-four hour training with professionals who have had experience in the area of child abuse and neglect. Before and during this training, all potential lay therapists are screened carefully by staff members. Some of the topics covered in training are: "Why Do Parents Deviate?" (Dr. Lois Malkemes); "Identification of Physical and Emotional Abuse (Dr. Linda Markland, Pediatrician); "Understanding of Sexual Abuse" (Dr. Joan Hebeler); "Legal Aspects of Child Abuse" (Ted Skokos, Attorney); "Transactional Analysis: A Framework for Understanding Human Behavior" (Phyllis Oddie, Clinical Transactional Analysis Therapist); "SCAN Treatment Modality" (Sharon Pallone, Founder-Director, SCAN); and, "The Role of Lay-therapists: Caution, Human Beings Live Here" (Rita Clubbs, State Coordinator, SCAN).

The SCAN training presents information regarding child abuse and neglect. In addition to the information, time is spent in the area of developing self-awareness on the part of the lay-therapists. The areas of self-awareness that we feel to be important are the lay-therapists' recognition of their own fear and anger toward child abusers and, finally, a deeper awareness of their own humanity. After the initial training, lay therapists are in contact with the professional staff members at least once a week and are required to attend a staffing for in-service training and case management every other week. Consultation teams are available to the lay therapist in staffings.

Each lay therapist provides intensive support services to three families. The lay therapist (as well as the total staff) is available to the family (on call) 24 hours a day, seven days a week. The lay therapist's role is to visit the home frequently. Many lay therapists spend as much as 20 hours a week in the home. Their role is to help the client develop a positive self-concept and self-understanding—to "reparent" the parent, to set limits, to provide child development information, to provide community resource information, and to provide transportation. They encourage the clients to: sort, reorder, and be aware of their own needs; to explore ways to meet their needs and manage lifetime patterns; to examine unrealistic expectations of life; and to develop impulse controls by assuring small successes and develop energy release systems, such as structured recreation. Each lay therapist is reimbursed $50 a month.

Since 1972, SCAN Volunteer Service, Inc. has been used as an alternative delivery system to families with child abuse problems, the lay therapist being the prime caseworker and coordinator of services. SCAN has been effective in nine Arkansas counties, with no appreciable abuse recurrence in the SCAN-aided families. In 4½ years, there has been not a single fatality in any of those families. SCAN and Arkansas Social Services have developed cooperative procedures which include procedures for reporting and foster care placement. SCAN has successfully coordinated programs with community agencies and has developed a network of

services for families with a child abuse problem. The legality of SCAN is confirmed through the Arkansas State Plan for purchase of services contract (Title XX) with Arkansas Social Services.

SCAN LAY THERAPIST TRAINING

To further explain the role of the lay therapist in our program there follows the initial information presented to potential lay therapists by a SCAN staff member at the beginning of their training:

When I began thinking of the remarks I would like to share with you, the idea for the title of this article came to me. I want to call it, "Caution, Human beings Live Here." I would like to share with you my thoughts and ideas on working with abusive families in their homes.

What do I do when I go to a home? What would you as a lay therapist do when you go up to that door and knock for the first time? When I think of the many times I have been out to homes and remember that the 500th time was almost as scary as the first time, I think I know what is probably going on inside of you. "I just cannot do this. This is for somebody else. The theory is great, but I just cannot bring myself to walk up to that front door." Yes, you can. We all have a first time. The first time out of the chute is a little scary, but the adrenalin will always be pumping, and it's going to help you. You're going to need it.

What do I do? I simply go up to the door. I knock. I wait for an answer. I say "Hi, I'm Rita Clubbs from SCAN Service. May I come in?" Sometimes, people think I'm the Avon lady or what have you. But once I get into the door, then I make it very apparent who I am and why I am there. Now as a lay therapist, you are not going to have this problem. The people are going to be expecting your visit because the director or evaluator will have broken the ice prior to your visit.

My favorite lines, which perhaps are no longer very original but still prove effective, are: "I understand you may be having some problem with your children. I'd like to talk to you about that." Then I ask for permission—for everything. "May I come in? May I sit down?" I always remember that I am in another person's house by invitation only. I have no right to push myself into his house without his permission.

Once in the house, relax. This is perhaps the most difficult thing you lay therapists will do in the first visit. But remember that your body language says lots of things. If you are sitting there very tightly rolled into a ball, or if you are sitting with your purse clutched tightly in your lap as a protective shield, it will be obvious that you are extremely frightened and this may escalate their fear. I truly believe that fear is contagious. So if you possibly can, relax and try to realize that you are just human beings sitting in a room talking together. It's really not that frightening a situation when you think about it.

On the other hand, as nonprofessionals, some of this fear could work for you. Somehow, if I know that the person I am sitting across the room from is as frightened as I am, then he is not quite as threatening to me. So if it is there in spite of yourself, go with your fear. If it is real and you cannot relax, go with it and enjoy it, so to speak. The fear will go away in time.

On the first visit of the evaluator, there are certain things that he or she looked for. However, evaluators cannot always pick up all the necessary information in one interview, so it may be helpful for you lay therapists to try to mull over in your heads the type of things that the SCAN staff needs to know about the families with whom we work. I'll go through them very briefly.

It is important to understand the social history of the people we are working with. By that I mean a number of things. What pattern of stability or instability has there been in the past? Has the family experienced many moves, job hopping, financial stress, marital problems? Are they new in the community? Has there been prior agency involvement? Trouble with the police? If they start telling you about their social worker at the MHC or their outreach worker from OEO, you should begin to realize there are other agencies in the community that have obviously felt that this family was or is in distress. That's a good indicator that SCAN is not the only agency that suspects a problem. That, of course, in no way implies that the family is definitely abusive, but it may be a valuable piece in a puzzle whose whole picture will tell us much.

A thorough social history should also include information about the parents' own childhoods. And I do mean parents. Never make the mistake of omitting one parent. Ask appropriate questions. "How do you remember your Mama and Daddy?" Or, "Were you raised within other arrangements, such as by your grandmother, in foster care, etc.?" "Are you close to them now?" "What was your relationship like with your father?" What you (lay therapists) will be looking for in gathering this information is a feel for the kind of parenting your clients received. Was there good role modeling in their backgrounds? Or was there violence or

indifference in their family histories? Is indeed this person before you a product of an abusive environment? We know that a large majority, perhaps as high as 90 percent, of abusive parents were abused themselves as children, either physically, sexually, verbally, or emotionally. So knowing about people's own childhoods is helpful.

What is the marital situation? Are mother and father supportive of each other? Do they generally agree on child rearing practices? Nobody agrees all the time, but overall, in general do they agree on the proper way to handle a child? Is this the sixth marriage or the first? Indeed, are they married at all? If not, I think it behooves us to remember that everyone does not choose the same way of life. Try to be nonjudgmental about it and try to understand that SCAN works with the family unit as we find it. And that may mean working with mother and boyfriend or two grandparents.

Try to get some information about the finances and employment situation. If father has been unemployed for the last eight months, you can bet that the family's stress level is very high. Perhaps father flits from one job to another. That's a good indicator of his instability and probably points to financial problems within the family. Maybe both mother and father work odd hours. If mother works from twelve o'clock at night until eight in the morning and then comes home to two children under the age of six, I think you can see that's a setup for real problems, (and that situation is taken from an actual case history). We find many mothers and fathers who work all night and then try to deal with preschool children all day. That's a powder keg for anyone!

It is also important to thoughtfully observe the appearance of your clients, and by that I do not mean simply physical appearances. Yes, it is important to note that it is two o'clock in the afternoon and mother is still in her house coat and nothing much seems to be going on in the way of personal hygiene. Please learn to be quietly observant. Don't overlook the obvious, such as mom's black eye; these things should be apparent simply by looking. But also look for the affect of the client. How does he present himself? Does he maintain eye contact? When he talks to you, do his eyes flit nervously from one side to the other? Are they comfortable or fidgety, calm or on guard? The answers to these questions, of course, must be weighed carefully, as any number of reasons can account for human responses to a situation.

Can you find out if they have a doctor? Get his name. Has there been medical care for the children in the past? If a child is five years old and has never seen a doctor, general neglect or lack of concern in the parents is evident.

Observe the living arrangements. What is the housing like? Is there adequate space and furniture? Bathroom facilities?

All of the questions I have spoke of so far are relatively easy for all of us to obtain answers to, but it is the hard dynamics of abuse that are the most important items. Let me share some of these dynamics with you.

First, is isolation. Is the family emotionally or geographically isolated? The family may very well live in a large apartment complex but not know their next door neighbors. The isolation may be self-imposed because of the existence of a second dynamic, mistrust. By and large, abusive parents are unable to view others as trustworthy. Something happened in childhood to make them decide that people, even life in general, is not trustworthy. Perhaps the very persons they turned to for love and warmth and protection were the very people who turned on them violently and bashed heads and broke bones, or hearts, with words. So eventually they withdrew or became hostile as a means of self-preservation. By the time we in SCAN meet them, a pattern of mistrust has been long established. It has become their way of dealing with the world. Believe me, it will take a tremendous amount of time and patience before you will be able to overcome their mistrust of you.

A third abuse dynamic is unrealistic expectations of children. Many abusive parents have little or no knowledge of children's developmental stages and demand far more than their kinds can give. Do they expect nine-month-old Johnny to be toilet trained? Do they expect four-year-old Suzy to care for three-year-old Michael while they go shopping? Do they expect a two-year-old to be still and not heard while he is in the house? Do they not allow their children to have friends and playmates? Do they expect their children to parent them and fulfill their emotional needs?

A fourth dynamic is inability to cope with stress. Evaluate the stress factors in the family and remember that what may not be a stress to you could easily be a monumental stress to the parent. So I am not asking you to look for what would be stressful for you. It's what's stressful to the parents that counts. The fact that the mother-in-law is coming for the weekend can be a severe stress-causing situation to a girl who views that person as a critical parent. Or the stress

can be precipitated by something as small as the refrigerator breaking down. The cause of stress is always personal.

The last abuse dynamic, I feel, is the most important. It has to do with the client's self-concept. Most abusive parents that I work with have very low self-esteem. They perceive themselves as worthless and inadequate. And chances are when you first meet them they are functioning in a manner that bears witness to their beliefs in their worthlessness. Undoubtedly, this started in childhood at the hand of a parent. It will be a major portion of your job as lay therapists to enhance the self-esteem of your clients by positive stroking.

The aforementioned are certainly not the only abuse dynamics. I do feel that they are the five most important: isolation, mistrustfulness, unrealistic expectations, inability to cope with stress, and low self-esteem. One other, however, bears mentioning.

I always want to know what the word discipline means to the parents. This is very significant. Many abusive parents feel that discipline and physical punishment are synonymous. I personally do not believe that, nor does Webster. The definitions are different. If they feel that they are one and the same, then I call this their "normal" way of discipline. It is going to be interesting to give them some information about appropriate means of discipline. Discipline is a way of life. My child gets up and goes to school willingly in the morning because her father and I get up and go to work willingly in the morning. We always have, whether to work in the home or office, and she has always seen this. My child comes to the table and eats dinner because that is what the rest of the family does around six o'clock in the evening. It is truly a way of life. It is not something I have had to impose on her by force. However, many of our clients do not understand discipline in that way.

Now while you are looking for all of these psychological indicators, you may, out of the corner of your eye, see a child who has a slash mark across his face. Or it may be a little boy who in ninety-degree weather has on long sleeves and long pants. One of our lay therapists told me about seeing an infant, who, in the summer, was still wearing a cap. So look for the obvious signs of abuse. Then, if you can, focus on it and say at some point, "Can you tell me what happened the hour Johnny was hit? Let's go back and reconstruct what was going on with you, (mother or father), before you doubled up your fist and socked Johnny in the stomach?" Generally speaking, if you can help the people get some insight into the stress factors, they will learn to recognize high risk situations and perhaps get themselves out of them before they trigger abuse.

Another thing I want to tell you is, please, go with your subjective impressions. Many times a lay therapist has come back into the office and said, "I saw no bruises. Mary seemed very happy to sit on her mother's lap. Everything looked wonderful, but I have a gut feeling that something was wrong."

I once went out to a home because there was a report that a child had been blinded and crippled due to severe abuse. I was told that there were four boys in that family and that the one being abused was the three-year-old. I saw four boys in the family and none of them looked as if they had been severely abused. But the story had been so specific, so bizarre, something told me that there really were five children in that family. There had to be another child somewhere in that house. I decided to go with my gut feeling, and when I walked into the back bedroom, I found the most abused child that we have ever removed in Jefferson County. Call it woman's intuition, call it social worker savvy, but go with it. If you are wrong, you just walk back out of the bedroom, and no harm has been done. Use some of your gut level instinct. It is coming from somewhere.

Let me give you some examples of some typical remarks that you might want to discuss with the people to whom you are talking.

Do you have a "bail out?" Whom do you go to when times are really rough? I know to whom I go. There is a certain hierarchy in my bail out system. Husband first. If he is unavailable, mother second. If she is not there, sister, and I go right down the line of ten people until I get the help I need. The people we are working with do not have this system. They feel that they must resolve their own problems. That's what being adult is all about, they tell me. You have to take care of everything yourself. Give them the information that this is not necessarily so, that it is really okay to reach out to another human being when you are in distress.

Ask your clients if there is one child who is more difficult to manage than another. Any of you who are parents can probably think of your own two, three, seven children and pick out the one who would "get it" if you were abusive. Every family has one. There is a child who is a little bit more difficult. He is extremely active, too shy, or very, very bright. He is always coming up

with crazy remarks, and the parent does not know what to do with him. Perhaps there is a chronically-ill child that requires a great deal of attention. So find out if there is a child who is perceived to be more difficult than another.

Ask them, "What pressures are on you right now?" Keep them in the here-and-now. Often you will find clients who will tell you what happened to them when they were two years old and living at grandmother's house. Try to make them focus on now. There is nothing we can do about the past. It is gone forever. We are not really sure what the future is going to bring, but let us deal with just a little chunk of what we've got right now.

Now in doing all this, what are your goals or what should your goals be during a visit? The goal could be to have a good time, to establish rapport and do nothing. Never underestimate what that could mean for you and your client. Often, just going out for a hamburger works wonders.

Overall goals would be, especially in the early part of the relationship, to establish a warm rapport, even with a hostile client. Most hostility comes from a base of fear. Once parents are not quite so fearful of you, you can establish a relationship. Think of the things that you have in common. Sometimes it must be very basic. We are both women. And if we are not, we are both human beings. There is going to be something you have in common. Work on that.

Offer hope. We run into people who are living many times in spiritual and emotional vacuums. They feel helpless and hopeless. If, for a while, it has to be your strength and your energy that pulls them up a little, give them that. If I saw a man drowning in a swimming pool, I would not shout instructions on the Australian crawl. I would jump in and pull him out and then later teach him how to swim. So first things first. Get them out of the water.

Explain, perhaps, why abuse does happen. These parents really are not monsters. Any truthful parent has had angry feelings toward a child. Any truthful child has had angry feelings toward a parent. It is not that you have the angry feelings that matters, it is what you do with that feeling. One of my favorite sharings with my clients is, "Just because I fantasize myself running off with Paul Newman does not mean that I am really going to do it. But it's fun to think about. Your fantasies are not really going to get you into that much trouble; it is acting out your impulses that is going to get you into serious difficulty."

Explain SCAN to them. They will probably know that SCAN is a child abuse agency. The evaluator who has been there before you will have gone into some cursory explanation of it, but tell them what SCAN is really all about. "Yes, it stands for Suspected Child Abuse and Neglect, but I am here because I am a volunteer, because I really want to be." Remember how healing that can be. I know how much better I feel when someone has come to my house because they really want to see me, rather than because they are being paid for a job. Explain to them what a lay therapist does. "I want to be your friend. I want to help in any way that I can, and I will stick with you. We will walk through this problem together. If you just need someone to talk to at two a.m., I am going to be available to you at two a.m." And make sure that you are.

Perhaps you should explain Parents Anonymous to them, and what that group has to offer them. It is a self-help group. Lots of other people will be there who have experienced abuse problems with their children. Some are new and some have already worked through many of their problems. Wouldn't it be nice to have somebody to share these things with?

Most of this until now has been fairly cut and dried. Remember these techniques; use them when they seem appropriate. And if you don't like any of them, throw them out, because they're mine. If they're not effective for you, don't use them.

I can say just a few things in general about relating to clients, remembering all that we have heard before about the type of people that we will be seeing. Remember things that you know yourself about relating to families and friends. Be a good listener; that's so important. I know that I have a tendency myself when I get nervous to chatter. That's my defense mechanism. But because I know it, I can handle it a little better now, instead of denying it. So, if I get very nervous and start chattering, I immediately just stop talking. Silence is very effective. I have never yet met a person who could sit with me for 30 seconds of dead silence without feeling compelled to say something. Now I may tomorrow, but usually the silence becomes so uncomfortable for them that they start saying something.

Clients can perceive your disinterest, your value judgments, and your animosity easily, so be careful about those and think them through yourselves. Say to yourself, we are human beings here, and because he is a human being, he is worthwhile.

Never make promises that you will not be able to keep. This goes into some of the mechanics of foster care. Never promise a client that you can remove a child from the home or

that you can return a child to the home. Only the juvenile court referree has that power. So don't make promises that you don't know you can keep.

Be punctual. Model punctuality and honesty. Sometimes parents are going to ask you questions that you would rather not deal with. Some may be of a personal nature; some are going to be hostile. For example, "Why don't you stay at home and take care of your own kids instead of being so nosy and coming out here?" What would you say? How would you feel? "Why don't you lose ten pounds and quit telling me what to do? You're a fat slob." Everybody has an Achilles heel emotionally, so deal with some of this inside yourself and be honest with what you have to offer.

Make sure that your nonverbal messages to the client are positive. Be yourself, you really are enough. As a matter of fact, not only are you enough, you're all you have. There is no more. So use what you've got. Make up your mind to sit down in the feces on the sofa. Your clothes will wash. You really aren't going to die from that.

Sometimes you are going to have to move around 30 boxes to find a place where you can sit. But try not to make a negative judgment that is obvious to the parents. Trust yourself to know what is appropriate. Know that you don't know all the answers. Neither do I. Neither do the psychologists or the psychiatrists. I haven't met anybody yet who knows all the answers. So do what you feel is appropriate. Remember you are 20, 40, 60 years old and you have learned some things in those years. You've learned about socialization, about being a friend, about parenting. Use what you've got.

And the flip side of that is let your clients use what they've got. Don't be afraid to listen to what your clients are saying to you. I have learned more from my clients than I could ever have possibly taught them about what it is for me to be a human being. About what it is to live in a different manner, and to feel different things, and think different thoughts. Listen to them. You'll be surprised at what you hear. And in the listening, I think it's an effective technique to occasionally reword or repeat what you think you're learning.

I know a woman who was going and on about how her husband drank all the time, and it was driving her crazy. And immediately my head was turning with this violent man who would come in and beat the kids and swat her around, and it was awful. She said, No, no, that's not what I am saying. He drinks too much, but the only reason it bothers me is because then we don't have enough money to buy groceries with. He really kind of giggles a lot when he drinks. He's really kind of nice. Easy to get along with. But I just wish he wouldn't spend all that money on liquor. So remember to reword what you think you're hearing, and have it validated by the client.

Don't be afraid to be used. Now this is a little bit different from what you may have been told before. For years in traditional social work, we were told, "Don't become involved. Don't be manipulated. Get the upper hand." Once you realize that it's really not going to kill you to have somebody manipulate you a little bit, I think you can learn to relax. We manipulate people all the time. What's mother doing when she cuts a sandwich in the shape of an elephant and hands it to a two year old? It's manipulation. It works, and the kid gets fed. People manipulate one another in nice ways all the time and nobody's hurt. So it really is not the absolutely worst thing that can happen to you. So if your clients outguess you, and they will, don't feel like you're demolished. This relationship is not a power struggle. It's a friendship. You don't have to be one-up and they don't have to be one-down. You can just "be."

Do concentrate on the client. It's much more fun to pick up and cuddle the little two year old, but it's dangerous, because if mother gets jealous of that child when you leave, he is going to be targeted. He is going to be in danger. If you're into a situation with an intact family, and you give more attention to one spouse than the other, some jealousy is going to arise. So try to be careful about whom you're concentrating on, how, and for how long.

An example of how to get something done for the child without zeroing in on him is to say something such as, "I notice Johnny has had a bad cough. Were you up all night with him? Well, maybe if we got him to the doctor, he would stop coughing and you could get some sleep." The emphasis is on mother being tired, not on Johnny's cough. I think that you will get to the doctor much faster than by saying, "That child probably has pneumonia. Let's go." Mother will like the feeling that you're worried about her fatigue and not Johnny's cough.

Or ask, "What can I do to help you with this problem about Bobby? I see that you're really uptight about the fact that he's three years old and he's still wetting his pants. Is there anything that I can do to help? Have you thought of some things that you can do?" Keep the focus in the right area.

Please respect the client's opinions. It's taken me a lifetime to form my opinions. They're mine and I am rather pleased with some of them. If you were to come into my home to tell me

that those opinions were all wrong, I am not sure how I would receive you. So respect that parents' right to have an opinion that differs from yours. Remember that marriage may not be their bag. Christianity may turn them off, or they may feel cursing is a deadly sin. Clients are individuals and will hold many diverse opinions.

My clients' opinions seem in need of discussion only when those opinions appear so far afield from average societal ideas that holding them may cause parents consequences. One example of such an opinion would be the belief that children are parents' property, mere chattel to be dealt with as the parents see fit. If a parent believes that to the point of justifying severe abuse in the name of discipline, I feel the parent must be advised of his legal obligations as well as the child's rights and those of the state. In other words, at this point a parent may need factual information.

I would like to close by opening myself a bit more; sharing what I guess is offered as advice based on personal experience.

Take your client at his own pace. Don't push and do not take for granted adult functioning skills that may be completely beyond the scope of your client. I may have had a good education, but I do not know how to do many things you do. Each individual has different skills and areas of expertise, so do not assume all people can bake a cake, read a thermometer, drive a car, enroll a child in school, follow doctor's orders, get a lawyer, or understand credit buying.

I would also like to alert you to the possible hostility you will encounter. Verbal abuse can be scary, but it doesn't frighten me anymore. I finally learned that the only thing that is going to be injured is my ego, and it will mend. So get your support system going for you. If your ego is wounded, call the SCAN staff for first aid. I remember deliberately going to my supervisor for strokes when my ego was shattered. And, God love her, Fran Millard gave me what I needed. She told me how great she thinks I am and reminded me that anger is an outgrowth of fear.

Try to remember, when a client verbally assaults you, to reassure him by saying, "John, I am a volunteer. I am only here because I want to be. I see you are angry, so I will leave. I'll come back later." Or you could say, "I am going to sit down on the front porch. When you are ready to talk to me, come outside." The latter approach has been used quite successfully by our state director, Sharon Pallone. She once waited for almost one hour, then the mother came out and started talking.

However, I wish to point out in this discussion of hostility that you should not allow yourself to be overly abused by your clients. Many times new lay therapists think that no matter what the parents dish out, they are compelled to put up with it. Well, I don't believe that. Occasionally, I have told a client that I value myself too much to allow her to victimize me by discounts. What I am saying is that somewhere there is a happy medium, and that I can choose how I am going to react to hostile remarks. If I am feeling good about myself, I will be able to maintain my equilibrium.

Lastly, I wish you joy. There is no feeling in the world like working with these parents. The reward comes from walking through a life experience with another human being, sharing your humanness with each other. What a pleasure it is to see an unfolding of potential before your eyes and to know that you have been privileged to share in this. Every once in a while, it hits me that another person and I have connected on a primary level and I feel sheer, unadulterated joy!

Do We Need Alternative Delivery Systems?

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INTRODUCTION

The title of this panel discussion is "What Kind of Alternative Delivery Systems Do We Need?" Implicit in the title is the assumption that we need alternatives to our current protective services delivery system. I would argue that this is not exactly the case. I believe that we do not need to establish distinct alternatives to existing protective service systems. Rather, I believe that we need (a) to upgrade that which currently exists and (b) to extend or add on to that which currently exists by coordinating protective services with other community services.

I believe that public protective service agencies can, and indeed should, remain the focal point of the child abuse and neglect service system. I have studied the responses of many different communities across the country to abuse and neglect; the most successful responses appear to be those in which the different agencies and the various disciplines concerned with family problems have made concerted efforts at working together within the context of the existing protective services structure, rather than outside of it. At the moment, it appears that we have no reason to accept anything other than the case management model provided by protective services as the basic focal point of our child abuse and neglect systems.

IMPROVING PROTECTIVE SERVICES

Most public protective service agencies require significant organization. First, we need to allow for better triage or sorting of cases at the point of reporting and intake. We need to make sure that, at the "front end" of the system, cases get to the services they need, when they need them, and that we maximize our use of the skills of various service providers. Reported cases of abuse and neglect differ greatly; they do not need to always be handled in the same way. Some need immediate help; others do not. Some need intense therapeutic assistance; others need help getting jobs or medical care. Some need a lot of supervision, almost daily contact; others need minimal intervention. In most communities, cases are more or less randomly assigned to workers at the time the report is received, irrespective of the families' needs or the workers' qualifications. Each worker conducts investigations and responds accordingly. The result: all cases tend to be handled in the same ways, while maximum use is not made of a particular worker's skills. Some communities have established intake units to conduct preliminary investigations and, minimally, weed out inappropriate cases before referral to a treatment worker. In a well-functioning system, the intake process is a bit more sophisticated. It operates on a basis similar to a medical triage or sorting system on a battlefield. Not only are cases not needing "care," i.e., inappropriate cases, weeded out, but the remaining cases are further screened with respect to the nature and severity of the case. Based on that intake assessment, a case is referred to the service group best equipped to handle the particular case. Thus, cases needing intense, immediate intervention would be differentiated from other cases and would be assigned to those best prepared for immediate, intense intervention. Sexual abuse cases would be assigned to those with skills in that area, and so on. In a sense, a case is assigned a priority depending upon the child's safety and the general family situation; responses to the case differ, depending upon priority assigned. In this way, cases are most likely to get the services they need, and providers most likely do that for which they are best prepared.

Second, we need to upgrade case management. The actual day-to-day case management has a lot to do with the overall effectiveness of treatment and, thus, the overall effectiveness of the system. I don't know of any protective service systems with a perfect record as far as case management goes. The most common problems are: not all reports are investigated; some reports are investigated weeks after the report was made; all cases are given the same services (social work counseling) irrespective of a family's needs; no real diagnosis and case planning takes place; cases are referred to other agencies for services but never get there; cases are kept open for months, even years, with no reviews of progress and often with no services provided (such a situation does neither the child, the parent, nor the social worker any good); cases are terminated and never followed up to see if the termination occurred at the right time, or what problems the family experiences after termination. In the well-functioning system there is a quick response to initial reports thorough case diagnosis and service planning, follow-up of referrals, termination

time is appropriate, and cases are followed up after termination. Perhaps most importantly, there is no duplication of functions for individual cases. Parents are not interviewed two or three times about what happened to their children. No family needs to have social workers, at two separate agencies, independently planning what services the family will receive unless the workers are carefully coordinating services with each other. No social worker needs to fill out 10 different forms all requesting the same information on the same case. In a well-functioning system, all such duplications are eliminated, to the benefit of both families and workers.

As a step toward improving the quality of case management, we need to substantially reduce the caseload sizes of treatment workers, in part by creating more appropriate incentives for workers to open as well as close cases. Workers with caseloads of 40 or 50 families, or even 30 or 35 families, simply cannot provide quality services, at least for any length of time. Cases are not reviewed. Workers burn out. Neither the family nor the agency benefits.

Third, protective service departments need the input of all different disciplines and agencies at all points in the intervention and service process. Child abuse and neglect are multifaceted, multidimensional problems. They are triggered by many different combinations of attitudes, situations and behaviors. There is no single cause of abuse or neglect. And, there is no single solution, cure, or treatment. Child abuse is a legal problem, a medical problem, and a social problem. Treating abuse requires an understanding of medicine, law, human behavior, child development. It requires skills including counseling, therapy, advocacy and child care. It is unreasonable to assume any one person possesses all this knowledge and skill. Indeed, it is unrealistic to think that all this can be found within any one agency. Rather, lawyers, doctors, social workers, and therapists must all contribute their expertise. Thus, protective service agencies must take an interdisciplinary approach. Then, throughout the treatment process—from intake, initial investigation and diagnosis, through treatment and termination—there can be input from many different perspectives. Some workers are capable of appreciating and responding to the array of problems a particular family confronts, but most often, no one person is able to both perceive and effectively respond to the range of a family's needs. In general, there is a need for several people to review and have input into a case; it is preferable for them to represent different disciplines, or at least different ways of viewing the world.

Finally, protective services need to have close working relationships with other agencies in the community, notably law enforcement and the juvenile court, and preferably other health, education, and social service agencies also. Schools, hospitals, juvenile courts, and police must all work with protective services, each filling their own specified role or function with respect to abuse and neglect. Resources are scarce. The problem is a serious one. We can ill afford duplication and inefficiencies in the handling of the problem. We must take a community-wide approach, with different agencies, as well as different disciplines, working together.

EXAMPLES OF SUCCESSFUL EXPANSIONS OF OR ADDITIONS TO PROTECTIVE SERVICES

Throughout the country we see more and more examples of existing protective service systems which have successfully improved service delivery with programmatic expansions or additions. Many of these changes have occurred in communities fortunate enough to receive special funds (typically, federal demonstration grants) earmarked for such purposes. The permanence of these changes will depend a great deal on local motivation and commitment since most of these grants are only of three years' duration.

Examples of such successful efforts include:

Arkansas' SCAN

In several select counties, Arkansas' state protective services department has contracted with SCAN, Inc. (a private, volunteer-based group) to provide protective services—primarily in the form of lay therapy—to all identified cases of child abuse. County protective service workers maintain responsibility for cases of neglect. Thus, this resource-poor state has substantially expanded its capacity (at reduced costs) to provide services to families in need.

Baton Rouge, Louisiana's Child Protection Center

In Baton Rouge, and indeed throughout the state of Louisiana, children's protective services has expanded its capacity for quality screening, diagnosis, and services by linking with local health facilities—most notably, the local children's hospital. By more directly involving medical personnel in the intake and treatment planning process, a more effective interdisciplinary approach is taken.

Arlington, Virginia's Pro-Child
Children's protective services were greatly improved with the additions of a multidisciplinary diagnostic team, homemaker and nursing services, expanded numbers of social workers, group counseling, and a day care program for children. This county agency, which once provided only diagnosis and social counseling, is now in a position to develop treatment plans for families based on their needs.

Union County, New Jersey's Protective Services Unit
In one New Jersey county now serving as a model for others, protective services sought to develop working agreements or contracts with other public and private social service agencies in the area, so that workers could purchase needed services for their families. Such written contracts have allowed for tremendous expansion of protective service workers' options with respect to their cases, by making use of many existing non-protective service-based programs.

Adams County, Colorado's Family Center
The protective services unit established a separate program under its guidance to conduct extensive intakes/diagnoses on all reported abuse cases and to provide specialized ongoing services to select abuse cases, including children's services such as a crisis nursery and play therapy.

Bayamon, Puerto Rico's Child Abuse/Neglect Unit
A special unit was established, as part of the existing protective services structure, to provide intense services to families with the greatest need. As a result, the most severe cases of abuse/neglect now receive not only social work counseling, but also psychiatric counseling, medical care, housing and job assistance, and other needed advocacy and supportive services. Most novel of these services is a summer camp run by the program for its parent clients and their children.

IN ADDITION TO PROTECTIVE SERVICES
I have presented a case for maintaining while enhancing existing protective service systems. I have mentioned examples of communities that have so done successfully. However, our experiences studying child abuse/neglect systems across the country suggest that the strongest systems consist of blends of public and private, professional and lay, paid and volunteer. Such blends invariably require that child abuse and neglect treatment go beyond protective service agencies and include additional options. The complexities of abuse/neglect cases and the vast differences between them require many different treatment responses; no one kind of agency can be expected to be equipped with all necessary responses. Indeed, non-protective service agencies are perhaps the most obvious sources of preventive activities. Interesting, and apparently successful, alternatives to protective services include the following:

Denver, Colorado's National Center for Prevention of Child Abuse and Neglect
The National Center for Prevention of Child Abuse and Neglect in Denver is a prime example of an addition to protective services. While working closely with existing public programs, the center provides rich and varied treatment services for parents, children, and families under the auspices of the medical center. The center thus exists as an alternative source of treatment for select abuse and neglect cases in the area, while also serving as a training center for and a model of how things might best be done.

Parents Anonymous
With chapters across the country, Parents Anonymous is a group support service organized by and for parents with parenting difficulties. These self-help groups provide a kind of anonymity as well as support not available from the professional worker and, as such, an essential complement to (for some parents an alternative to) protective services.

Northern California's Parental Stress
In counties around San Francisco, volunteer-based groups of lay persons operate 24-hour counseling hotlines for anyone experiencing parenting problems. The hotline, perhaps best seen as a preventive service, allows people to reach out for help anonymously. Hotline operators can tie a family in with protective services, if needed.

Tacoma, Washington's Panel for Family Living
The Panel for Family Living, initiated and maintained primarily as a volunteer-based program, provides back up to protective services—in the form of lay therapy, group therapy, parent education classes, and home counseling—for select cases, while taking a major responsibility in the community for various preventive activties, such as community education and the development of parenting classes in the local high schools.

St. Louis, Missouri's Family Resource Center
The Family Resource Center, affiliated with a local children's hospital, provides family-oriented services, with a focus on therapeutic services for children. The children's services in particular are ones the local protective services agency would have difficulty providing and thus the center complements the existing system.

CONCLUSION
I believe that public protective service agencies should be the focal point of our community-wide child abuse and neglect systems. Most protective service agencies need substantial upgrading and expansion to adequately respond to clients' needs. They also need to be coordinated with treatment facilities for parents and children as alternatives to protective services. Protective services cannot provide all the treatment needs of abusive/neglectful families. Indeed, even the protective services and those hospital-based, volunteer-based, private agency-based services that are now developing around the country cannot service all of a family's needs. Support must come from other places. These other places consist as much of the more broadly based service systems in our communities, e.g., the welfare system, schools, etc., as they do of more natural helping networks, such as the extended family and the church. Both of these sets of groups are much better equipped to handle broader questions of the primary prevention of abuse and neglect than is the child abuse/neglect system itself.

Lay Therapy: Intimacy as a Form of Treatment for Abusive Parents

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INTRODUCTION

In recent years, as programs for abusive parents have been created, the concept of lay therapy has been developed and implemented in several communities across the country. The basic assumption of lay therapy is that a relationship with an intimate and nurturing person allows the abusive parent a more healthy expression of his emotional needs, and prevents excessive, unrealistic demands being made on the child. The goal is to enhance the emotional growth of the parent through supportive techniques combined with environmental modification. It is expected that the parent will eventually feel comfortable in establishing a natural and ongoing support system for himself or herself and will use the relationship with the lay therapist as a model for this.

The lay therapist is introduced into a family as a "parent" person rather than a "child" person. His role is to help parents grow emotionally so that they can provide a sounder base for the child's emotional development. The goals of lay therapy are to prevent repeats of abuse, to shorten the treatment by providing a more intensive program, and to promote more independent functioning of the parent by assisting in the development of more effective coping mechanisms.

The concept was first developed in 1969 at the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado. In their work with abusive families, the professionals found they were often unable to meet parents' enormous dependency needs in the time available to them. They decided to experiment with the use of lay people who could develop close relationships, spend several hours weekly with the parents, and be available in crises.

In this paper we will share our observations of and experiences with two lay therapy programs. The first was implemented at the Family Center in Westminster, Colorado, a federally-funded demonstration and research project in child abuse. This program was funded by the U.S. Department of Health, Education, and Welfare through the grantee agency, Adams County Department of Social Services. The second was implemented at the Peoria Area Office of the Illinois Department of Children and Family Services.

PROGRAM CONSIDERATIONS

The process of establishing a lay therapy program within a protective service agency is greatly enhanced by input from line staff. This was encouraged by conducting individual and group conferences with Adams County protective service supervisors and workers to determine their feelings about the concept, ideas on program structure, ideas regarding the needed services, tasks lay therapists could perform, training needed, and suggested evaluation methods. Ideas were also sought from other community people.

The advantages of input from line staff at the planning level were that: (a) practical considerations based on a knowledge of the protective service system were included in the program; (b) more appropriate cases were referred to the lay therapy program; (c) an increased commitment to program goals was encouraged through administrative channels; and (d) improved communication with protective service personnel was achieved, which served to reinforce all of the above.

Although the advantages of this input outweighed the disadvantages, it should be noted that the extensive involvement tended to cause delays in program implementation and at times resulted in communication issues between protective service workers and Family Center staff taking precedence over client treatment services.

In Illinois, line staff were involved to a lesser degree, with the result that staff were misinformed regarding the program, and fewer referrals were received for lay therapists.

One of the initial program considerations was whether lay therapists were to be paid. In both programs, most were paid, while at the Family Center some volunteers were also used. Both functioned well. We felt, however, that by being able to pay lay therapists, we were able to recruit from all socioeconomic levels. Without some compensation for personal expenses, low income people would be unable to accept positions as lay therapists. We also recognized the

value of money as a motivator and as an indication of the value of the service performed. In our experience, volunteers worked only a few months, significantly less than the tenure of the paid lay therapists. We feel strongly that funds should be made available to include lay therapists as valued and salaried employees of the protective service system.

Although a pay standard based on fifteen hours per week was established, it was understood that this might vary week by week or family by family. When families are functioning with minimal difficulty, the lay therapist spends less time with them. When crises occur, more of the lay therapist's time is required. Also, regardless of planned face-to-face time, the lay therapist is required to be available on a 24-hour basis. This available time also merits compensation. Flexibility of contacts is necessary for a successful program, and this is best served by a set salary plus expenses for mileage and incidentals, rather than hourly pay only for actual face-to-face time with clients.

RECRUITMENT

Applicants for lay therapy positions were referred by people familiar with the program. The position was also advertised through local newspapers and the personnel department. Notices were sent to a wide variety of community agencies. In Illinois, a feature news article assisted in the initial recruitment. Despite this, recruitment was more difficult in Peoria, perhaps because of the size of the community to be served. Affirmative action guidelines were used in recruitment and hiring.

It was important to find people who were comfortable being supportive and who would not make unrealistic demands upon parents because of their own needs to see someone else succeed. We looked for the "natural helpers" in the community. As the program became more visible in the community, these people were more readily identifiable.

SCREENING

After reviewing the applications, individual interviews were arranged. Interviewing was conducted by a team, preferably the team of people who were working together with the lay therapists. The inclusion of present lay therapists as interviewers is highly recommended whenever possible.

Areas considered in selecting lay therapists were:

1. The adequacy of the applicant's own parenting; how sound an emotional base this person has. Had they received enough care and attention in their early years to be able to give some to another person? If their own early experiences and conditioning were negative, what have they done to overcome this? Have they received help with this? Was it effective? What insights do they have into how their early life experiences are related to their desire to help abusive parents as an adult?
2. Do they have the ability to be a nurturer? Would they be comfortable in this role?
3. How adequate are their own coping mechanisms in handling personal problems?
4. Do they have a personal support system that is functional?
5. Can they separate the needs of the parents from the needs of the child?
6. What are their feelings about discipline? How should children be disciplined?
7. Can they work as a member of a team, or will they feel the need to be the sole advocate for the client? Are they open to group supervision?
8. Do they accept program sponsorship? This is especially significant when programs are sponsored by agencies which have negative images in the community.
9. What are their stated feelings about child abuse and abusive families? Can they admit to having angry or unpleasant feelings? Does it appear that they are willing to look at feelings and how they affect what they might do with the families?

We strongly recommend that people selected as lay therapists be parents themselves. Not only does this give them the first-hand knowledge of the frustrations and difficulties of parents, but it also is an initial advantage with the parent, who cannot dismiss the lay therapist with the familiar complaint, "What does she know; she's never had any kids." We also suggest that applicants' children be beyond infancy, as the responsibility of very young children severely limits the availability and flexibility of time. If candidates are not parents, we feel they should at the very minimum have had extensive experience caring for children on a 24-hour basis.

TRAINING

The basic skills used in lay therapy cannot be taught. They are skills learned through the lay therapist's own life experiences. Training is geared to orientation and improvement of existing skills, as well as introducing the dynamics of child abuse.

Training is also a time to introduce lay therapists to the people and systems with whom they will be working. Involving social work staff and community people has been productive. In addition, we have used the comments and suggestions of each group of lay therapists in planning future and ongoing training efforts. As in the selection process, lay therapists themselves have much to offer to those in training.

Content, affective, and skill areas we feel necessary are:

1. Basic information on child abuse: medical, emotional, and social factors pertinent to understanding the dynamics of child abuse.
2. Sensitivity training as related to abuse. This would include an understanding of the significance of the lay therapist's own style of discipline with his or her own family. Therapists must also be sensitive to how they really feel about parents who physically injure a child. Discussion of this must take place in a non-judgmental atmosphere so that the lay therapist can adequately explore and deal with these feelings.
3. Information on legal issues related to child abuse: lay therapists should have a good understanding of the child abuse law for the state and their responsibilities as private citizens as well as agency representatives.
4. Understanding the social service system.
5. The training program should include time for practice and sharing. It is important that the lay therapists develop group cohesion, which provides a mutual support system.

The Family Center's training consisted of two weeks of intensive orientation with follow-up inservice sessions and weekly group supervision. The Peoria Area program extended the initial training program to three months before a case was assigned to the lay therapists. The advantages of the shortened training period were that it allowed the lay therapist to get involved with families at a time when his enthusiasm was highest and his training experiences were fresh, as well as increasing the length of direct involvement with parents. We also recognized the value of learning through problem-solving with actual situations. With the shortened training period, one risks having a lay therapist who is less comfortable and less knowledgeable than he might be, as well as possibly lacking sufficient time for the lay therapy coordinator to evaluate the lay therapist's skills and commitment prior to case assignment. This choice will probably be decided by time limitations of the agency, prior experience and training of the lay therapists, and the philosophical orientation of the program coordinator.

CASE SELECTION

The case selection process began with agency decisions about the type of situations in which a lay therapist could be used. For instance, a decision was needed as to whether they would be used in actual and/or potential abuse situations, and whether cases would be referred at intake or only after being in treatment for some period of time and having some of the immediate crises resolved. Decisions were also made regarding coordinating age, sex, and ethnic background of the lay therapist with those of the client.

In addition to these basic determinations, the following criteria were applied:

1. Cases of severe emotional illness were screened out. It was felt that lay therapists should not be expected to handle situations resulting from potentially psychotic or dangerous behavior.
2. Cases where parents' unmet dependency needs were particularly severe were given priority.
3. The parents had to be willing to accept a lay therapist.
4. The primary therapist for the family had to be willing to accept responsibility for consulting with the lay therapist on a regular basis and being available for crisis situations.
5. Personality matching: It was essential that the lay therapist supervisor get a feel for each lay therapist as an individual and attempt to assign clients that the lay therapist would feel comfortable with as a friend. If a lay therapist had a strong dislike for certain kinds of behavior or personality types, he needed to be comfortable in refusing the case.

SUPERVISION

Lay therapists were supervised three ways. The basic and most essential was a weekly group meeting with the lay therapy coordinator. At these meetings the lay therapists discussed their cases, gave and received mutual support, and ventilated their feelings. During group sessions a lay therapist received essential support and positive feedback for independent functioning, and the knowledge and skill which the lay therapist brought from his or her own life experiences were recognized and reinforced. By hearing the issues and problems with which other lay therapists were struggling, they could more easily put their own struggles into perspective. An atmosphere was created where the lay therapist had permission to fail without reprimand.

Individual conferences were also necessary at times. These usually involved a crisis in the family, but they were also utilized when an issue or problem arose which was inappropriate for group supervision. Since the lay therapists were asked to be available to their families on a 24-hour basis, they needed to feel that they had constant supervisory backup. Therefore, the lay therapy coordinator was available to the lay therapists at any hour.

The third mode of supervision was that of conferences with the protective service worker. The coordinator must encourage regular communication in order to help them to get to know each other, feel comfortable with each other, and trust each other's judgment. To facilitate this, the primary therapist (usually a protective service worker) was brought together with the lay therapist at planned intervals. This served to reinforce the concept of the joint treatment plan. It also allowed for continuing clarification of the differences in roles of the two therapists with the family, and for clarification of the functions of the coordinator and the primary therapist in their relationship to the lay therapist. The coordinator functioned more as a program planner and group facilitator, while the primary therapist acted more as a case consultant.

During group meetings, the lay therapy coordinator identified problems a particular lay therapist was having and related them to other issues discussed in the group. Ideas and suggestions were sought from everyone. The coordinator also identified gaps in training needs and planned any special sessions in regard to them, in addition to inviting lay therapists to attend relevant workshops or agency meetings.

In addition to the responsibilities outlined above, the coordinator served as an advocate for the lay therapists and a buffer between the lay therapist and the system. The coordinator and the protective service supervisor consulted on case management problems. It was the coordinator's responsibility to help the lay therapist maintain the role of "parent person" rather than protector of the child. Other duties of the coordinator included activities to encourage referral, initial screening of cases, and assignment of cases to individual lay therapists.

EVALUATION

An evaluation process was undertaken by the Family Center as a part of the total program plan. In Illinois, unfortunately, an evaluation component was not included. It is important to plan such a process as early as possible. Some of the factors which can be assessed before and after a lay therapist is introduced into a family are listed below:

1. Incidence of abuse.
2. Severity of abuse.
3. Length of treatment of cases with and without lay therapists.
4. Effectiveness of treatment.
5. Time-cost effectiveness analysis.
6. Behavioral indicators of parents.
   a. Support system.
   b. Ability of parent to initiate relationships.
   c. Ability of parent to initiate activities.

Additional data which can be collected are profiles of the families served by lay therapists, types of contacts the lay therapists had with the family, who initiated the contact, length of contact, and activities related to the parenting of the abused child identified by the lay therapists.

Through an appropriate and adequate evaluation process, an agency can determine the value of the program to their clients and to the agency. This will undoubtedly be critical to continuing support and funding.

SUMMARY OF FINDINGS

After the first ten months of the Family Center project, nineteen families had received services from a lay therapist. In the next twelve months, eight more families were served. After the first twenty-two months, half of that total (13) were active cases. The reasons for "closing" lay therapy cases were (in order of frequency): (1) family moved; (2) lay therapist left the program; (3) family referred for treatment elsewhere; and (4) family refused involvement of a lay therapist.

The profile of the families referred for services in the first ten months of the program was as follows: average age of parent—26½ years; average number of children in the family—2.7; severity of abuse—29% severe, 29% moderate, 12% mild, and 29% potential; income—all families had incomes less than $10,000, and 21% were receiving public assistance.

Each lay therapist completed a monthly contact report for each family. From these reports, the following data was collected in the first 22 months.

Primary Reason for Contacts with Parent

1.	Visiting and companionship	68%
2.	Transportation	10%
3.	Recreation with parent	6%
4.	Recreation with parent and child	3%
5.	Babysitting	2%
6.	Assistance with family finances	2%
7.	Meal planning and nutrition	2%
8.	Assistance with medical needs	3%
9.	Food shopping	1%
10.	Other	3%

Type of Contact

Home visit	54%
Telephone	46%

Contact Initiated By

Lay Therapist	71.5%
Client	28.5%

Average Number of Contacts Per Month 7.5

Average Length of Contact 1 hour 35 minutes

Major Changes Occurring in Family During Lay Therapist Involvement

Total Changes	39	Percent of Total Change
Change in Marital Status	3	8%
Change in Employment	9	23%
Change in Address	7	18%
Serious Illness	16	41%
Placement of Children	2	5%
Other	2	5%

Techniques of parenting described by the lay therapist fell into two basic categories: (1) parenting techniques related to the client's children; and (2) techniques related to reparenting for the client by the lay therapist.

In the child-related parenting, the techniques used were: (a) discussion of parent-child communication; (b) discussion and actions regarding the child's need for additional services such as speech therapy, tutoring, evaluation, etc.; (c) modeling "how to play" with children; (d) modeling behavior modification techniques; (e) discussions regarding appropriateness of parental expectations of the child; (f) information on children's developmental stages; (g) counseling

regarding consistency of discipline; (i) counseling regarding helping the child to express his feelings.

Activities involving reparenting the parent included: (a) encouraging the client to "take care of himself or herself"; (b) encouraging the parent to follow through on individual goals; (c) encouraging the parent to be more assertive; (d) giving advice on how to improve housekeeping; (e) providing praise for doing a good job with the child; (f) encouraging the parent to plan leisure activities for self; and (g) allowing for expression of negative feelings toward the lay therapist.

CONCLUSION

We view child abuse as a symptom of a matrix of problem-producing potentials in a parent. Basic to this treatment approach, lay therapy, is the premise that failure to adequately resolve very early stages of emotional development is inconsistent with acquiring personality traits necessary for healthy parenting as an adult. The introduction of a positive nurturing relationship is one way of reworking these early developmental problem areas. Lay therapy is thus one element of a more elaborate plan of treatment, and never the sole method of intervention. It intensifies a process which usually requires a much longer period of treatment with traditional psychotherapeutic techniques. It becomes a part of that process along with other components such as therapeutic day care, services of a crisis nursery, temporary foster care, support group therapy such as Parents Anonymous, and other approaches still being developed.

Lay therapy is often spoken of as a reparenting process for the client. It is essential then to seek out as lay therapists people whose personality traits will be complementary to those of the client, so that positive parent messages may be substituted for the negative messages received earlier. A nurturing acceptance of natural feelings and behaviors must replace the rejection, criticism, and control experienced by the parent as a child. It is for these reasons that the recruitment and selection process becomes the point at which the program succeeds or fails.

We cannot overstress: (1) the need for a theoretical base that sees lay therapy as part of a complex treatment approach and not as an isolated, inexpensive panacea, as well as (2) the lay therapist as a unique individual who is able to promote, allow, and nurture the expression of childlike needs and feelings in another adult. Some of the obvious potential hazards in this process are: (1) the creation of an overly-dependent relationship which will require the lay therapist to be there permanently to meet the parent's needs; (2) psychological regression with fixation at an earlier developmental stage; or (3) possible neglect of the children due to a preoccupation of the parent with his/her own needs as opposed to those of the child. This is why constant communication is necessary between the primary therapist, the lay therapist, the program coordinator and other treatment specialists who may be involved. A constant effort to monitor and objectify what transpires is necessary to assure treatment effectiveness. We have attempted to present the techniques used in two lay therapy programs to demonstrate how this can be done. We have shared our mistakes, as well as our successes, in hopes that our experiences can be used in other situations to make lay therapy an asset to other treatment programs for abusive parents. This is a feeling and doing kind of treatment. Contrary to popular opinion, it is not inexpensive. It requires time and money to plan and implement such a program. It includes the stress of change and the threat of exposure, but also the advantage of improved services to families.

Volunteers as Parental Socialization Agents: Applications Within the Military Culture

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In the fall of 1975, the Parenting Guidance Center, Inc. was established in Tarrant County, Texas, mandated by the work of a community-wide child abuse task force spearheaded by the Fort Worth Junior League. The goals of the center are four-fold:

I. To provide opportunities for Tarrant County residents to acquire the attitudes, knowledges, and skills necessary to perform the role and functions of parents.
II. To provide resocialization experiences for abusive and neglectful parents.
III. To prevent child abuse through education and reeducation of parents.
IV. To provide opportunities for collaboration of professional and volunteer workers in preventing child abuse.

This paper will present a descriptive analysis of a Parenting Guidance Center (PGC) service model involving volunteers in a socialization program for potential as well as already identified abusing and neglecting parents. The rationale for the program will be discussed along with a specific application of the service model in a military culture. The model has been designated by the agency as the Parent Partner Program.

CHARACTERISTICS OF ABUSING AND NEGLECTING PARENTS

Researchers have identified a number of personal characteristics of abusing and/or neglecting parents (De Francis, 1963, 1972; De Lay, 1973; Gil, 1970; Helfer, 1975, 1976; Justice, 1976; James, 1975; Kempe, 1972; Mulford, 1967; Polansky, 1975; Rohner, 1975; and Steele, 1975). Only those characteristics germane to the rationale of the Parent Partner Program, social isolation and maladaptive socialization to the role of parent, will be addressed in detail.

Social isolation, for our purposes, is defined as that functional state in which a parent or parents have few or no friends and no one to turn to in a crisis. Correlates of this social isolation are the personal characteristics of abusing and neglecting parents: low self-esteem, distrust of self and environment—with accompanying reluctance to seek help, inadequate social skills, and little ability to experience pleasure. Extended family (relatives) may be physically or emotionally unavailable to help the parents. The memories of childhood, then, become the guide and model for the adult's role as parent. The balancing factor of interaction with experienced parents or with other inexperienced parents, a common learning and norm-setting experience, is absent.

Maladaptive socialization to the role of parent includes a number of behavioral and knowledge misconceptions and deficits. Parental expectations of children are unrealistic and inappropriate. Knowledge of child development is skewed. In actuality, the simple knowledge that children unfold and develop is missing; babies and children are endowed with all the capacities and emotions of miniature adults. It is common for a neglectful mother to have no understanding of signs of illness in a child, or of how to use and read a thermometer. Children are expected to nurture and meet the needs of parents, not vice versa. Perceived behaviors of the child are interpreted in unrealistic and bizarre fashion, e.g., "The baby cries because he hates me" or "The baby (six months old) wets her pants because she's mean" or "Everybody else only eats three meals a day. The baby is just greedy (if she wants to be fed more)". It is the contention of the authors that these behavioral and knowledge deficits and misconceptions are the result of insufficient or unrealistic learning and that the abusive or neglecting parent is the product of maladaptive socialization to the role of parent.

THEORETICAL CONSIDERATIONS

Consequently, socialization and learning theories provide the theoretical underpinning for the Parent Partner Program. Socialization occurs throughout one's lifetime; it is not limited to childhood. It encompasses the learning of motives and feelings as well as skills and cognitive sets. The implication is that norms are to become internalized as standards for behaviors (Clausen, 1968, p. 3-6).

Socialization to a role, such as parent, can happen in a formal or an informal manner. The child can learn shoe tying or baby feeding through structured instructions from mother or from absorption or just "soaking up" what he hears or sees. Much of the socialization to parenting is incidental rather than formal.

Probably the most important element in socialization is the learning of social roles. Wherever there is a role, there is a set of behaviors that the performer has to learn. People do not automatically know how to be a second baseman, wife, parent, clerk, divorcee, or neighbor. There are not "natural" ways of doing these things. Most people ask questions, watch others, or read books to gain understanding of new roles they are gaining. However, it is hard to learn a role, in this case parenting, when it is presented in a chaotic, unpredictable environment (Campbell, 1975, p. 5).

Many abusing and neglecting parents assume the parent role having had maladaptive socialization experiences. An outcome of the experiences is lack of social competence as a parent. A competent parent has, first, the ability to learn and to use a variety of alternative pathways or behavioral responses in order to reach a given goal, which in this case is child rearing. Secondly, the competent parent comprehends and is able to use a variety of social systems (e.g., school, hospital, social agency) and benefit from resources they offer. A third characteristic of the competent parent is effective reality testing and an understanding of the world (Clausen, 1968, p. 274).

Since abusing and neglecting parents fall short of the desired outcomes of adequate socialization, remedial and preventive intervention goals are suggested. General goals for the program then are to increase the ability to use social systems to achieve one's goals and to perform effectively for self and society in one's social role as parent.

Socialization theory also leads one to the use of reference groups for a resocialization process. A reference group is any group or coherent body of persons that the actor (e.g., parent) compares himself to, or "refers" himself to, when selecting or evaluating his behavior, or whose perspective he tries to assume when settling upon his attitudes or forming his conduct. In the case of the Parent Partner Program, the volunteer Parent Partner becomes a reference person and the group/class, consisting of volunteers and client, becomes a reference group.

Group members then become cohesive as their common learning needs and areas of personal interest are addressed. Two concepts from learning theory are actively employed to maximize expected outcomes. Group participants, both volunteers and clients, are encouraged by a relaxed non-threatening atmosphere to share incidences of parenting behaviors. Praise and approval are offered when clients indicate the use of new parenting skills with their children.

Another concept utilized in the group is modeling. As role models for clients, the Parent Partners can model both general approaches to child rearing and specific skills to be used. The modeling aspect of the program allows clients to be socialized to the parent role both formally and informally in a manner similar to the natural socialization process.

Thus, the examination of socialization and learning theory gives direction for the establishment of explicit program goals. Theory also provides a rationale for the concept "Parent Partners" and for the use of a reference group as treatment of choice.

PARENT PARTNER PROGRAM GOALS AND OBJECTIVES

The Parent Partner Program is designed to prevent abuse and neglect by systematically reversing two of its most prevalent precursors: social isolation and knowledge deficits. Program objectives are to provide a beginning social network, teach reaching out interpersonal skills, model nurturing behaviors, provide a safety valve for tensions, enable reality comparisons, engage parents with acceptable help, correct misconceptions related to child care, and enlarge the parents' knowledge and behavioral repertoires.

Community professionals provide knowledge content for group meetings of parents and Parent Partners. The program is presented as a club/class for parents to help them to be better parents or, in the case of new parents, to get a good start. PGC staff lead and coordinate the group, provide some content and train volunteers. Several community agencies share goals related to education for healthy family life and child care and are cooperative in sending staff professionals to "teach" the group.

Community volunteers (Parent Partners) provide transportation and model social and nurturing behaviors in their interactions with parents in the group. Each volunteer Parent Partner is linked to one or two parents as a helper/friend. Parent Partners offer themselves as persons to contact in time of crisis and make at least one phone call a week to check on "their" parents. Acting as surrogate extended family, they often share practical knowledge of child care out of their own experience. A concerted effort is made to build peer relationships among isolated parents through structured and unstructured activities in the group. Perhaps the best way to explain the objectives of the Parent Partner service model is to describe one application in a military culture.

THE CARSWELL PROGRAM—APPLICATION IN A MILITARY CULTURE

The uniqueness of military life needs little explanation here. It does dispose toward separation from extended family, frequent and sometimes prolonged separation from the spouse on military duty, and frequent relocation of the nuclear family, thus providing conditions for social isolation. The military parent rarely has extended family at hand for emotional support or help in learning how to care for children.

Through the cooperative efforts of the Carswell AFB Mental Health Clinic, the Red Cross, and the Parenting Guidance Center, what came to be known as "The Carswell Parent Partner Program" was developed. Each organization had its own functions: the social worker from Carswell Mental Health Clinic cleared military channels and gathered parent referrals to the program; the Red Cross recruited volunteers to serve as Parent Partners and arranged an orientation meeting; PGC provided the group leader, orientation and training for Parent Partners, arranged topics and speakers for group meetings, and obtained free meeting and nursery space in a church near the base. Representatives from each organization formed an informal steering committee for decision making and planning.

This Carswell—Parenting Guidance Center coalition has sponsored three Parent Partner groups—in the spring of 1976, fall of 1976, and spring of 1977. With the transfer of the base hospital Red Cross worker, volunteer recruitment functions were absorbed by the Parent Partners. PGC has continued to provide training and coordination. The church has become an enthusiastic "home" for the project. The base officers' wives' club now underwrites babysitting and refreshment costs. Local MHMR and family service units provide speakers, along with PGC, the community Red Cross and the local public health unit. A sample program listing distributed to participants is shown in Table 1.

Table 1

Subject Listing for Parent Partner Group

Subject	Agency Responsible for Content Presentation
Introduction	Parenting Guidance Center
Building a Marriage Relationship (2 meetings)	Family Services
Military Life and Stress	Carswell Air Force Base, Mental Health Clinic
Human Sexuality	Family Service
Introduction to Child Behavior	Parenting Guidance Center
Child Development	Mental Health-Mental Retardation
Child Management	Parenting Guidance Center
Physical Care of the Child	Public Health Department

CLIENT GROUP COMPOSITION

The client group in the Carswell Parent Partner Program is composed of mothers of young children. All are married to Air Force personnel or are members of the Air Force themselves. All but one of the client mothers are married to airmen below the rank of sergeant. Most of the client mothers live in off-base housing and have limited financial resources.

While the original intent of the project was to serve young first-time mothers, referrals from base pediatricians and mental health workers included some multiparous women. Grouping of new mothers and mothers with several young children provided the group with much material for discussion so succeeding groups have continued this accidental pattern. Many of the client mothers have first babies under six months of age, but one mother had four children under the age of six years.

One risk in accepting referrals from the mental health clinic is the possibility of including a client mother whose behavior is too bizarre for the rest of the group to accept. With a dual focus of reducing isolation and upgrading knowledge of child care, the group is capable of meeting the needs of known abusing or neglecting parents, as well as inexperienced ones. One or two suspected "abusing" mothers were integrated into each group without the knowledge of Parent Partners, other client mothers, or the group leader. Major difficulties occurred only when a lack of social skills or other unmet needs caused a client mother to dominate the group with her concerns.

LEADERSHIP

Experience with the program indicates the need for a knowledgeable and capable group leader to facilitate the group. Content of the sessions and discussions can trigger client responses best handled by a trained therapist. If, however, a carefully screened group of client mothers with moderate personal problems is constructed, a lay group leader will suffice. The Carswell Parent Partner program has proven to be such a non-stigmatizing way of accepting help that young mothers of various capacities are asking to participate. We project that more and more mothers who suspect they have an abusing potential will request participation.

SELECTION OF VOLUNTEERS

Parent Partners in the Carswell program were all invited to participate in a program to help young isolated mothers. Since a general call for volunteers was not issued, a great deal of control over Parent Partner characteristics was maintained. Recruiters looked for experienced Air Force wives who were mothers themselves. Personal qualities sought were warmth, maturity, coping abilities, and the ability to relate to all kinds of people. Chronological age was not considered, but was implied in seeking experience. Officers' wives, because of available leisure time, were the prime target of volunteer recruitment.

Much discussion of military rank and protocol preceded the formation of the first project group. Unanswered questions were many. Could Parent Partners and young mothers bridge the rank gap? The generation gap? Do Parent Partners need to be military wives? Will Parent Partners be imposed upon with midnight calls and should women be selected who can handle these? What will a young airman think if his wife goes to a meeting with the Colonel's wife? Should Parent Partners be mothers? Answers came quickly. Parent Partners bridged rank, generation and status gaps with ease. Military life was an important commonality and recruitment of Air Force wives would continue. Young mothers did not call at odd hours or in any way take advantage of their Parent Partners. Conclusions are that Parent Partners should have successfully negotiated the common life experiences of the client mothers, i.e., military culture and motherhood.

In other PGC applications of the Parent Partner model with abusing parents, both male and female partners were trained. Both single and childless married Parent Partners were utilized. Pilot programs indicate that experience as a parent provides a link between volunteer and client that facilitates the program. Further applications of the model will test whether a high degree of common life experience will have a positive effect on the relation of volunteer and client and upon program goals.

TRAINING OF VOLUNTEERS

Volunteers receive six hours of training for the Parent Partner role. Group exercises to build cohesion and facilitate learning are used in each session. Experiential techniques and role play are employed along with didactic methods. Content covered in the training includes an overview of the Parent Partner Program, a review of helpful behaviors utilizing Carkhuff's Core

Facilitative Skills, a review of helpful responses and communications techniques, group theory, network theory, discussion of the helping relationship, and support for the Parent Partner.

The main thrust of the training program is to build confidence in the Parent Partners and help them understand their role as model. Many of them are unaware of the high skill levels they possess as natural helpers and role models. The Parent Partner role is delineated and rules established. Sources of help and support for the Parent Partner are presented and contingency plans established. Volunteers are matched to client mothers and brief information about client mothers is shared.

The role outline is brief. The Parent Partner is a helper in a helping relationship, not a social friendship. She provides transportation to class/group and has private helping sessions while traveling. She makes one check-up phone call a week. She provides information and support for the client mother and is available in a crisis. Inappropriate behaviors are to babysit or provide transportation other than to meetings. These "rules" are restated at the first full group meeting and have been followed with no difficulty by volunteers and clients.

PROGRAM EVALUATION

The Parent Partner program has been implemented three times as a pilot or demonstration of the model. Rigorous objective measures of program effectiveness are currently being developed, but have not yet been used. However, subjective self-report measures have been used with each group to provide feedback for program development and refinement.

Group members were asked to estimate their level of knowledge concerning eight subject areas before and after completion of the program. Participants rated their greatest changes (at least 3 points) in child development, child management and introduction to child behavior. Sessions considered by the members to be the most helpful included an introduction to child behavior and child management. Group members also reported that they benefited from the two sessions on building a marriage relationship.

When asked if they had used what they had learned in class, every group member reported that she had. This is the true test. If a followup report can objectively identify changed behavior and happier children, the program will have been successful.

So far, all of the group members believe that they have benefited from the program. They report not only increased ability to fulfill the parent role, but better feelings about themselves and less social isolation. Friendships built on common interest began in the group sessions and have continued beyond termination.

SUMMARY AND CONCLUSIONS

This description of the Parent Partner model for offering acceptable help to potential and identified abusing and neglecting parents is only one of many possible applications of the model. It can and will be adapted to other cultural contexts. Plans are underway with racial and cultural minority groups. Common life experiences such as parents of handicapped children, single mothers and divorced mothers or fathers are being used to link Parent Partners with clients.

The use of Parent Partners has not been limited to mothers. In the future, greater emphasis will be placed on the involvement of fathers as well as mothers.

The Parent Partner model is aimed at reduction of social isolation and resocialization of parents to their roles. It is founded on empirically generated facts and supported by theory. So far, reports by group members and Parent Partners are encouraging. Followup reports along with application of the model in different cultural contexts will allow for a judgment on the relevance and durability of the model for prevention of child abuse and neglect.

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A Background History of the Self-Help Movement

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The origins of the self-help movement have been two-fold, secular and sacred, with, as might be expected, a good deal of overlap between the two.

The notion of witnessing and confessing, central to many modalities of self-help as well as to psychotherapy, has its basis in religious practice. In the Old Testament there are many references to people who had done deviant things, felt painfully guilty, publicly admitted their deviance and made restitution, and been restored to the community. The Book of Leviticus is essentially a Jewish manual on how to deal with guilt and penance. In late pre-Christian Judaism, societies were formed whose members were pledged to weekly confession. This tradition was continued in post-Biblical times. Public confession and repentence were, and still are, features of the Day of Atonement.

Public confession ended after A.D. 325 when the Roman Emperor Constantine called the Council of Nicea which created a mass church with universal and catholic appeal. By the 12th Century, confession was no longer congregational, but was made in secret to a priest. Mutual criticism and aspects of group confession were continued in Catholicism, however. The Exercises of St. Ignatius, the spiritual discipline of the Jesuit order, is also a manual of self-help, comparable to the 12 steps developed centuries later by Alcoholics Anonymous.

In secular terms self-help is as old as man himself. Cave men knew that banding together for the hunt made the task easier. Mutual aid societies of workers were formed long before the Industrial Revolution, and were the genesis of the labor movement. One of the unique institutions developed by common people in England to cope with the stresses of industrialism was the Friendly Society. This was an outgrowth of the guild system of the Renaissance. Early examples are the Incorporation of Carters in 1555, the United General Sea Box in 1634, and the Fraternity of Dyers in 1670. The crossover between the sacred and the secular is clear in the Huguenot foundations of the oldest Friendly Societies in England, where the French Huguenots were excluded from help under the Elizabethan Poor Laws and were forced to develop self-help groups.

In 1793, the British Parliament officially sanctioned the formation of such societies with the passage of an "Act for the Encouragement and Relief of Friendly Societies," probably the first governmental sanction of self-help groups. The Preamble to the Act states: "Separate funds for the mutual relief and maintenance of the said members in sickness, old age, and infirmity is likely to be attended with very beneficial effects, by promoting the happiness of individuals, and at the same time diminishing the public burthens."

Notwithstanding this government support, the Friendly Societies elicited adverse reactions from some quarters. An observer of the Leicestershire woolcombers wrote in 1751: "For a number of years they have erected themselves into a sort of corporation; their first pretence was to take care of their poor brethren that they should fall sick, or be out of work...and when they became a little formidable they gave laws to their masters, as also to themselves--viz. that no man should comb wool under 2 shillings per dozen, that no master should employ any comber who was not of their club, if he did they agreed one and all not to work for him...and often times would abuse the honest man that would labor; they further support one another in so much that they are become one society throughout the kingdom. And that they may keep up their price to encourage idleness rather than labour, if anyone of their club is out of work, they give him a ticket and money to keep for work at the next town where a box club is, where he is also subsisted; by which means he can travel the kingdom round, be caressed at each club, and not spend a farthing of his own or strike one stroke of work. This hath been imitated by the weavers also."

The Friendlies grew and prospered, forming a quasi-primary kin group for their members. Their function far exceeded support and protection for the working man and extended into the social lives of its members. Friendly Societies still exist in Britain today.

In this country the foundations for self-help were laid in the days of the earliest settlers who were forced to band together for protection from the elements, the natural environment,

and the Indians whom they had displaced. The notion of neighborliness, of relying on others in the community for help as opposed to turning to institutionalized forms of aid is deeply ingrained in the American character. The breakdown of the extended family and the mobility of Americans in general have served to destroy the sense of community for many. The proliferation of self-help groups in the latter half of this century demonstrates a basic need on the part of many to re-establish the sense of community that technology and the success ethic have partially destroyed.

The massive wave of immigration which began in the late 1800's accounts for much of the growth of the self-help movement in this country. Immigrants turned to each other for help and support in a land that was often callously indifferent to their needs. Saddled with the problems of learning a foreign language and alien customs, and lacking outside supports, the immigrant groups turned inwards and organized large networks for self-help and mutual aid. One such group was that established by the Greek community. Known nationally as the Pan-Hellenic Union, the organization had 20 branches in Massachusetts by 1912. Its primary function was to dispense sickness and death benefits. Italian immigrants did not set up such an umbrella organization, but rather created societies based on geographic origin in the mother country. These societies were pledged to assist the new immigrant with a variety of needs. In the ghettos of New York, Chicago, Philadelphia, and smaller cities, Russian and Polish Jews set up their own mutual benefit societies. A book published in 1906 by the Liberal Immigration League described the panoply of Jewish self-help organizations existing in several cities by 1892: free loan societies, burial societies, societies for maternal relief, brotherhoods for visiting the sick and wayfarers' lodges. Almost all of these benevolent groups were relatively independent of the official religious institutions.

World War II and following events obscured the growth of self-help movements in this country until fairly recently. It was not that the movement stopped, but rather that public attention was focused elsewhere. Parents of mentally and physically handicapped children waged a battle against great odds to secure funding for special programs for their children. Many disease-specific organizations such as the National Association for Retarded Children and the National Cystic Fibrosis Foundation began with groups of concerned parents seeking help for their disabled children.

In the area of mental health an underlying belief in what Nathan Hurvitz identifies as the psychologistic view of human nature has prevailed in this country. This view holds that when man fails to find satisfaction and happiness, the fault or root cause lies within the man and can be found in intrapsychic dysfunctions. Treatment therefore consists of applying the medical model to the problem. This view tends to exclude societal forces as being the cause of human failure and, as Hurvitz points out, "By denying the social conception, the psychologistic conception protects the American ruling class." This is a provocative notion and one that bears further study.

Abraham Low, a psychiatrist, developed a form of self-help therapy called Recovery, Inc. which began as an after-care program for ex-patients of mental hospitals. Low denied that adults are driven by irrational instincts and asserted that they are guided by will. He developed a form of group therapy based on his book *Mental Health Through Will Training*. This approach emphasizes individual self-reliance.

The concept of self-reliance is also utilized in Synanon, a form of communal self-help begun by a former alcoholic, Charles Dederich. Synanon began as a program for drug addicts, but has since branched out to offer an alternative life style for many individuals who are not seeking relief from deviant symptoms, but who simply wish to find another way to live in this culture.

The work of Otto Rank helped to begin the task of freeing treatment from the medical model. Carl Rogers was influenced by Rank and through him, and the popularizing of the non-directive approach to therapy, others were influenced. Rank's techniques were introduced to social work, the profession with the largest number of non-medical psychotherapists, by Robinson and Taft at the Pennsylvania School of Social Work. Moreno's work in psychodrama also had an important impact on the practice of psychotherapy, as it involved the therapist and the patient in a spontaneous and public relationship. Pure economics played a part here as well. Due to the length of time and the costs involved in the training of psychiatrists, as well as increasing demand for psychotherapeutic services, it became expedient to utilize social workers in the delivery of mental health services. All these factors tended to free therapy from the medical model.

Perhaps the greatest push for the acceptance of the self-help model came from the granddaddy of self-help organizations, Alcoholics Anonymous. In AA we find the genesis of the

self-help model as it applies to many of the newly formed symptom groups of today, including Parents Anonymous. It is hard to remember now, but at the turn of the century alcoholism had the same stigma that is now attached to child abuse. Like child abuse, alcoholism is found in individuals of all social classes, races, and religious persuasions. In a country still tied to the Protestant Ethic of work as a good in and of itself, for a man to be incapacitated to the point where he could not hold a job branded him as inherently evil. The heavy drinker was viewed with the same alarm and prejudice that attends the child abuser today.

A. A. was an outgrowth of a movement called the Oxford Group, which emphasized the changed life. This was achieved by public confession of the member's failures, disclosure of his sins, and his testimony of how he had triumphed over them. Two alcoholics, Bill W. and Dr. Bob, who had participated in the Oxford Group, met in Akron, Ohio in 1935. They applied the principles of the Oxford Group and found them mutually beneficial. Both Bill W. and Dr. Bob sought out other alcoholics, and, as they succeeded with them the movement grew. Bill W. became increasingly interested in the religious and spiritual sources of self-help and it was he who developed the 12 Steps which are a focal part of A.A.'s methodology. The wide popular acceptance which A.A. has received over the years has done much to remove the stigma of alcoholism and to give credibility to self-help as a viable treatment modality. While Parents Anonymous does not utilize A.A.'s methodology, it is very much in its debt for paving the way by demonstrating to a psychologized society that it is possible for people to be helped by others who share the same problem.

A central issue of the self-help movement has always been distrust of professionals. To quote from the *Journal of Applied Behavioral Science:* "One of the most striking characteristics of self-help adherents is distrust of professionals. In fact, the easiest way of being accepted as one of the in-group is to make a few slurring remarks about physicians, social workers, or the whole academic establishment."

The following case history is illustrative. In May of 1972, a wealthy businessman with metastatic cancer approached the American Cancer Society and suggested the formation of a program of visiting volunteers using cancer patients with uncertain prognosis as the volunteers. A media program conducted without ACS sanction described such a program as though it were already operational, producing a deluge of individuals wishing to act as volunteers. With a certain amount of agency embarrassment, the Los Angeles ACS initiated a two-year demonstration project. The social worker chosen to act as project director was given a vague mandate by ACS to establish a volunteer self-help program. The director's assurances to the CanCervive volunteers that they could set their own policies and guidelines alarmed her ACS supervisor and resulted in adversary relations between the agency and the volunteers. The director was replaced after four months, engendering a great deal of anger from the volunteers who saw her dismissal as an agency attempt to control them and their program. Feelings were so intense that a research consultant hired two years later was immediately inundated with dramatically differing accounts of the director's behavior and the reasons for her dismissal.

The repercussions of the director's dismissal point up an issue that is central to the success or failure of self-help programs—autonomy versus control. Cancer patients, unlike victims of other diseases, are for the most part limited to passively following the treatment regimen prescribed for them while they endure the disease's encroachment on their bodies and their lives. The volunteers' feelings of frustration and impotence engendered by the disease were reinforced by the blunt reassertion of agency control of the program. It is ironic that in seeking to provide a corrective emotional experience for patients, the agency reproduced within CanCervive many of the same problems they hoped to relieve.

Referrals to the volunteer program were few and volunteers blamed this on the resistance of doctors and hospital staffs. The ACS staff suggested a meeting between the volunteers and the oncology staff of one of the major Los Angeles hospitals. Although the hospital staff recognized the volunteers' good intentions, they were reluctant to entrust their patients to them. To circumvent this problem the chief oncologist suggested a hospital-based volunteer program utilizing some of the CanCervive volunteers under hospital staff supervision. The ACS staff enthusiastically supported this compromise, but the volunteers were angered and felt debased, bitterly complaining of the professional elitism they felt the hospital staff had demonstrated. Two of the CanCervive volunteers opted to go along with the suggestion and they subsequently became estranged from the other volunteers.

Another area of disagreement between ACS staff and the volunteers was screening of volunteers. The volunteers viewed this as just another means by which ACS sought to control them. As cancer patients they felt that the only qualification necessary was experience of the

disease and they resented what they felt to be the imposition of arbitrary and irrelevant standards. Although the experienced volunteers resisted the screening, as the program continued they came to see themselves as old hands, and eventually they expressed a proprietary interest in the quality of the new volunteers that markedly resembled the concerns they themselves had earlier denounced.

Several conclusions can be drawn from this example. A major cohesive force in self-help groups is the egalitarian belief that all members are capable of counseling. Yet the professionals evaluated the volunteers according to their own criteria and assigned patients to those they saw as more skilled. The imposition of a hierarchical structure, with its inevitable jealousy and rivalry, effectively destroyed much of the supportive peer-group atmosphere. The ego involvement of both volunteers and ACS staff turned a dispute over organizational issues into a personal vendetta and prevented development of a collaborative relationship.

This illustration has nothing to do with Parents Anonymous and yet it typifies many of the developmental problems which self-help groups face. Control by a sponsoring agency can be the death of the program, or, as with Parents Anonymous and its happy relationship with the federal government, it can mean great benefit to the program. Alcoholics Anonymous has consistently avoided accepting any help from government sources, firmly believing that such help also means control with consequent cost to the viability of its program. Many self-help groups assiduously avoid the involvement of professionals. Some, like P.A., depend on the volunteer involvement of professionals for the maintenance of the organization at the direct service level. Some self-help organizations do not seem to need interdependent relationships with other community organizations and agencies. Others, like P.A., depend for their survival on building strong ties to the communities in which they exist, both for referral sources and to give assistance in many areas of functioning for the parents who are involved in its chapters.

In 1954 the International Conference of Social Work had as its theme "Promoting social welfare through self-help and cooperative action." The Dutch social welfare leader, J. F. DeJongh summarized the major theme of the conference with these words:

> "In the life of the individual, as well as in the life of groups, self-help and help from others are equivalent factors. They reflect basic aspects of the human situation. The one begins where the other ends or fails. Seen in human life as a whole, self-help and help from others are not contrasts but complements."

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Future Planning for Child Abuse and Neglect Programs: What Have We Learned from Federal Demonstration?

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INTRODUCTION: ON THE NEED FOR PLANNING

The problems of child abuse and neglect are becoming more visible, and we are learning, almost daily it seems, new and promising ways of preventing and treating this problem with which we are all concerned. This is happening, however, at the exact time that resources for all social service programs are becoming more scarce as more and more competing demands are being placed on programs for services to other populations. It is imperative, then, that those of us working in this field be able and willing to make hard choices about the best use of scarce resources. In effect, we must be committed to the idea of planning programs or changes in programs long before they become realities. Most simply stated, planning is a method of determining, first, where we are; second, where we want to go; and third, the best and least costly way of getting there.

One of the most effective methods of beginning the planning process in community child abuse and neglect systems, and one which, unfortunately, is rarely carried out, is to assess what exists in relation to what is desirable, i.e., to conduct a community-wide needs assessment to identify any fragmentation, duplication, and gaps in community services that contribute to inefficient and ineffective systems. Such an assessment includes identifying all key agencies and individuals in the community that would potentially deal with child abuse/neglect problems and collecting from them information about their staff, the services they provide, the way their services are coordinated with other agencies, and the problems they experience dealing with child abuse and neglect cases. Once this information is collected and analyzed in relation to what is desirable, most problems in the system will be highly visible; efforts to resolve them can then begin. The primary problems should be addressed first. When those are resolved, others on the list can be tackled.

We would like to present some ideas about the areas which should be evaluated in any complete needs assessment, and which, if implemented, would help to move community systems for dealing with child abuse and neglect in directions that we would like to see the field go, namely, the prevention of all preventable abuse and neglect; the cost-effective and timely treatment of all treatable abuse and neglect; and, in cases when effective treatment has not been possible, the early and permanent resolution of cases in the best interests of the child and his or her right to a protected and stable childhood.

The ideas we present are based on careful study of 12 child abuse and neglect service systems, carried out during the past three and a half years, and on observations of numerous other projects and programs around the country.[1] In addition to determining the costs and effects of various treatment services to clients, we have compiled a series of recommendations about what an effective and well-functioning community system should include. In planning for new or expanded child abuse and neglect programs, or in attempting to coordinate existing resources, the elements of the community system which appear critical include:

1. A coordinated, interdisciplinary, interagency community response;
2. A comprehensive treatment program;
3. Quality management of cases;
4. An active preventive program;
5. Quality program management.

Each of these is discussed in detail below.

I. Elements of a Coordinated Community Response

The development of a multi-agency coordinating or advisory body is an important first step in creating a system capable of responding to all facets of child abuse and neglect problems. This body, which should include at a minimum representatives from protective service agencies,

police or sheriff's departments, the juvenile court, the schools, local hospital(s), private service agencies, and community representatives, would have the overall responsibility for planning the necessary changes or expansion in the community system and would provide a forum wherein all interested individuals could communicate to solve real or perceived differences.

In order to accomplish this, it is important that the coordinating body set definite goals to pursue, and be vested with some legitimacy (although this need not be actual legal or political authority) to pursue those goals. Without goals, and a framework for accomplishing them, advisory board or committee meetings may be reduced to little more than social gatherings where many problems are discussed but little action is taken.

The second important element of a coordinated community system is a 24-hour centralized reporting and response system. Many state laws already require that some mechanism exist for 24-hour reporting of cases. Obviously, a critical ingredient of a 24-hour reporting and response system is access, at any time, to a place to call. However, a repository of calls is not sufficient, particularly if it is statewide. There is also a need for immediate response to calls—minimally by phone—to determine if there is immediate danger to a child, and if so, for action to follow. It is best if that response is undertaken by someone at the local level. In other words, the well-functioning system has the capacity to intervene in family situations on a child's behalf at any time, and that intervention is undertaken by someone who is knowledgeable about the dynamics of abuse/neglect.

Many programs have developed arrangements with local "hot-lines" to accept reports of child abuse or neglect and immediately forward them to program personnel who are "on call." Other programs use a "beeper system" so that workers can be notified of reports immediately. However a 24-hour reporting and response system is organized, we need to know that we can respond quickly to emergencies, not just record them as reports. We also need to know that skilled people are providing immediate intervention and that we are not over-responding—i.e., removing children from their homes when there is no need to.

The centralization of reporting, that is, the designation of a single agency in the community to receive reports, is likewise a provision of many state laws. When more than one agency has the responsibility of receiving—and responding to—reports, there is a danger that cases will get lost between agencies, and no service will ever be provided to some clients, or that some cases will have duplicative services provided, that is, one case will be investigated several times by staff of different agencies. Both problems can be avoided if only one agency is designated to receive reports, and both professionals and community citizens are aware of which agency that is. However, if your state law designates two agencies to receive reports, these problems can be minimized by requiring that copies of all reports received by one agency be forwarded to the other agency for information purposes. It is then incumbent on both agencies to coordinate their investigative and treatment-planning activities so that duplications are eliminated.

The third element of a coordinated community response is the existence of formal, clearly articulated methods for all key agencies to work together around both individual cases and general system problems.

The key to the well-functioning system is one in which different agencies work together, sharing resources, sharing expertise, communicating with each other and solving problems to everyone's mutual satisfaction. "Working together" doesn't just happen, particularly among bureaucratic agencies; it is something that requires effort on everyone's part. Police and protective services, the schools and the courts, the medical center and the mental health center must all be willing to remain open to new ways of solving problems while retaining their agency responsibilities for various aspects of services. Agreed-upon relationships between any two agencies for reporting or referring cases, for service provision, or for input into case decisions should be known to and understood by more than high-ranking officials in those two agencies; line workers need to understand how they can relate to or depend upon another agency. Other agencies in the community need to know about interagency agreements as well. Putting working agreements into writing can help—this forces careful articulation of what is being agreed to and can serve as a record as workers leave and are replaced. However, working together should not be limited to that which can be formalized in writing. Informal linkages are also important. Knowing workers in other agencies on a first name basis, for example, can go a long way in facilitating working together. Careful effort to include as many people as possible in any planning endeavor or problem-solving session helps to reduce isolation and ensure cooperation. An advisory board or coordinating committee composed of representatives from all key agencies is one way of assuring this input, and various communities have used other clever techniques to

trigger informal communication and cooperation as well: a retreat, a monthly breakfast meeting, conferences and workshops.

The fourth element of a coordinated community response to child abuse and neglect is the education of all citizens of the community so that they understand the dynamics of child abuse and neglect and the system which is in operation for receiving reports and providing treatment for parents and children. The development of an adequate, well-functioning system in the community will be of little value if the people most often in a position to detect child maltreatment are not aware of their reporting obligations or of the proper agency(ies) to contact. Providing community education is the responsibility of all agencies involved with child abuse and neglect, not just protective services or demonstration projects. Each agency should have at least one person (preferably several) capable of providing educational presentations to community and civic groups when requested. Agency staff should also encourage groups to request education sessions.

II. Elements of a Comprehensive Treatment Program

Each community has at least one, and usually several, treatment programs that are appropriate for providing treatment to child abuse and neglect clients, even though they may not be labeled child abuse and neglect programs. Clearly, protective services is one such agency, but mental health centers, private counseling agencies, and therapeutic centers for children also may be highly qualified and often under-utilized agencies of treatment, and each should be considered part of the community's treatment options.

The first necessary element of treatment programs is ability to handle the full range of child maltreatment cases, including physical and emotional abuse and neglect, sexual abuse, and both high risk or potential as well as actual cases. Although physical abuse is perhaps the best recognized form of maltreatment and engenders the most immediate response, there is ample evidence to suggest that the other forms of abuse—and neglect—are equally threatening to children's well-being, if not to their lives. Community systems should strive to provide treatment options for all types of child maltreatment and not limit themselves to narrow definitions of the problem. These options will likely be slightly different for different problems, and designing appropriate alternative service strategies for these various problems should be a priority. It is particularly important that high risk families, especially those that reach out for help, be afforded the intervention services that might stave off future maltreatment.

The second element of treatment programs is a triage mechanism for promptly assigning reported cases to the most appropriate service providers. Cases of child abuse and neglect differ greatly in amount, type and timing of the services they require at the point of intake. Many need immediate, intensive therapeutic assistance because the family is truly in crisis; others with less serious problems may require long-term but less intensive intervention to slowly change their patterns of behavior and relating. Likewise, treatment workers are apt to be more skilled and experienced in dealing with certain types of cases than with others. In order to assure that the services provided to clients are the most appropriate to their needs, and that these services are provided by those most capable of providing them, cases should be screened at the point of intake (much like a medical triage system) and referred to the appropriate service providers. Often this will mean simply that cases are assigned to different staff members of the same agency who have specific skills, but it may sometimes mean that cases will be immediately referred to completely different agencies for treatment. Again, adequate coordination and cooperation between agencies is imperative for this type of initial sorting of cases to occur smoothly.

The third element of treatment programs is the availability of a full complement of treatment services for both adults and children. Since the problems of child abuse and neglect are often interactive between the parents and children, a community system should not limit itself solely to the treatment of parents. Likewise, since the predisposing problems in the family which trigger the maltreatment are different for different families, no single treatment service or even combination of services is likely to be appropriate for every client. Thus, communities should strive to have available a variety of treatment options so that both parents and children can be offered what is most appropriate to their needs, and so that services can be offered in combination with one another for optimal effectiveness.

A full complement of services would include:

— individual and group services;
— supportive and advocacy services as well as therapeutic and educational ones;
— crisis or emergency and long-term treatment;

— day services as well as residential care; and
— professionally-provided services as well as self-help endeavors.

Services to parents, then, would include individual counseling and group therapy; financial, legal and medical assistance; parent education classes; a crisis hot line; lay therapy; and self-help groups such as Parents Anonymous. Services for children would include crisis nurseries, day care programs, play or art therapy, child development classes, and social enrichment programs.

The final treatment option which must obviously be available in every community is foster care. Although there is a prevailing belief and commitment to the idea that families should receive whatever intervention is necessary to maintain children safely in the home, removal of a child will be necessary in some cases. In a well-functioning system, these necessary placements will be made, but intensive services will be provided to the family at the same time so that the child can be returned quickly to a safe and stable environment. When there is indication that returning the child to his or her parents is unlikely within a reasonable time, plans for permanent removal of the child should commence to avoid the damage that multiple long-term placements can have on children.

III. Elements of Quality Case Management

In order to provide the highest level of services to the large number of child abuse and neglect cases that are currently being reported in most communities, it is important that staff of all agencies follow optimal case management practices.

The first element of case management is the adherence to standards of quality in the day-to-day management of cases. In a well-functioning system, there is quick response to all initial reports--no report is left "open" for longer than one week; there is adequate diagnosis and service planning so that parents and children receive the services they need, not just the most common ones or the ones that are immediately available; there is follow-up on all referrals so that cases are not lost; there is periodic review of cases to determine current need; there is timely development of termination plans; and there is some follow-up on all terminated cases to determine the current status of the family. All of these quality case management practices, of course, need to be carried out with sensitivity to the unique situation of the clients and with a genuine concern for providng them with the skills and support that will enable them to eliminate abuse or neglect from their families.

The second element of adequate case management is the availability of interdisciplinary input at all stages of the service process. In the well-functioning system, throughout the treatment process, from intake, initial investigation, and diagnosis through treatment and termination, there should be input from many different perspectives. It is true that some workers are capable of appreciating and responding to the array of problems confronting a given family. In general, though, it is rare for a single worker to be able to both perceive and effectively respond to the range of a family's needs. In general, several people need to review and have input into a case. And, in general, it is preferable for these people to represent different disciplines or at least different ways of viewing the world. Protective service workers should have access to legal consultation when preparing a petition for court; a school social worker should have psychiatric consultation when determining a therapeutic treatment plan for abused children; an emergency room physician should have social work consultation when deciding if a child has suffered abuse.

One increasingly common method of insuring interdisciplinary input is the use of a multidisciplinary review team. Such a team, typically composed of a social worker, a pediatrician, a psychiatrist and/or psychologist, a lawyer, a teacher, and a police and/or court worker, meets to discuss individual cases in detail and make recommendations about treatment. Such meetings may occur at intake and/or during treatment. In some communities, such team reviews are provided for every case referred to protective services; in other communities, workers select a few cases—perhaps the most difficult—for team review. These teams have important benefits: they provide valuable training to workers while insuring thorough review of the case. However, they are expensive, well over $100 per case review, and time-consuming. A well-functioning system need not provide team reviews for every reported case or even every substantiated case, but should be able to provide reviews for any cases which individual workers would like to be able to bring to the team. An important concept for such teams is that they be available for use by anyone in the community. In other words, the team does not "belong" to protective services or to the hospital, but rather is open to reviewing any cases being handled in the community.

IV. Elements of Preventive Programs

It is finally becoming recognized that preventive efforts are as important in child abuse and neglect systems as treatment services. Both must be carried out simultaneously if we are to to bring the problems under control.

The first element of preventive programs is the availability of primary prevention activities. Primary prevention might be defined as those activities which are aimed at eliminating the situaions and behaviors often cited as responsible for child maltreatment before they become realities. Although the elimination of poverty and high unemployment and the provision of adequate education to all might be the best answers to the problems of child maltreatment and are goals we must work towards, they are unlikely to be achieved in our lifetime. Other primary prevention activities, however, are very much within our power to accomplish. These include adequate preparation and education of school age children for the responsibilities of adulthood, sensible and early sex education, and family life and parenting education. Good parents are not born, nor does physical maturation ensure the emotional maturity necessary to assume the responsibilities of adulthood and, more importantly, parenthood. In many cases, coping with a rapidly changing world, or a rapidly changing child, is a skill that must be taught at a young age and then reinforced periodically. An adequate community system for dealing with child abuse and neglect will provide these front-line prevention activities.

The second element of preventive programs is the availability of secondary preventive services. Secondary preventive services are those activities which intervene at the point in a family's situation when abuse or neglect are imminent, but before maltreatment has occurred. These activities are usually of two types. The first are those in which professionals identify situations or behavior that might be called high risk, and encourage families to seek assistance. Examples of these services are pre-natal screening to determine ambiguous or hostile attitudes about the pregnancy and hospital screening of new parents to determine how easily they are adjusting to the new baby. In both instances, appropriate services and supports which might reduce the potential for child abuse or neglect are offered. The second type of secondary preventive activities are those which are sought by parents themselves when they realize there is a possibility of their mistreating their child. These activities are often crisis oriented, such as 24-hour counseling hotlines, but may be more planned and long-term, such as parenting classes for families encountering difficulties and frustrations with their children.

V. Elements of Quality Program Management

Several considerations about the management of all types of programs for dealing with child abuse and neglect are important for communities to consider when evaluating the adequacy of the community system.

The first element of program management is adequate provision for the ongoing training of all categories of staff. We have found that the more informed the professional staffs of all agencies in a community are, not only about the dynamics of abuse and neglect, but also about the way their community system functions, the better the care abused and neglected children and their families receive. Lack of knowledge leads to prejudicial and often injurious treatment of both parents and children. Because of the high turnover rates in many of the professions dealing with abuse and neglect, because we are continually advancing our knowledge about maltreatment, and because people forget, it is important for training to be ongoing, not one workshop or one seminar series, but an ongoing process of dissemination, sharing and discussion of information. And, it is important for such training to reach all relevant professional groups who are involved in the detection, treatment, or legal aspects of child abuse. This implies that some group or agency be responsible for such training and that the responsibility include delineating all relevant agencies and professional groups in the community and systematically making sure that they receive training.

The second element of program management is the active pursuit of methods which reduce or at least prepare for burn-out among treatment workers. Dealing with problems of child abuse and neglect on a daily basis is an emotionally wearing and oftentimes ill-rewarding business. Studies have shown the burn-out rate to be extremely high among protective service workers and the reasons are understandable. Working with physically or emotionally damaged children, dealing with dependent parents who are extremely needy and almost child-like themselves, and often having to separate families against everyone's desires is emotionally and

physically draining. Program directors must make provisions for reducing the burn-out workers experience if highly qualified people are to remain in the system. Some ways of accomplishing this include providing for rotating the intake function among workers, since this is a demanding job with few of the rewards of long-term association with individual families; providing a variety of experiences for workers in addition to direct client contact, such as presenting community or professional education sessions or participating on community advisory boards; and providing timely and adequate supervision to staff so that the entire burden of dealing with difficult, often frightening, cases is not being carried by the single worker alone.

Workers themselves can contribute to reducing their own burn-out by seeking support and advice from other staff members and supervisors, by sharing their concern about problematic cases, and by consistently attempting to provide their cases with high quality services without over-identifying with clients or becoming so enmeshed in their problems that their own pleasures and strengths are minimized.

The final element in program management is the appropriate use of volunteers in all aspects of the child abuse and neglect system. There is no question that most of the agencies and programs available in communities to deal with child abuse and neglect problems are understaffed. It is unlikely that significant new manpower will become available and it is thus incumbent on all communities to take advantage of available resources. Chief among these often under-utilized resources are volunteers. Programs around the country have had extremely positive experiences in using volunteers in a variety of capacities ranging from providing education to community groups to staffing hot lines to direct client work in the form of lay therapy with parents or children. With appropriate training and adequate supervision, these volunteers have contributed immeasurably to extending the services available in their communities. In addition to middle-age women, who are most often used in this capacity, many other types of volunteers are available: school-aged children can be used in day care settings to play with children; social work students are often fully qualified for direct client contact (under supervision, of course) and can gain valuable experience as well; and retired people, both male and female, provide wonderful role models and teachers in therapeutic settings for children. Although the training and supervision of volunteers does require extensive professional input, making volunteers not a totally "free" resource, the investment appears to more than pay for itself in the long run, and the community gains a cadre of people who are invested in the problem and supportive of the efforts undertaken.

CONCLUSIONS

Child abuse and neglect are serious problems; there is much that each community can do to respond to them. Resources are scarce. We all must make a concerted effort to make optimal use of what resources do exist. We have studied models around the country that point the way to well-functioning, indeed ideal, child abuse and neglect systems and have extracted from those models what appear to be essential elements for any community-wide system. It is time now for all communities to consider these elements, and others, in light of what currently exists locally, and to systematically plan for needed improvements.

FOOTNOTE

[1]Part of this work was completed under contracts HRA 106-74-120 and 230-75-0076, National Center for Health Services Research, Division of Health Services Evaluation.

Management and Staff Development

Evaluating Case Management

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INTRODUCTION

Workers engaged in the delivery of child abuse and neglect services who are attempting to better serve their clients constantly need new knowledge and new information to guide service delivery. Evaluation is a tool which can provide new knowledge. Evaluation (the examination of the workings of a program coupled with judgments based on the results of the examination), serves to illuminate deficiencies as well as effective processes and procedures. Policy and procedural modifications based on the evaluation can then contribute to the overall improvement in service delivery.

There are two basic types of evaluation—large-scale evaluations, and evaluations carried out within a given program, usually called self-evaluations. While large-scale evaluations cover a multitude of program components or several programs, usually require full-time evaluation staff, and cost a lot of money, smaller self-evaluations fit within the operating budget of an agency and are conducted in conjunction with regular staff and administrative duties. This paper will discuss how the methodology and results of a large scale evaluation can be applied to child abuse and neglect programs' self-evaluations, and thereby help improve their functioning.

THE LARGE-SCALE EVALUATION

Berkeley Planning Associates of Berkeley, California, has been working for the past 2½ years on the National Evaluation of the Joint Demonstration Program in Child Abuse and Neglect. This evaluation of eleven service projects across the country and in Puerto Rico is the prototype of a large-scale evaluation in the abuse/neglect field. Our effort has employed five to six full-time people to carry out a complex and comprehensive study of the operation of these projects. Briefly, the major components of the evaluation are:

1. Assessment of the projects' goal achievement;
2. Assessment of the impact these projects have had on their communities;
3. Assessment of the impact of services on adult clients;
4. Assessment of the impact of services on child clients;
5. Assessment of the dollar costs of these projects' services;
6. Assessment of how management processes and organizational structures contribute to worker burn-out; and
7. Assessment of the quality of case management practices.

This evaluation has used a wide range of methods for data collection and analysis. Periodic structured and unstructured interviews, organized group process techniques, tabulations of yearly program statistics, maintenance of client data, record reviews, and staff surveys were all used. Case studies, descriptive statistics, and complex multivariate statistical techniques are all means being used to analyze the vast amount of data collected.

TRANSLATING THE LARGE-SCALE EVALUATION TO THE PROGRAM LEVEL

This evaluation effort, with four months yet to go on its three year contract, has put out more than 20 reports, as well as many working papers. While the evaluators firmly believe in the value of those reports for individual child abuse and neglect programs, we have been frustrated by the lack of integration of the published findings at the program level. I would like to attempt to bridge the gap between evaluation results and their utilization and implementation by administrators and staff. All aspects of the National Evaluation have applicability to individual service agencies, but this paper will focus on one of the components, that of the assessment of the quality of case management.

WHY FOCUS ON CASE MANAGEMENT

Most of the National Evaluation's original study design focused on examining program outcomes. We were doing some process analysis, primarily using a case study approach to examine the projects' implementation problems. However, within the first few months, in response to the

people in the field and to the federal government, we decided to look more rigorously at another element of service delivery, that of case management. Case management in a child abuse/neglect service agency includes all phases of service delivery from intake through diagnosis, development of a treatment plan, management of service delivery and referral, to case termination and subsequent follow-up. The field agrees that case management is an important part of service provision. Good case management implies continuity of service provision, planfulness (i.e., rational decision-making) in designing and executing a treatment package, coordination among all providers of services, effective involvement of the client, timeliness in moving clients through the process, and maintenance of an informative and useful case record.

In our assessment of case management practices, we asked three basic questions: (1) What are the standards for case management?; (2) What specific practices or activities are critical to overall quality case handling?; and (3) Does the quality of case management make a difference in terms of successful outcomes for the clients? This last question is important, for if it can be shown that quality case management is significant in predicting successful case outcomes, then an evaluation of an agency's case handling practices can serve as a proxy measure of the effectiveness of services in improving the functioning of clients.

THE CASE MANAGEMENT ASSESSMENT APPROACH

The development of this evaluation began with a workshop in February, 1975; some of the participants present were experienced in abuse and neglect service delivery and others in quality of medical care assessment. Based on the deliberations of the workshop and the suggestions of other consultants, criteria defining quality and a general approach to assessing the quality of the case management process were developed. The criteria and approach were translated into procedures and instruments which were then pretested at five agencies. Finally, in the spring of 1976, a first round of data collection was carried out by two teams of consultants who were acknowledged expert abuse and neglect practitioners. Site visits to nine of the eleven demonstration projects resulted in reviews of 275 sampled cases. A second round of visits, using only one expert clinician, was held nine months after the first, and data was collected on an additional 100 cases.

First of all, it is important to point out that the primary sources of information for the assessment were individual cases. Our case review instrument, applied to a sample of cases, covers seventeen elements in eight basic areas of case management:

1. Timeliness of the process: e.g., time between referral and first contact, time between first client contact and beginning of treatment, and total time as an active case.
2. Amount of contact between manager and client: e.g., number of contacts prior to diagnosis and treatment plan and number of contacts during treatment.
3. Outside case review: e.g., use of multidisciplinary review teams or consultants.
4. Referral for treatment: e.g., number of project staff providing services to client; use of outside treatment providers.
5. Reassessment of case: e.g., use of case conferences or staffings.
6. Coordination between manager and other treatment agencies: e.g., contacts with referral source, contacts with outside treatment providers.
7. Service continuity: e.g., number of primary case managers per case.
8. Client participation: e.g., presence of client at review meetings and case conferences.

The case review instrument also gathered the client's socio-demographic characteristics, the facts of the case (such as severity of abuse or neglect and whether or not there was court intervention) and primary case manager characteristics (such as age, sex, training, experience, and caseload).

The assessor reviewed each case, then rated the quality with which the case was managed on a five-point scale.

DATA COLLECTION PROCEDURES

Most of our data was collected by two-person consultant teams making four-day site visits to the participating projects. The first step was an interview with the project director. Use of a topic guide ensured that all important background information, such as organizational structure, case handling policy and procedure, and names of key referral agencies were covered in the orientation.

Following the initial interview with the director, each assessor reviewed a number of randomly selected cases. The cases were sampled in advance of the actual site visit from projects' lists of all cases opened between January, 1975 and January, 1976. The case lists were first stratified by case manager; a random selection of cases was taken from each strata. The number of cases per case manager depended on his or her caseload's proportion of the agency's total caseload, with a minimum of two cases per worker. Each review required 30 to 45 minutes to abstract the record for the case review instrument, and 15 to 20 minutes for a follow-up interview with the primary case manager to obtain additional information not found in the record or to verify any unclear record data.

Each assessor reviewed approximately 20 cases during the course of a site visit. Only 35 cases per project were reviewed, because five cases were reviewed by both assessors. This overlap was meant to allow subsequent reliability testing of the case review instrument.

After the case reviews were all completed, the assessment team held a one to two hour debriefing with the project staff, during which time they provided general feedback and offered suggestions for changes in case handling practices. Although in these sessions the assessors did not refer specifically to the individual cases reviewed or to particular items on the case review instrument, they did leave behind a copy of the questionnaire.

ANALYSIS OF THE DATA—RELIABILITY

Two kinds of analysis have already been carried out on the data brought back: establishing the reliability of the instruments used, and determining the norms of case management as practiced in the nine abuse and neglect projects. Despite the fact that we still have important analyses to do, such as determining the case, client and case manager characteristics that are associated with particular case handling practices as well as with high or low quality, and determining which case management practices have effects on the outcome of clients in treatment, the evaluation results generated to date can already be useful to program staff in monitoring the quality of their own case management.

In order to determine if two assessors reading the same record and talking with the same case manager recorded the same responses and the same ratings, at each site five cases were reviewed by both experts, who completed their forms independently. These case review instruments were then analyzed for exactness of response. For most of the items in the instrument, there was agreement across assessors 80% or more of the time, either in an absolute sense or when the ranges or scales were collapsed into fewer categories. We consider the 80% cutoff an acceptable level of reliability; administrators and staff can use the case review instrument with confidence.

Specifically, the results of the reliability testing on the instrument items are as follows:

1. For variables describing the case, client and caseworker, there was a very high percentage of agreement.
2. Variables describing the management of individual cases were also reliable, although some categories had to be collapsed in order to achieve a higher degree of agreement. (For instance, our instrument has seven choices for frequency of contact, but for analysis we have collapsed the responses into five categories.)
3. Judgments on the adequacy of case records were highly unreliable, leading us to conclude that the assessors (and maybe other experts in the field also) could not agree on the necessary contents of a written record. These items will not be used in future analyses.
4. Quality ratings on various aspects of the management of individual cases were not acceptably reliable on either a five-point or a three-point scale; an acceptable level of agreement could only be achieved on a two-point scale. While this may be due in part to different expectations of the assessors, it is our interpretation that, given the 'state of the art' for most aspects of case management, there can be agreement on what is good or not good, but not on the finer distinctions of what is less than good.

ANALYSIS OF THE DATA—STANDARDS FOR ABUSE/NEGLECT PROGRAMS

In addition to developing a method for self-evaluating case management practices, the preliminary findings of our large-scale case management quality assessment are also useful as minimum standards or benchmarks against which a program can measure its own performance. Because the programs which participated are demonstration projects, they are assumed to be

equipped to provide at least adequate, if not exceptional, management of their cases. Therefore, if significant negative deviation from that norm for the various case handling practices is observed during an evaluation of another program, that staff would benefit from examining the reasons for the differences. There may be reasonable explanations and justification for deviation from the norm, but examination and comparison will serve as an alert mechanism to draw present practices and procedures to the attention of staff.

Depending on your own experience you may be surprised or disappointed with the norms of case management as found in the nine projects. However, keep in mind that the projects represent a wide range of service models, from large, urban protective service units to hospital-based programs and free-standing, voluntary agencies. Norms, then, are based on averages and ranges found across all the participating programs. The following are the norms of case management as determined by the case management assessment:

1. The norm for time between referral of a case and the first contact with the client was within three days.
2. In 85% of the cases, the worker recontacted the initial referral source for additional intake information; in 70% the initial referral source was recontacted while the client was in treatment, to provide feedback.
3. Following the initial contact, the typical case had at least one more contact with the client before a decision was made on a treatment plan; 42% of the cases had two or more client contacts before a treatment plan was developed.
4. For 2/3 of the cases, therapeutic treatment services began within two weeks of the first contact with the client.
5. Despite the emphasis in the field on the use of multidisciplinary review teams, most cases in our sample did not have these reviews either at intake, during treatment, or at termination; only about 35% had multidisciplinary reviews at any time.
6. The use of outside consultants on the management of the case also was not the norm, although 38% of the cases did have at least one such consultant.
7. For about 60% of the cases, case conferences or staffings were used sometime during the case management process, most often during the treatment phase rather than at intake or termination.
8. For more than 40% of the cases, the case manager was in contact with the client once a week or more; in only 14% was there contact less than once a month or once or twice only.
9. 80% of the cases reviewed had only one case manager, but
10. 60% of the clients in the sample had at least one other project staff person providing services.
11. In most cases (66%) there was another agency or individual outside the project providing services to the client; of these cases, there was agency communication with the outside agencies or individuals 85% of the time.
12. After termination, most cases (56%) had at least one follow-up client contact. In 50% of the cases, at least one follow-up contact was also made with outside agencies from which the client was receiving services.

(Information in this paper based on findings from an evaluation funded by the Health Resources Administration's National Center for Health Services Research under contract numbers HRA 106-74-120 and HRA 230-75-0076.)

The Concrete Use of Management Tools in Child Welfare: Integrating Nominal Group Technique, Time-Motion Studies, and Functional Job Analysis for Decision-Making in a Child Abuse Hotline

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BACKGROUND ON THE CHILD ABUSE HOTLINE

The Child Abuse Hotline (CAH) was developed and implemented by the Texas Department of Public Welfare in conjunction with the Child Abuse Campaign in September of 1974. The objectives of this program were (1) to extend the telephone intake of child abuse and neglect reports to a 24-hour, seven days per week process, and (2) to supplement the local child welfare intake units throughout the state. Its mandate was to take all telephone referrals of child abuse and neglect and relay these reports to appropriate county child welfare units.

Existing hotlines were not used as models for developing the CAH, although some information was obtained from a Florida hotline program which aided the Texas Department of Public Welfare (DPW) in avoiding some predicaments which may have negatively affected its implementation and functioning. Funding for this program came predominantly from unspent tranferrable social services monies already in the DPW budget. The level of funding has remained stable during the 2½ years of operation. The State Child Abuse Campaign Coordinator had charge of the development, implementation, and supervision of the CAH. He was directly accountable to the Deputy Commissioner for Program Administration. Thus, the CAH was not a part of any existing DPW department and had a minimal hierarchical ladder regarding accountability.

Staff for the CAH consisted of six positions at the Public Welfare Worker I (PWW I) level, based on state merit system qualifications. The rationale for using this level of personnel was the DPW administration's feeling that a staff of PWW I's would be required to cope with the responsibilities placed on them by the objectives of the program. No functional job description for CAH staff was ever developed at the state personnel office level or at a program level. The function of CAH staff was seen as essentially the same as that of PWW I's in large metropolitan areas (Dallas, Houston, El Paso, San Antonio), who do nothing but take telephone reports of child abuse and neglect from their geographical areas of jurisdiction.

PROBLEM

This paper will address two issues which presently affect CAH staff and current program managers of the CAH. The first issue deals with the prior lack of need for a functional job description for a CAH worker. At present there is no statement of the job functions of this position. Initially, the mandate of the CAH and the functions of its staff were clear and explicit. Currently, the question of whether or not the job functions of the CAH worker have evolved into others which are not contained in the mandate has arisen. The lack of any evaluative research directed to program "efforts" or analysis of CAH worker "tasks" does not permit an adequate response to this question. There exists little information on what CAH workers actually do and how much of their time is spent doing it.

The second issue contains two evolutionary processes of the CAH: (1) alternatives in CAH staff job levels, and (2) supervision of this program. Presently, the CAH employs four full-time PWW I's, two part-time PWW I's, and two full-time Welfare Service Technician II's. This is in contrast to the original staff of six PWW I's. The issue is: "If all members of the CAH perform the same functions, shouldn't they be at the same job level?" The supervisory aspect is one which has developed over a recent period of time, during which (1) the location of the CAH was moved to another location which was not acceptable to CAH staff, (2) the CAH became part of the Division of Child and Family Services of the DPW State Office, and (3) the program had a succession of three different supervisors. These three events have led to CAH staff being unsatisfied with their work environment and conditions and unhappy about being part of the traditional bureaucratic framework of DPW which incorporates multiple levels of accountability, and also to supervisory instability causing staff not to know a supervisor's expectations and the new supervisor not to know his staff and their tasks.

OBJECTIVES OF THE RESEARCH STUDY

In light of these issues, an evaluative research study was conducted with the following objectives: (1) to delineate the specific tasks performed by a CAH worker in carrying out the objectives of his job, (2) to assess the CAH worker's job function in terms of the specific and predominant tasks which he/she performs and the time required to perform these tasks, and (3) to devise a framework which would allow staff input regarding CAH supervisor job functions and the concerns of the CAH worker about the performance of his/her job function. The results of the data collected from this study generated conclusions and recommendations.

REVIEW OF THE LITERATURE

Tripodi defines social program evaluation as "the systematic accumulation of facts for providing information about the achievement of program requisites and goals relative to efforts, effectiveness, and efficiency within any stage of program development. The facts of evaluation may be obtained thru a variety of relatively systematic techniques, and they are incorporated into some designated system of values for making decisions about social programs (Tripodi & Fellin, 1969). He goes on to say that this framework is based on the notion of "differential evaluation", which simply means that the evaluation of the program should be primarily geared to the present stage of program development. For the purpose of this study we shall focus on the present issues stated earlier which are part of this program's stage of development. The research strategy will be directed to the evaluation of program efforts within the CAH.

The assessment of program efforts is concerned with the kind and quality of activities developed and engaged in to satisfy program objectives. Where the main concern is with efforts, results of the evaluation are usually at the descriptive and often highly subjective level (Carter & Wharf, 1973).

Suchman (1967) proposes five categories of criteria by which the success or failure of a program may be evaluated. He defines one of these, the effort category, as evaluations that have as their criterion of success the quantity and quality of activity that takes place. This represents an assessment of input of energy regardless of output. It is intended to answer such questions as "What do you do?" and "How much time did it take?" Although effort evaluation does not give key answers, it can be valuable. It indicates that something is being done to meet the objective of the program, which is a necessary condition for accomplishment.

Glisson (1974) categorizes social program evaluation techniques into three broad categories: (1) monitoring techniques, (2) social research techniques, and (3) cost-analytic techniques. The monitoring technique utilized in this research effort includes the "administrative audit", describing what is done by staff in relation to established standards, and time-motion studies describing the use of time in relation to staff activity.

Thus, it can be seen that evaluative research can be classified according to (1) particular categories of criteria regarding degree of success or failure of a program and (2) the particular technique utilized in the evaluation effort.

After a proposed evaluative research study has been formulated in terms of categorical criteria and technique, the next step is construction of the research design. The design decisions depend on the purposes of the study, the nature of the problem, and the alternative designs appropriate for the investigation. Once the purposes and focus of the study have been specified, the problem then plays the major role in determining what approaches are suitable. Design alternatives can be organized into functional categories based on differing problem characteristics (Isaac, 1971).

The category of "descriptive" research is utilized to systematically describe the facts and characteristics of a given population or area of interest factually and accurately. It is the accumulation of data base that is solely descriptive—it does not necessarily seek to explain relationships, test hypotheses, make predictions, or get at meanings and implications, although research aimed at these more powerful purposes may incorporate descriptive methods. Research authorities, however, are not in complete agreement on what constitutes "descriptive research" and often broaden the term to include all forms of research except historical and experimental.

Borgatta (1971) specifies four steps in carrying out descriptive research: (1) defining objectives in clear specific terms, (2) designing the approach by which data will be collected, what observational techniques will be utilized, etc., (3) collecting of the data, and (4) reporting of the results.

The descriptive research design varies in the units of study and in the simplicity or complexity of the phenomenon to be described. In simplest form, these studies describe a population by reporting characteristics (variables) one at a time. More complicated descriptive

studies consider two or more variables simultaneously for greater precision and concreteness. Thus, this category of research design requires carefully defined populations and representative samples. Data may be gathered through various means, observation being an important method. Such studies are usually ends in themselves (policy, planning, administration) but also generate hypotheses (Finestone and Kahn, 1960).

Designing the methodological approach is the pivotal step in developing and implementing a descriptive research design. It is imperative that the specific techniques one selects or develops meet the needs of (1) adequately addressing the objectives of the study, and (2) providing reliable information from the data generated by these techniques.

METHODOLOGY

Three specific techniques were utilized in conducting this research: (1) a Nominal Group Technique for decision-making, (2) the theory and operations of Functional Job Analysis, and (3) a Time-Motion study. Each procedure was performed in three separate phases of this study and in the sequential order listed above because each generated the data necessary to implement the succeeding technique. Each technique will be described and its utilization discussed.

Nominal Group Technique (NGT)

This technique was developed by Andre Delbecq and Andrew Van de Ven in 1968. It has been widely employed in human service organizations and increasingly as a tool for evaluative research.

NGT is structured group meeting whose primary purpose is decision-making. The following is a typical format for an NGT meeting: (1) Silent generation of ideas in writing. (2) Round-robin feedback from group members to record each idea in a terse phrase on a flip chart. (3) Discussion of each recorded idea for clarification and evaluation. (4) Voting for priority ideas with the group decision being mathematically derived thru rank-ordering. Thus, NGT facilitates decision-making performance by overcoming a number of critical problems typical of interacting groups. Some of the problems of interacting groups are: (1) Discussion tends to fall into a rut, with group members focusing on a single train of thought for extended periods, with relatively few ideas generated, (2) High status, expressive, or strong personality-type individuals tend to dominate in search, evaluation, and choice of group product, (3) Meetings tend to conclude with a high perceived lack of closure, low felt accomplishment, and low interest in future phases of problem solving.

The NGT theory and process was utilized to obtain information from CAH staff regarding:

1. Tasks performed by CAH workers, to establish a framework to develop standards to be employed in succeeding portions of the study.
2. What a CAH supervisor's functions have been and what they should be.
3. Concerns of CAH staff related to job performance.

Information gathered from the first topic allowed the study to proceed to its second phase and implementation of the second technique.

Functional Job Analysis (FJA)

Functional Job Analysis is an approach to job analysis developed by Sidney A. Fine during the 1950's. FJA deals specifically with increasing the accuracy and precision of descriptions of what workers do. It can be seen as (1) a conceptual system which defines dimensions of work activity and thus a way of conceiving the world of work, (2) an observational method and thus a way of looking at people at work, and (3) a method of analysis—of evaluating the design of work and its performance.

FJA is operationalized by the formulation of a "task statement" and utilization of scales of worker function—the primary tools of FJA. The task statement is a description of work, composed of action verbs, e.g., asks, listens, writes, etc. which are coupled with the fundamental unit of work, the "task". In these terms, a job, which is made up of a series of tasks, can be adequately described. Also essential to FJA is the need to match skills to levels of complexity of tasks. This is done by assessing the level at which a worker performs in relation to data (information or ideas), people (clients or co-workers), and things (machines or equipment). While there are many ways to describe what people do in relation to these criteria, there is only a handful of significant patterns of worker behavior (functions). These reliably articulated patterns of behavior can be defined in terms of the "Worker Function Scales" mentioned

previously, which provide a standardized, controlled language to describe what workers do in the entire universe of work. Thus, FJA provides (1) a uniform language to describe what workers do and (2) a means of assessing the level and orientation of what workers do (Fine and Wiley, 1975).

The data gathered from the NGT regarding the tasks of a CAH worker can be utilized to formulate task statements which describe the essential activities required to perform the job function. The development of the task statements then allows assessment of the level measure, which indicates the relative complexity or simplicity of a task compared to other tasks. This level measure is expressed by selecting the function (from the Worker Function Scales) that best describes the pattern of behavior in which a CAH worker engages to perform a given task effectively. The ordinal position on this rank-order scale is the level measure. Information provided by the formulated task statements can then be utilized to accomplish the third phase of this study.

Time-Motion Study (T-M Study)

Fredrick Taylor, at the turn of the 20th century, was the first to measure labor in terms of time. His was the first scientific attempt to measure labor (Myers, 1944).

The T-M study is a method of measuring the time consumed in performing work. It implies measurement of all the essential elements of a work operation by means of an instrument developed for that purpose (Lowry et al, 1927).

In the area of human service organizations T-M studies attempt to describe the use of time by program staff and administrators in relation to the activities in which they are involved. The purposes of these methods are to specify the total amounts of time devoted by staff to program activities, to locate the uses of staff time which were not anticipated, and to recommend reallocations of staff time to other activities which might be more directly related to the potential achievement of program goals (Tripodi and Tellin).

Although time can be measured accurately by the use of a stop watch in combination with observations of staff activity, many of these studies do not require such precise documentation. For example, to describe the use of time during a given month, two weeks may be randomly selected. Following that selection two half-day periods from each week may be chosen. Then, on those designated half-days, staff would be observed and specified tasks would be timed. This method was employed in the conducting of the T-M study phase of this research effort.

The T-M study gathered information pertaining to the specific and predominant tasks performed by a CAH worker. Task statements formulated in the FJA phase of the study provided a list of the most important tasks performed which would be observed and timed during selected time samples.

Thus, the three data collection techniques utilized provided four types of information:

1. Information about the tasks of a CAH worker, in order to their importance.
2. Formulation of specific task statements, information regarding levels of complexity or simplicity, and orientation of these specified tasks to data, people, and things.
3. Identification of specific and predominant tasks which could be measured in terms of time.
4. Information on CAH worker perception of what are and what should be the functions of a CAH supervisor and particular concerns related to job performance.

SUBJECTS OF THE STUDY

The subjects participating in this study were the six full-time staff members of the CAH. One half-time person did not participate because of school commitments; the second, because he was part of the research team. Here we must indicate a biasing effect in the form of observer or evaluator bias because of this person's knowledge and preconceived notions about the results of this study in general. This biasing effect was dealt with in the research design by the use of techniques which were objective from an evaluator's perspective (NGT, FJA) although extremely subjective from the perspective of the participants (NGT). With regards to the T-M study, which this person conducted, it is to the benefit of the observer to be able to anticipate the CAH workers' functions. Thus, this person, although introducing some bias, can be seen as beneficial in terms of provision of expert information and insight into unstandardized worker job functions. This person was the only member of the research team authorized to enter the maximum security building which houses the CAH and thus was the only access to staff during the T-M study.

All six staff participants took part in the NGT process; five of these six were observed in the T-M study.

PROCEDURE

The first step was to hold a staff meeting in which to conduct the NGT process. The purpose for using the NGT to obtain staff's input was explained and a brief description of NGT process was given to the staff. They were then asked to respond to each of the following questions, putting down not less than three nor more than five responses, using a rank-order from most important to least important. The subjects were asked to respond silently, in writing. Sufficient time (about 10 minutes) was provided for each question so as to yield adequate and reliable information. The questions (each asked separately) were:

1. What do you see as your major tasks in performing your job?
2. What do you see as the functions and/or responsibilities of the CAH supervisor?
3. What concerns do you have regarding your job functions?

After each question had been asked and the responses collected there was discussion which aided in clarifying responses and provided an overall perspective of how the CAH staff as a group responded to the questions. This procedure was very important, for it provided the basis or framework on which the study would rest.

The next step was to focus on the responses to the first NGT question, categorizing them according to specific task descriptions and rank-order response. Totaling the rank-order responses for each task description allowed the researchers to develop a list of tasks performed by a CAH worker according to importance (Appendix A). This same procedure was followed for questions 2 and 3. (Appendices B and C).

The task descriptions were then utilized to formulate four task statements in accordance with the framework of FJA. Utilization of the People Function Scale and Data Function Scale provided functional levels at which a CAH worker performs.

The next phase in this process entailed the breakdown of CAH worker tasks to be observed and timed during the T-M study. Six specific task functions were selected to be observed and times. These encompassed all task descriptions provided by staff input and delineated into task statements. The T-M study would involve six specific observations:

1. Total time of all in-coming calls which were assigned a code utilized by the CAH to categorize each call.
2. The portion of the telephone time utilized by the CAH worker to notate information obtained from the caller.
3. The time required to log in calls on "calls received" and "calls made" forms.
4. The time required to transcribe notes taken during phone intakes on to referral form 214 which is utilized to provide written information to appropriate field staff concerning a child protective services situation.
5. The time required to verbally (over the phone) relay information regarding CAH intakes to appropriate field staff.
6. The time required to compile statistical data for monthly reports of calls taken and category of calls according to the CAH category codes.

Observation of CAH workers occurred over a six-day period. Selecting time samples was not random because an adequate cross-section of the 7 day per week, 24-hour a day CAH operation required sampling of weekday morning, afternoon, and night, and weekend morning, afternoon, and night. All six time periods were sampled except for weekend afternoon. It was of primary importance to sample the traditional work hours of "Monday thru Friday, from 8 A.M. to 5 P.M." because the great majority of telephone calls received by the CAH occur between 9A.M. and 6 P.M. on weekdays. The researchers purposely observed two weekday morning time samples and two weekday afternoon time samples.

The researcher, using a watch with a second hand, timed all examples of the six categories as they occurred during the three-hour time sample. There was no need to utilize precision time instruments like those used in industrial T-M studies because "total time" was the focus of the observation and not increments of time as measured in other, more precise, T-M operations. At the completion of each time sample total time utilized by workers on duty was computed and related to the number of person-hours (minutes) in terms of percentages. Thus, we could analyze not only how much time was utilized by CAH staff, in a given sample, to perform specific categories of work (tasks) but also total work time in relation to the amount of potential work time available during this 3-hour period.

Information and data collected were then analyzed by category of technique utilized to generate it. These analyses provided the results of this evaluative research of efforts of the CAH.

RESULTS

The Nominal Group Technique yielded three charts:

1. Staff's perceptions of their tasks (Appendix A).
2. Staff's perceptions of their supervisor's tasks (Appendix B).
3. Staff's concerns (Appendix C).

Although the main focus of this portion of the study was on obtaining staff input regarding their perceived tasks, their perceptions of their supervisor's tasks and their concerns were added for the benefit of their supervisor and the administration.

The Hotline staff perceive their supervisor's main role as that of being a consultant and problem solver. Discussion during the meeting seemed to indicate that there is some concern that the supervisor isn't available for emergency consultation. Despite this interpretation of the supervisor's role, most staff members did not particularly wish their supervisor to be housed with them.

A secondary supervisor role is as a linkage between themselves and the administration. The discussion that followed indicated that the staff generally feels left out of the mainstream of DPW activity, and that administrators are doing things "to them" without their knowledge or input. This is also indicated in Appendix C, in which "little administrative support," and "supervisors have been unaware of staff's duties, responsibilities, and problems," fall in the mid-range. This seems to indicate communication problems.

The next major role of the supervisor is seen as educator. Training ranked highest of the staff's concerns and needs (Appendix C). The lack of training may contribute to the staff's feeling that they are being left out of the mainstream of DPW activity, since most everyone else in the Department attends training sessions.

Another major aspect of the supervisor's role is that of staff supporter. A number of statements made in the "staff's concerns" segment of the NGT meeting indicate that supervisors have not been perceived as fulfilling this role. The statements range from not getting supervisory support in working out difficulties with the field staff to not receiving enough individual feedback on job performance and not receiving strokes for doing an important job.

As was indicated earlier, the main focus of the Nominal Group Technique was to establish the staff's perceptions of their tasks. This exercise yielded an array of 13 perceived tasks, which ranged in importance from "relaying the report to the field by phone" to "office paperwork".

Utilizing the staff's tasks statements, in conjunction with Sidney Fine's "Functional Job Analysis", a functional job description was developed as follows:

1. Talks by telephone with anxious, confused and/or reluctant complainant, giving assurances and support, and expressing sympathy, in order to alleviate complainant's doubts/fears and put him/her at ease while making complaint.
2. Asks complainant questions, listens to answers, coaxes elaborations, and records answers on standard intake form, exercising discretion as to sequence of question in order to obtain needed information. Makes entries in calls-received log.
3. Relays the information gathered from the complainant to the appropriate county child welfare intake office by phone, and follows up by mailing a hard copy of the 214 intake form to the appropriate local unit.
4. Collects and enters complaint data on standard statistical compilation form. Totals figures to determine number and category of complaints. Also computes the number of complaints received during any given hour.

The functional job description detailed above involves the worker in dealing with people and data, and implies that a certain level of functioning is required to be able to complete the tasks.

The level of functioning required for each of the four subsections of the above functional job description has been determined utilizing Fine's "People Function Scale" and "Data Function Scale". The scales illustrate "level," i.e., the relative complexity of the task, the task definition, and examples.

Based on these scales, the level of functioning required to complete the tasks delineated in each of the four subsections of the above job description are as follows:

SUBSECTION	AREA	DEFINITION	LEVEL
1	People	Exchanging Information	2.0
	People	Diverting	30.5
2	People	Coaching	3A.5
	Data	Copying	2.3
	Data	Compiling	3B.7
3	People	Exchanging Information	2.0
4	Data	Computing	3A.0

The "People Function" and "Data Function" scales also allow comparison of the level of functioning required to be CAH staff member vis-a-vis the level required to be a protective service worker in the field. This comparison may have implications in terms of different salaries.

The Time-Motion study was undertaken in order to determine the amount of time the staff is spending in actual job activities. Table 1 shows the number of worker-minutes available in the various time slots, and the actual number of worker minutes utilized. The ratio of minutes worked to minutes available gives the "Work Efficiency Quotient", which is also listed in the table.

TABLE 1

Sample Time Period	Available Worker-Minutes	Minutes Worked	Work Efficiency Quotient
Sun. 11-21-76, 12am-3am	180	20	.11
Sun. 11-21-76, 8am-11am	180	51	.28
Mon. 11-22-76, 10pm-1am	180	74	.41
Tues. 11-23-76, 12pm-3pm	360	279	.78
Wed. 11-24-76, 10am-1pm	360	104	.29
Fri. 11-26-76, 10am-1pm	360	126	.35
Fri. 11-26-76, 2pm-5pm	540	53	.10
	309	87	.28 AVERAGES

From Table 1, it can be seen that the Tuesday 12 noon to 3 pm sample yielded the highest Work Efficiency Quotient (WEQ). The WEQ's in Table 1 are consistent with the Monthly Intake Log in that the highest quotients are observed between 9 am and 7 pm. It should be noted, however, that the WEQ is less than desirable in the majority of the time periods sampled. This conclusion, however, should be qualified by noting that theT-M study was conducted during Thanksgiving week, which may have slowed the reporting rate.

CONCLUSIONS AND RECOMMENDATIONS

The T-M study indicates that time is not spent uniformly, i.e., there are periods of high activity and periods of low activity. However, the study also indicates that the staff is never totally busy during any given shift. There is, in fact, a considerable amount of time available during which the staff could be doing other DPW-related activities. In determining if other tasks are to be assigned to the staff, one should take into consideration that peak loads are experienced during the normal working day, which may at times preclude completion of the tasks during these periods. Tasks which could easily be undertaken to be worked on during low activity periods include keeping mailing lists or directories current, or answering the telephone in relation to matters other than child abuse and neglect.

In relation to the staff's comments listed in Appendices A, B, and C, it is recommended that the supervisor, whether or not housed with the staff, increase contact in order to understand their needs, assess their functioning, and facilitate their feeling of belonging to the department. The improved communication concomitant with increased contact would also provide the staff with a feeling of access to administration.

It is also recommended that training be made available to the staff, not only to improve their functioning, but also to involve them in DPW activities. Because the staff receives a number of calls from people in need of counseling who refuse to be referred, it is specifically recommended that training in telephone counseling be made available.

It is also recommended that the functional job description developed and described above, or a similar functional job description, be utilized. Such utilization would not only facilitate the standardization of job activities, but would also provide a criteria against which job performance can be evaluated. Additionally such a job description would allow for the comparison between the activities performed and the level of functioning required to work on the CAH and the activities performed and the level of functioning required to work in protective services in the field at the same pay grade.

In conclusion, a greater emphasis should be placed on opening communication between the staff and supervisor, and on the supportive role of the supervisor.

APPENDIX A

Staff's Perceived Tasks

1. Relay report to field by phone.
2. Intake of abuse and neglect report.
3. 24-Hour coverage.
4. Screen calls.
5. Counseling.
6. Provide referral, abuse and neglect information.
7. Upkeep of worker locator directory.
8. Locate field worker.
9. Public relations.
10. Coax information.
11. Relay written report to field staff.
12. Write report.
13. Office paperwork (Logs, etc.).

APPENDIX B

Staff's Perceptions Of Supervisor's Tasks

1. Staff consultant/problem solver.
2. Represent H.L. staff to administration.
3. Pass information from administration to staff.
4. Staff education/development.
5. Support staff.
6. Maintain leave records/performance reports.
7. Be available for emergencies.
8. Hiring.
9. Develop H.L. policy.
10. Responsible for insuring 24-hour coverage.
11. Maintain and procure office equipment and supplies.
12. Interpret DPW and H.L. policy.
13. Buffering staff from hostility.
14. Sounding board for complaints.
15. H.L. paperwork (Monthly reports, etc.).

APPENDIX C

Staff's Concerns

1. Training in general.
   a. Specifically on how to screen calls.
   b. Specifically on telephone counseling.
2. Total point value for training responses.
3. Working conditions.
4. Limited advancement opportunity.
5. Lack of field cooperation in keeping after-hour worker list current.
6. Poor relations with field staff.
7. Little administrative support.
8. Difficult to get a stand-in for personal emergencies.
9. Supervisors have been unaware of the staff's duties, responsibilities and problems.
10. Boredom.
11. Unnecessary busywork (Weekly and monthly report).
12. Need better feedback about individual performance.
13. Want more input into decisions affecting the Hotline.
14. Need a good feeling about performing a necessary function.

Training Workers in More Effective Case Management

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Caseworker "burn-out" is a problem that plagues virtually every child welfare agency. "Burn-out" refers to the phenomena of a caseworker reaching the point of not caring, when clients become objects instead of people, and when feelings, both of the caseworker and of the client, are ignored. The training programs we have conducted for child welfare agencies over the last two years have been aimed at preventing caseworker burn-out.

The most common problems in working with clients that caseworkers cite are: (1) dealing with clients' hostility and defensiveness; (2) motivating clients; (3) establishing rapport; (4) setting goals; and (5) determining what information is real versus fabrication. The above information was given by forty caseworkers in response to a questionnaire given prior to their beginning training with us.

In the same questionnaire caseworkers were asked, "What do you need most to do a better job or gain more work satisfaction?" The overwhelming response was "information", including tools and techniques for working with clients and an understanding of the dynamics of abuse. The need for more information was closely followed by a request for smaller caseloads, positive feedback, a sense of competence, and competent administrators.

The main problems caseworkers see in working with their clients are: (1) parent-child difficulties; (2) marital trouble; (3) low self-image of clients; and (4) dysfunctional reactions to stress.

Given all the above data, it is not surprising that what caseworkers say they most want from training is: (1) training in counseling; (2) increased skills and knowledge; (3) experience in leading groups; (4) learning how to set goals with clients; and (5) being able to communicate better.

With this information in hand, we designed a training program to give caseworkers what they were asking for, specifically, the information, tools and skills necessary for them to have a greater sense of competence on the job. Three groups of twenty caseworkers were selected from five counties in and around Houston. They were selected by their agencies primarily on the basis of interest in being in the program, with some consideration being given to time they had been at the agency. Our initial conversations with the workers indicated that many were near the burn-out point at the time of entering training.

The first phase of the six-month training program consisted of a day-long introductory course in transactional analysis. We find that a strong foundation in the basic concepts of TA is necessary for understanding the work we will be doing later in the training. The day in TA is followed by a training day in Goal Attainment Scaling (GAS). While the format for the TA training day is primarily didactic, the GAS training includes both lecture and practice in using GAS.

After the two day-long workshops, the trainees (caseworkers) divide into two groups of ten, each group coming once a week for a two-hour training session. In addition to attending weekly training sessions, every other week one group of trainees watches us leading a group for abusive parents on Thursday night. The therapy group is immediately followed by a half-hour period in which the trainees can ask questions about what they observed in group.

The weekly training sessions are the heart of our program. We find it takes time, repeated exposure to new ideas, and several opportunities to try out new behavior before caseworkers become comfortable with new ways of relating to clients. The weekly session is structured as follows. One worker is assigned to bring in a Goal Attainment Follow-up Guide on a particular client he/she is working with. The Guide is put on the blackboard and discussed with the whole group. The presentation allows us to see problems the worker may be having in drawing up a Guide and to continue to teach the techniques of using GAS. After the GAS presentation and discussion, another caseworker either volunteers or is picked to role-play a caseworker working with the client presented in the GAS. The first caseworker then role-plays

his/her own client. The two role-play the caseworker/client situation for 20 minutes. The trainee role-playing the caseworker is critiqued on his/her work, including strengths and weaknesses. What we find is that a caseworker's difficulty in handling the "client" in the room is a reflection of difficulties he/she is having with other clients. Not infrequently the critique leads to a caseworker doing personal work then and there in the room. The contract to include personal therapy in the course of training was made at the beginning of the training and is a major factor in the effectiveness of our training. Much is learned, too, by the caseworker role-playing the client. The process of having a caseworker be his own clients leads to increased awareness of the dynamics involved and the feelings of the clients.

The second hour of the training is devoted to discussion of assigned readings and theoretical issues that may have come up during the role-playing. The assigned readings are: *Born to Win* (James and Jongeward), *The Abusing Family* (Justice and Justice), *A New Guide to Rational Living* (Ellis), *Children: The Challenge* (Dreikurs), and *Parent Effectiveness Training* (Gordon). Each worker is asked to bring in a question on the readings assigned for that particular week.

We have found that this combination of personal therapy, structured role-playing with an opportunity for applying new techniques, and reading discussions result in increased effectiveness and a greater sense of competence for the workers. Consequently, the rate of "burn-out" and resulting rapid turnover are greatly reduced for participants in our program.

Training in Interviewing: A Unique Approach

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Regardless of where one is placed in the delivery of human services, interviewing skills are an inherent and active part of the job. Whether an individual is an administrator meeting with subordinates or superiors or a worker meeting with clients, positive, facilitative, and productive one-to-one communication is necessary for acceptable performance.

Despite this most obvious fact, the analysis of what makes a "good" interview, and what specific verbal and non-verbal behaviors a "good" interviewer exhibits during the interview process, has come to the human services relatively late. In most social service organizations, individuals charged with the responsibility of training staff in interviewing skills have been dealing primarily with conceptual generalizations such as empathy, genuineness, and warmth. Agreement could often be reached among observers as to what a good interview expressed, but knowing how to construct such expressions and then to teach others to do so was another matter.

In the late sixties and early seventies, three somewhat disparate lines of research and development came together in a synergic process. The result, I believe, has produced what amounts to a quantum leap forward in the teaching and learning of basic interviewing skills for the human services.

THREE LINES OF INVESTIGATION AND DEVELOPMENT

First, investigation into interviewing became more inductive. Rather than try to "justify" a concept such as empathy, investigators agreed that certain people were perceived by others as being helpful in interactions. The investigation proceeded into analyzing what these people did verbally and non-verbally within these interactions (Carkhuff, 1969; Truax and Carkhuff, 1967).

Investigations continued, thousands of observations were made, and finally these behaviors became categorized, "concrete", observable, and definable in the literature (Ivey, 1968).

Second, investigation into learning theory began to indicate that if specific behaviors were modeled in front of an individual then that individual was much more likely to emulate and integrate those behaviors into his repertoire of skills (Bandura, 1969). In addition, investigations into adult learning seemed to suggest the need for adults to have active participation in learning processes through feedback chains and opportunities for integrating new knowledge with previous experience (Ingalls and Arceri, 1973).

Finally, developments in the electronics industry, specifically in the development of videotape equipment and systems, provided a vehicle for recording interactions, and for replaying these interactions for detailed analysis. For trainers and teachers skilled in its use, it also provided an extremely valuable tool for facilitating the learning process (Kagan, 1965; Onder, 1970; O'Brian and Mayadas, 1972).

From the above three lines of investigation and development the potential for a systemic training model emerged.

"Step by Step: An Instructional Program in-Basic Interviewing Skills" is the result of over two years of research conducted at the Human Resource Center of the University of Texas at Arlington into the conceptualization and training of both graduate students and human services personnel. The research was undertaken by Dr. Nazneen Mayadas and this author in the spring of 1973. A decision was made early in our investigation that we could not deal adequately with the total product (a "good" interview) in one training module, but rather should focus our energies on isolating specific, identifiable skills which, when properly combined, would result in a "good" interview.

We recognized that, should we be able to develop such modules, it would not mean that participants would automatically put them together effectively. Someone may know how to saw, hammer, and nail, but that doesn't mean he can build a house! It is difficult to conceive, however, how a house could ever be built without these skills.

The project was designed in two phases: The initial phase, now complete, incorporates a systematic Skills Transfer Model (STM) which uses video technology to effectively transfer specific, identifiable skills from the instructor to the participant. The second phase, dealing with appropriate combinations of skills used to reach desired interview objectives, is now being developed.

CONTENT AND TRAINING DESIGN--1ST PHASE

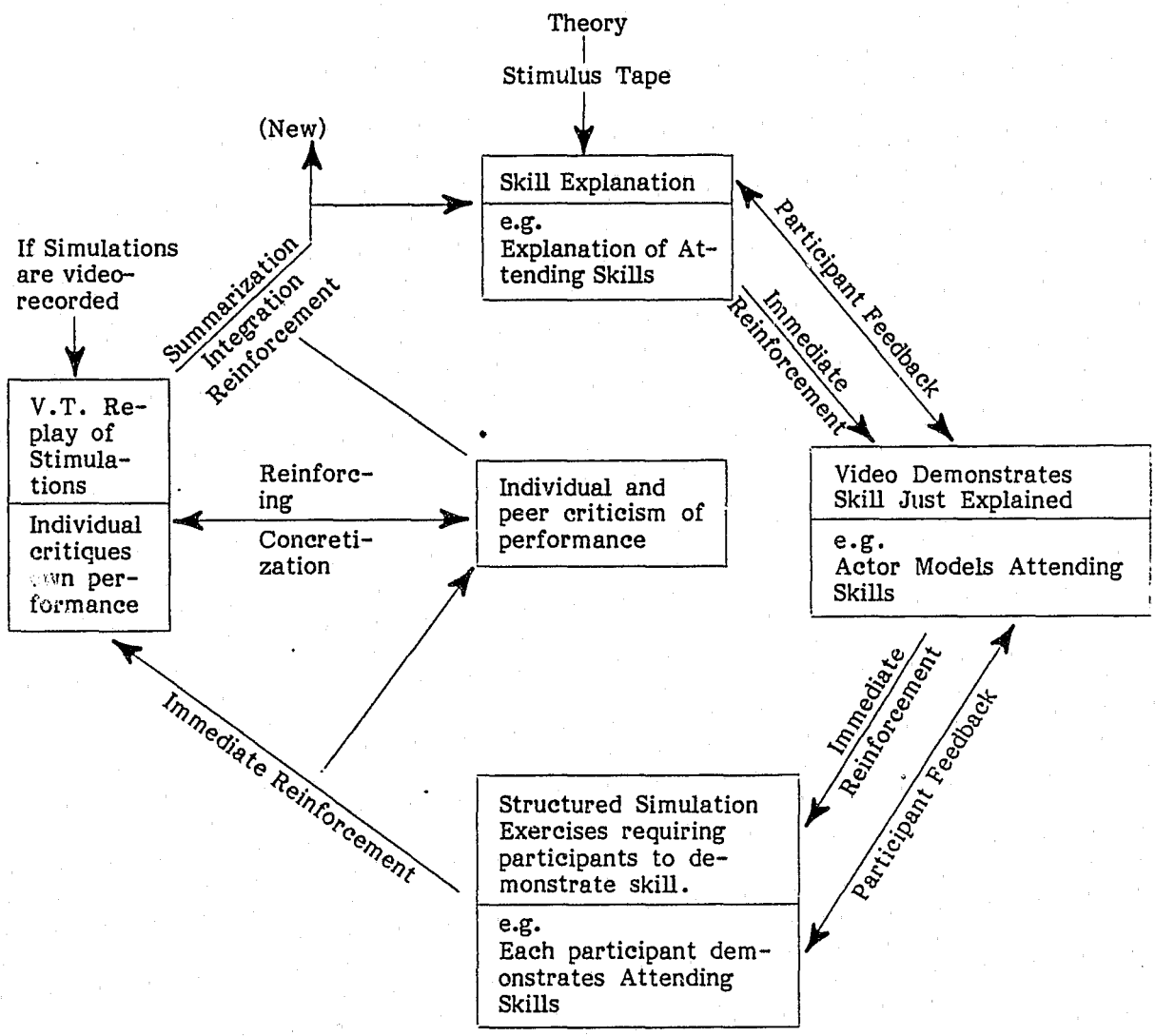
Much of the content, interview skills, and definitions used in the module are based on the work of Allen Ivey (1971), who lists five categories of interviewing skills:

1. Attending Skills
2. Questioning Skills
3. Reflective Skills
4. Expressive Skills
5. Interpretive Skills

Each skill or skill group is broken down into clearly perceived verbal and non-verbal behaviors. An accompanying videotape presents a series of expertly modeled vignettes. Each vignette is a skill demonstration in which the "interviewer" models only that skill under immediate discussion by the trainer and trainees. Vignettes are ordered in increasing complexity.

The entire training program is structured to enable the trainer to take participants "Step by Step" into the complexity of interviewing skills. Using the experience and research of Bandura (1969), Kagen (1965), Bodin (1969), Katz, Mayadas, and O'Brian (1975), and others, participants model the skills under discussion using videotape for instant feedback and evaluation of individual performance. Based on personal, peer and instructor evaluations, the participant can practice the skill(s) until he has mastered them. An illustrated model of the STM appears below.

THE SKILLS TRANSFER MODEL
"An Example"



The model above is the product of four generations of models designed and tested with both students and human service professionals. The final design was tested with approximately 120 continuing education professionals conducting or administering in-service education to human service employees. Objective evaluations were conducted by both participants and instructors on their own and their colleagues' performance. Upon completion of the training program, over ninety percent of the participants could accurately discriminate the skills taught and demonstrate them on command within a simulated interview process.

The final videotape production is the product of eleven generations of skill vignettes. Scripts were continually rewritten and modified, actors rehearsed, and video run. Panels of judges, unfamiliar with the content beyond that supplied by the instructor in the training process, viewed the last three generations of vignettes. The task of the judges was to decide the following:

1. Did the video modeling vignette portray the skill introduced by the instructor with clarity? and

2. Did each vignette portray only that skill under immediate discussion? (Was it pure?)

On the final production, judges reached total agreement upon clarity and singularity of skills presentation in each vignette.

The last stage of project development was to "package" the videotape and other materials in such a manner that teachers, trainers, and other staff development personnel unfamiliar with the specific treatment of the content and training design could utilize the training program in the most effective way.

THE FINISHED PACKAGE

The final training module entitled "Step by Step: An Instructional Program in Basic Interviewing Skills," is packaged in an 8½x11 three-ring notebook containing the following items:

1. Written materials including:
   a. Theoretical explanations of skills covered.
   b. Concrete examples of skills covered.
   c. A complete explanation of the training model including variations based on equipment availability.
   d. A "Step by Step" outline of format and progression of training through all skill areas.
   e. Sample evaluation instruments for both instructors and participants.
   f. A complete list of references and a selected bibliography on the use of video in training in human services.

2. A videotape (format of choice: color or B&W, ½" to Quad) including:
   a. A stimulus vignette (discussion starter).
   b. Eight modeling vignettes built around situations which vary from child abuse to alcoholism.
   c. Narration introducing each vignette and stressing key behaviors.
   d. Titling of specific behaviors as they occur throughout each vignette.

PACKAGE UTILIZATION

The training program was packaged during the summer of 1975. Since that time it has been utilized by teachers in graduate and undergraduate programs of nursing, social work, counselor education, and other fields. By far the greatest use of the training program has been made by in-service trainers and staff development personnel in public social service agencies. The training program is currently being used in seventeen states by private and public agencies, colleges, and universities.

Current estimates available from the Department of Public Welfare in the State of Texas indicate that approximately seven thousand employees, employed in a variety of service settings, will receive this training. Participants involved in "Step by Step" training have almost uniformly increased skill levels regardless of prior education and experience. The program has been used with volunteers having little formal education and professionals having both masters and doctoral degrees. Evaluations, both objective and subjective, submitted by participants as well as instructors, show a high degree of skill discrimination and demonstration, and satisfaction with the training format.

PHASE II

Currently the Human Resource Center is developing a sequel to "Step by Step" tentatively titled "Putting it Together." The goal of the training program will be to enable training participants to learn combinations of skills which facilitate productive interviews in a variety of settings and problem areas.

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Training for Child Abuse and Neglect Prevention

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Efforts now are underway to "institutionalize" child abuse and neglect training. What must be considered is how these efforts contribute to the prevention of abuse and neglect. In discussing prevention, we are discussing the issue of training in social service delivery. More is at stake than questions of who is to be trained or what the curriculum is to be. I want to suggest that the context for training is as important as its content. Further, training for prevention (as opposed to training for identification and treatment) will require a context much different from that in which most training currently is offered. I also will argue that the current context for training limits, if not in many ways defeats, training activities which might have preventive consequences.

To clarify that, I want to consider two models of service activity, and discuss their implications for prevention of child abuse and neglect. The first model is that of institutionalized child abuse and neglect programs as they have proliferated over the past decade. This is the traditional social service model, adapted to the child abuse problem and the comparatively recent public and governmental demand to have something done about it. This can be called a segmental model because a variety of discrete service units, each encased within its own institutional framework, provide a series of services to child abuse victims and clients. These service segments include physicians, clinics, police, judges, volunteer groups, child protective caseworkers, self-help groups, state departments of social services, federally funded resource centers, demonstration projects, private training curriculum contractors, schools of social work, and a host of other interested persons and organizations. The expectation is that this network of interests eventually will blanket the community with sufficient service functions until all types of abuse or neglect problems can be detected and handled. What should accrue from this segmental service network is eventual resolution of the problems of clients, and reduction of the incidence of child abuse and neglect in the community.

There are numerous features of this segmental model which are noteworthy, and which have implications for the quality of service and the training required to offer that service. The most obvious feature is the relative institutional autonomy of each service segment. Any one segment, such as a private agency for children, has a sphere of competence with responsibility within that sphere allocated to it alone. Decisions about client services which are made in one service segment are thus largely limited to that segment and may or may not dovetail with services provided in other areas. In addition, decisions about service policy are usually made by people in leadership positions within each segment, who, by definition, are furthest removed from regular, intensive contact with service consumers. These are individuals who necessarily are preoccupied with the institutional histories and personnel issues of the organizations they manage. Thus, these considerations are always given weight in determining the way services are provided, especially where demands for accountability of time and money are strong. Inevitably, such institutional maintenance activities also involve much time of decision makers and direct-service providers. Institutional maintenance, and the protection of institutional "turf," compete with the time needed for direct provision of services. One only need reflect on the interagency politicking of state social service departments, or the problems faced by caseworkers where no established and smooth working relationship exists with police, judges, or hospitals, to realize how much time and energy these things consume. Symptomatic of this process was a conference held recently in one state which brought together the leadership of child services in that area. The title of the conference was, "Child Abuse: Who Owns It?"

In addition to institutional autonomy, segmental specialization results in highly fragmented views of the nature of abuse or neglect. It is unnecessary to review the multitude of definitions of child abuse and neglect, ranging from psychopathology and character defects in clients to community disorganization and long term social trends. Neither do we need to analyze the problems of cooperation familiar to anyone who has tried organizing multidisciplinary teams in which each member has his or her own preferences in dealing with a specific abuse case. What must be remembered is that varying definitions of abuse and neglect are more than academic nitpicking or the predilections of specialists. Definitions reflect the career interests and official

folklore of professionals and professional groups. One of the hallmarks of professionalism is that each group regards itself as having possession of the central explanatory principle by which the baffling features of a problem can be exposed and resolved. Indeed, professionalized approaches are so sacrosanct that they sometimes are elevated to the status of deeply held and intuitively known understanding. Thus, the relatively straightforward process of talking with a client about coping with a specific problem is viewed as a professional trade secret for which much training and experience are required. Even a baptism by fire, the "burnout" phenomenon, may be necessary as a rite of passage on the way to full professionalism. Those who pass the test, either in terms of their research or their own casework activity, are entitled to speak of the "state of the art" in connection with these activities. As art, professional activity is elitist, and is protected behind barricades of professional accoutrements such as advanced degrees, various forms of licensing, and professional jargon. With the segmented service network, each individual applies the "art" of his or her profession to the problem: the art of counseling skill, the art of medical healing, the art of judicial decision making, or the art of interagency referral. At each level the client is dealt with in terms of the expertise of the professional, how that professional defines and labels the client's "real" problem, and what the professional believes will "work" in solving it.

The fragmented view of the client's world held within each of the segmentally discrete professional groups in the service network suggests the third feature of the traditional social service model. That is, service delivery is, for the most part, a clinical-type service. The service tends to be problem-specific with emphasis upon resolution of the presented symptoms. One function of casework in many agencies, for instance, is accurate identification and assessment of symptoms so that the client can be transferred to the appropriate treatment resource. Indeed, that is what much current training emphasizes. The caseworker is trained to be a diagnostician of client types and client problems so that more effective use of existing treatment resources can be made. The assumption is that through enhanced coping skill, the casework can better elicit the cooperation of hostile or apathetic clients and more efficiently arrange the services they appear to need. Training is for improved use of existing segmented organizations and personnel. Where problems in service delivery are identified, as in the common complaint of clients disappearing "through the cracks" of the system, high turnover rates among caseworkers, or low turnover rates of clients who make heavy demands on the system, training is often employed to facilitate office management procedures, to shore up caseworkers against job stress, or to better mobilize extra-agency resources. The assumption remains, however, that the service functions much like a clinic, and in extreme cases, a crisis clinic, complete with hotlines, public relations budgets, and 24-hour staffing. Yet, like much of clinically oriented medicine, clinically oriented social service often is patchup work. It cures rather than prevents; it deals with acute rather than chronic problems; and it is directed by people who, because of professional inclination or time and money limitations, must limit their service activity to what little they see or can quickly discover about the client. The system is like a black box: the client enters one end, emerges from the other, and the builders of the black box pronounce the job finished.

Following the implications of the segmental model as a general model of existing service delivery helps us identify a series of issues which make successful prevention training problematic. The segmental system is specialist- and agency-dominated. Individuals usually work in isolation from other persons or organizational units in the social service network. Their relationships with other units often are difficult. The development of good working relationships is time consuming because of differences in agency histories, policies which speak to agency rather than client needs, professional and career expectations, and the complex and usually petty issues of "turf." Consequently, work with clients is poorly coordinated and highly fragmented. In addition, clients are perceived as bearers of personal rather than community problems, and the treatment approach is highly particularistic and personalistic in its clinical emphasis on resolution of precipitating factors of child abuse or neglect. Training within this kind of system is inevitably for work with abuse and neglect after the fact, not training for prevention. One only need look at the contents of the current training programs produced for child abuse caseworkers, and consider their emphasis upon identification and investigative procedures to understand this.

To train for prevention presumes not only substantially different training, but a very different training context. I want to suggest one alternative to the segmental model of service delivery, and indicate what the training implications for a real effort at prevention could be.

There is increasing emphasis on involving consumers of social services and the community in government programs. This is a healthy effort, one which should be promoted from within the social work community before it is forced upon us by disillusioned taxpayers and disgruntled legislative committees. In part, consumer involvement requires the redirection of service activity and training which supports it at each of the three major problem points in the segmental model. A fully developed alternative to the segmental model could be called a community-oriented model. In conformity with the kind of thinking required by such a model, I begin with the client and the problem, rather than institutions and their relationships.

In contradistinction to the highly fragmented view of child abuse and neglect held by the professional interest groups which have a stake in the issue, abusive or neglectful behavior must be viewed as congruent with other aspects of a client's lifestyle. Those aspects include an adult client's own childhood and experiences, early learning of one's place in the world as dictated by class and ethnic background, informal and formal educational experiences, the opportunity structure available to the client upon reaching adulthood, the lifecycle of the domestic group as experienced by the mass of persons in a comparable role and place in society, and the personal as well as sociological events preceding the abusive or neglectful situation. In understanding abuse, and probably more importantly, neglect, attention must be given to the criteria clients use for identification of a problem, their life experiences in dealing with that problem, their assessment of resources available to them once a problem has been identified, and the consultative activity among friends or neighbors which may have been undertaken before a problem came to the attention of a social service agency. These are essential elements of the help-seeking process, all of which precedes an agency's involvement, and all of which are crucial factors in understanding why abuse or neglect occurs in a particular family.

Each of these topics is worthy of considerable discussion and analysis, but two points must be stressed. First, from the client's perspective, abusive or neglectful behavior stems from the long-term interplay of personal and social forces. The client sees abuse or neglect as having occurred within that context, and unless the service provider also can learn to see it that way, intervention strategies will be based more on guess than on knowledge about the client's problems. Second, abusive or neglectful behaviors are relative to the client's situation and the perspective of the community. The largely frustrated effort to define objectively what abuse or neglect is, so that like an inflamed bruise one can know it upon seeing it, overlooks the fact that abuse and neglect are defined by changing community standards rather than professional criteria which caseworkers can be trained to apply unerringly. Recognition of this is not a call for cultural relativism or for abandoning the training and intervention effort on the grounds that there are neither right nor wrong ways of rearing children. Rather, we are attempting to point out that the definition of abuse or neglect is a social construction and varies from place to place. Moreover, the fact that abuse or neglect behaviors vary according to community standards (especially where ethnic or minority communities are involved) is a strength, not a weakness, in the redesign of services and training.

The second element of the community-oriented model derives from this relativity of community standards and the strength of these standards. Abuse and neglect are personal and community problems. In some sense, the community must be held accountable for the traumas experienced by its members. To accomplish this, communities will require organizations that further community interest without dependence on outside professionals who supply patchup services according to their own standards. Models of such mechanisms are already available: free clinics, day care centers, youth service bureaus, legal aid services, mental health centers, drop-in centers for specific groups, and community-centered organizations ranging from charitable to profit-making, from street fairs to recycling centers. Community based and staffed organizations provide an alternative to the vertical structure of professional organizations described in the segmental model. As far as child abuse is concerned, the clear implication is that groups like Parents Anonymous would fill a greater central role in case identification, assessment and intervention. Such groups could set their own agendas for program objectives in their own communities. They might also contract with state social service departments to outstation caseworkers. In this way community organizations could set performance standards for those workers as well. Training social workers to be effective in community-based rather than agency-based efforts at control of abuse or neglect would require different skills than those now offered in most training programs. In addition to knowledge of manifest signs of abuse and neglect as the community perceives them, skillful casework would require a knowledge of the operations of community organizations, ways of attracting community participation, and methods of accounting to the community as a whole. Training would be required in the areas of

recruitment and selection of community volunteers, strategies for dealing with divergent or disruptive community factions and for constructively handling conflict, strategies for influencing legislative change, the development and management of client information systems, and procedures of program evaluation which reveal behavioral change in clients in addition to rates of work and paper flow within the office. In addition, training for prevention would require knowledge of community-based research methods, especially methods for undertaking needs assessments which are more than self-serving busywork. Training for prevention also will require a heavy investment in innovative, especially media-based, training for the lay practitioners and paraprofessionals who will be central to any community-based effort. Such training and organizational work is, of course, expensive but it would have to be compared to current agency staffing and efficiency patterns before the real expense to the community could be determined.

Finally, to overcome the clinical orientation of current abuse and neglect casework activity, schools of social work as well as hiring agencies will have to reconsider the professional values they inculcate in students and staff. Formal educational curriculum should contain a balance between training in community development, program management, research techniques, and direct intervention skills. Students may then perceive their professional careers as an investment in the family health of the next generation, not solely a bandage for the cuts and bruises of this one. Furthermore, state social service departments must develop meaningful career ladders for their personnel. Effectiveness as a caseworker should be rewarded with greater responsibility for building all types of community-based service organizations, not absorption into the bureaucracy and the petty, internal jostling characteristic of all vertically structured hierarchies. Clearly, performance rather than credentials or "time endured on the cross" should be the criteria for promotion. At the same time, the community-based model assumes a high degree of autonomy and self-direction for caseworkers who organize communities to deal with abuse or neglect. Centralized state agencies would have to disperse responsibility rather than concentrate it into their programs.

In summation, we argue that within the current institutional framework, training alone will not contribute significantly to prevention. Training for prevention must be coupled with program redesign so that the needs of clients and communities rather than of agencies and their professional staff have highest priority in service delivery. Training in identification and investigation of abuse must continue, but it must be linked to training in a context where intervention will be meaningful for clients. That context includes community-based organizations representing community interests. Caseworkers should be provided the research, organizational, managerial, and lobbying skills needed to promote the viability of such organizations. Only then can real prevention begin.

The Implications of Emotional Involvement with Client in the Field of Child Abuse and Neglect

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Emotional involvement with clients is an issue for all helping professions. In child abuse and neglect, a form of treatment known as "reparenting" is based upon an intense emotional involvement between the abusive parent and the therapist who functions as a surrogate parent. Concern over emotional involvement in the child abuse and neglect field revolves around such problems as worker burnout, ineffective intervention on behalf of the child, and inappropriate use of the "caring" that develops between client and therapist.

I want to address the issue from another perspective which examines how emotional involvement between therapist and client affects the power balance in the therapeutic relationship. Power in such a relationship is weighed towards the therapist. The power of the therapist is evident in the following descriptions of the therapist-client roles: (1) in a helping relationship, the therapist "gives" while the client "receives;" (2) in the helping relationship, the therapist makes assessments, keeps records, writes reports on the relationship—rarely, if ever, do clients keep case records on the therapist; (3) in the helping relationship, the therapist is seen as the person who is "healthy" (or objective, trained, knowledgeable), while the client is "sick" (or under stress, emotionally deprived, inadequate); and (4) in western society, a person who is independent and self-sufficient is identified as successful; a person who seeks outside help to resolve emotional issues is identified as less than successful.

Not only is the relationship weighted towards therapist control, but frequently the therapist or agency participates in activities which reemphasize client inequality. The following examples are taken from observations I have made of social work-client relationships in the field of child abuse and neglect: (1) social workers rarely are personally available for their clients after office hours or on weekends—the time when crises among abusive families are most likely to occur; (2) social service agencies frequently restrict clients to one part of the building. Clients are not allowed into workers' offices. Interviews are either held in the client's home or in anonymous cubicles in the agency; (3) relationships between the social worker and the parent generally increase the parent's powerlessness (i.e., services are offered on an individual rather than a group basis where clients could develop a power base); parents are often not informed of the legal implications of the services offered; and parents are not given access to their records or allowed to attend conferences held to discuss their treatment; and (4) parents are not given opportunities to evaluate or discuss services offered (i.e., parents are not given the opportunity to keep a record on their social worker); parents do not have the authority to evaluate the social worker's effectiveness; and there are no procedures in most agencies for parents to evaluate or request additional social services.

Most professionals in the child abuse and neglect field state the situations described above result from the parent's inability to accept or become involved in treatment rather than from the professional's need or desire to maintain power in the therapeutic relationship. It is true that abusive-neglectful parents are difficult to engage in the treatment process. What is unknown is whether their resistance can be lessened by an approach which changes the weight of power from the therapist to a shared power by both parties.

Unfortunately, most of us cannot accept this shift, and refer to the difficulties involved in getting a hostile, denying parent to a multidisciplinary team meeting—never mind having them participate in a case planning session. Or, we determine our clients are unable to understand or accept our assessments of their behavior and dynamics, thereby denying parents access to "our" records or reports (they are, in actuality, the client's). When all else fails, we state that although we wish to equalize the professional-client relationship, it is against agency policy and the laws of confidentiality, so really there is nothing we can do.

Until four years ago, I accepted the role of power in the therapeutic relationship. As a social worker, I was trained to be an objective, caring professional who maintained a detached involvement because I used that relationship as a therapeutic tool to help my client understand, and (if he or she so chose) to change his or her behavior. However, as I related to clients who shared their most personal and intense feelings with me, I responded with emotional reactions

that, according to supervisors and consultants, limited my professional objectivity. I began to feel as if I prostituted myself by accepting pay to care about people. I learned how to communicate that I cared even though I was, in fact, angry, scared, hurt, bored or, even worse, uncaring. I found the development of a professional sense of caring took away my professional objectivity—phrases such as: "You seem to be upset today."; "I wonder how that makes you feel?"; and, "I can see you feel strongly about that." I also discovered that I learned as much, if not more, about effective casework from my clients as from my supervisors. As I listened and accepted my clients' input about what I, and my agency, did to help and harm clients, agency representatives told me I was being manipulated. I was evaluated as being too involved with my clients to assess their behavior. When I organized a group of abusive parents and helped them protest the type of medical care they received at the county hospital, I was told I did not have "group work skills," and did not use the group setting to help parents accept the reality of their life situations.

Despite my resistance to the agency's approach, I recognized the relationship I shared with my clients was therapeutic, and my level of personal involvement with clients had definite implications. I recognized that, although I was an effective social worker, I frequently could not be objective, and was, therefore, limited in my ability to help parents change their behavior. I also recognized that I burned out quickly, and was developing a relationship of trust I would have to leave because of my own exhaustion.

In 1972, I directed the Extended Family Center (EFC), a federally-funded research and demonstration program which was established as a treatment center for abusive parents and their children. The EFC allowed me to develop a new approach to the therapeutic relationship which would allow equal power between professional and parent.

The EFC program's treatment philosophy addressed two basic characteristics in abusive parents: lack of trust and poor self image. The parents' resistance to treatment and lack of progress were seen as the result of these two dynamics. Additionally, traditional agencies' lack of success in combatting child abuse was assessed as resulting from their inability to deliver services which enhanced self-esteem or fostered trust.

The EFC hired and trained a nonprofessional staff that was committed to developing relationships with parents based upon respect for the parents' ability to determine their own lives. Staff commitment to this respect was heightened by the presence on the staff of two abusive parents (hired as parent consultants) who had been clients in the traditional protective services network. The parent consultants offered the staff a unique perspective of what it means to not only endure the stresses an abusive parent experiences, but also to struggle to change the abusive behavior. The EFC staff began their approach to the dynamics of low self-esteem and lack of trust in parents by serving as friends and family to the parents. Staff members were available around the clock. They went to parties with parents, provided transportation on weekends, helped parents move, watched television together, washed laundry together, and acted as babysitters along with various other activities.

Within three months, the staff was exhausted and resented the parents. Rather than seeing parents as equals, the staff viewed them as ungrateful, demanding children. When the staff began to withdraw emotionally from the parents, it became necessary to reevaluate the philosophy of being "an extended family" to parents. The first step in the reevaluation process involved the staff admitting that EFC was, in fact, an agency, and that their role in the agency was a job—not a life-time avocation. The staff also admitted their relationships with parents occurred because of their jobs; that, in fact, they were friends with most of the parents in the program only because, as employees of the center, they were assigned to work with the parents. Finally, the staff recognized they were depriving, not obtaining, support for themselves. Because they spent all free time with the parents, staff members could not relax, see their own peer groups or families, or have fun. One staff member stated, "I feel like I work seven days a week, 24 hours a day." This self-deprivation resulted in anger and resentment of the parents, thus heightening the dynamics in parents the staff hoped to ameliorate.

Parents and staff began a series of joint meetings in which staff discussed their perceptions of the crisis. Parents responded with anger and disappointment that the staff would not be family. From these discussions a framework for a new program developed which emphasized the importance of parents to each other. Staff were identified as facilitators who would help parents organize activities and programs that would meet parental needs. Slowly, parents turned to each other for friendship, socialization, help with babysitting, and other activities. Staff continued to relate to parents on an intensive, but more structured basis. Twenty-four hour availability was put into a rotating on-call schedule that guaranteed staff

members time for themselves. Parents were encouraged to develop resources for themselves and to accept the assumption of this responsibility as a sign of personal growth, rather than staff abandonment.

At the parents' request, the staff initiated several procedures in the program that replaced total availability and unrealistic attempts at friendship with new ways of communicating respect. Parents were included in regularly-scheduled case conferences to assess their progress in the program. Case records were made available to parents and were regularly reviewed at case conferences. Parents were encouraged to write in their case records, particularly if they disagreed with the recording of the worker. Whenever written reports were sent to other agencies, parents were given copies of the reports. Parents remained active in program planning and met regularly with staff to discuss new aspects or needed changes. This involvement created a very different atmosphere in the center. Parents became more involved in the therapeutic process and viewed the center as a treatment entity as well as a social outlet. Parents took more responsibility for their behavior and could better articulate what they desired from the program to deal with their problems. Most important, parents viewed the program as only one part of their lives rather than as the answer to all their needs.

For staff, the change in emphasis resulted in a needed detachment from intense personal involvement. They accepted the responsibility of helping rather than caring for parents. Together with parents, staff could better assess the strengths and weaknesses of the parents as well as the program. Together, parents and staff worked on programs that enhanced the parents' strengths and devised strategies to deal with their weaknesses. This shift did not come easily. Staff needed much support to maintain the delicate balance between their functions of support and care, and facilitation. During the initial phase of treatment (generally the first three months a parent was in the program), this balance was particularly crucial. It was important to help parents accept the role of the worker, and at the same time communicate the caring and love necessary to develop parent trust and acceptance.

The success of the staff in developing a new approach to involvement with parents was due, in large part, to the parent consultants. Despite their initial overinvolvement, the staff was able to maintain an effective and unique relationship with parents—largely at the insistence and support of the parent consultants. What allowed the shift in power balance was the staff's respect for and recognition of abusive parents' potential, not only to change their own lifestyles, but to teach others to do the same.

I hope this paper will encourage professionals to reevaluate their responses to power in the therapeutic relationship, and, if needed, allow our clients to become more equal partners.

The Battered Worker Syndrome: Everything You Wanted to Know About Staff Morale But Were Too Burned-Out to Ask

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THE NEW PROTECTIVE SERVICES WORKER
(a not so unique dialogue)

EMPLOYER: "How do you do, Mr. Worker. I'm glad we can discuss the position you're being hired for.

EMPLOYEE: (Enthusiastic, positive) "Thank you for your time. I must tell you I am very excited about this kind of work.

EMPLOYER: "Do you know much about the job?"

EMPLOYEE: "Well, no, only generally, but I'm eager to know more."

EMPLOYER: "Your job will include investigation, which means you knock on the clients' door and tell them you're there because someone thinks they are lousy parents. They will want to know who referred them, but you can't tell them."

EMPLOYEE: "How do they usually respond?"

EMPLOYER: "Madder than hell."

EMPLOYEE: "At the complainant?"

EMPLOYER: "At you!"

EMPLOYEE: "Perhaps if I deal with it gently...?"

EMPLOYER: "Yeah, if they let you in."

EMPLOYEE: "What happens if I can't get in?"

EMPLOYER: "You might consult the lawyer about getting court authority."

EMPLOYEE: "Will that work?"

EMPLOYER: "Maybe, maybe not. Anyway, you'll just have to keep going to see the client."

EMPLOYEE: "Well, gosh, is this dangerous?"

EMPLOYER: "No. We've never lost anyone yet. Mostly threats."

EMPLOYEE: "Threats?"

EMPLOYER: "Yeah, like a month ago, a client said he was gonna strangle a worker in the parking lot."

EMPLOYEE: (Swallows hard) "Well, seems tough, but I am still eager."

EMPLOYER: "What's your primary motivation for this job?"

EMPLOYEE: "To help—you know—enable the clients to change."

EMPLOYER: "They don't change much—mainly one crisis to the next.

EMPLOYEE: "Maybe I can stop that."

EMPLOYER: "It'll be hard. See, you'll have over 50 cases."

EMPLOYEE: (Astonished) "When will I see them?"

EMPLOYER: "Oh, any time. Whenever they call. Your phone is listed, isn't it?"

EMPLOYEE: "Will I get calls at home?"

EMPLOYER: "Oh yeah, nights, weekends, holidays."

EMPLOYEE: (Shows no enthusiasm) "Boy, that'll be a lot of overtime pay."

EMPLOYER: "Nope. No pay. Course you'll get comp time if you ever get a chance to use it."

EMPLOYEE: "Well, at least I'll be making more than when I was certifying people for food stamps."

EMPLOYER: "Actually, you get the same."

EMPLOYEE: (Astonished, but recovering) "The same? Well, even so, protecting the kids, working with them. That'll be good—it's so important. Helping them adjust—providing them with services."

EMPLOYER: (Warning) "Keep in mind you will be lucky to see the kids once a month. A lot of times you'll be trying to decide whether they stay or go, trying to find foster homes and so on. Try not to lose any."

EMPLOYEE: "Oh yeah, decisions. Hard ones, I bet."

EMPLOYER: "Life and death. Breaking up families. That sort of thing."

EMPLOYEE: "Well, it will be reassuring to have others help me with those decisions."

EMPLOYER: "Yeah, if they are available. Your supervisor (he's new) has seven workers, spends most of his time with administrative matters, but he may have a few minutes a week to spend individually with you. Otherwise, for the most part you'll be on your own."

EMPLOYEE: (Really overwhelmed) "Will I have my own office?"

EMPLOYER: "Well, you'll have your own desk, chair, notebook, and phone directory. You share a phone. The office has three others in it."

EMPLOYEE: (Smugly) "At least there will be recognition in the community for what I do."

EMPLOYER: "Well, half the people think you're a bleeding heart liberal, the other half think you're the Gestapo."

EMPLOYEE: "Gee, sounds like you're damned if you do and damned if you don't."

EMPLOYER: "You can please part of the people part of the time and none of the people all of the time."

EMPLOYEE: "Golly, hard decisions, low pay, threats, danger, no appreciation, no time, no help. Seems like nothing about the job is positive."

EMPLOYER: "Well, every job has a few drawbacks. I did tell you you'll have your own notebook, didn't I?"

EMPLOYEE: (Trying hard to recover) "Well, all in all it still will be good to work with people rather than paper." (Pausing) (Cautious) "There isn't much paperwork is there?"

EMPLOYER: "Naw, just record narrative, social summaries, court reports, monthly reports, payment forms, medical forms, quarterly reports, letters, memos, custody studies, daily reports, travel vouchers and a few others. (Pause) By the way, I need you to sign this form saying you were here today."

EMPLOYEE: (Signs)

EMPLOYER: "Thanks for coming in. We'll look forward to your starting work Monday."

EMPLOYEE: (Totally dejected) "Yeah, right."

PREMISE

We are considering three factors that present problems to administrators and staff members of protective service programs. These three factors are: absenteeism, turnover, and burn-out. We all know what absenteeism and turnover are. That's when the new caseworker sitting next to me works like a dog to save the world for six months, then he starts getting sick a lot, and he's absent off and on for the next three months. That means I have to take a lot of telephone messages for him. Then one day, he comes in and quits with no notice, and I have to take over his whole caseload for him. Pretty soon, I start feeling sick a lot, coming in to work late...and the cycle begins again.

Burn-out includes the symptoms of absenteeism and turn-over—along with a number of other symptoms like apathy, anger, inefficiency, social and emotional isolation and finally resignation. For one worker resignation might be actually quitting the agency. Another worker might become resigned to her hopeless situation, and live in a shell. Either way, the agency loses a good worker, and the worker loses a potentially satisfying job. Burn-out is a major problem in protective services work.

Turnover and absenteeism are organizational problems. Burn-out is an individual phenomenon—it happens to one person. We postulate that morale, a group phenomenon, can have the effect of decreasing absenteeism and turnover. We are also saying that good morale can have a controlling effect on burn-out, either by giving group support toward rehabilitating the burned-out person back into the system, or by hastening his elimination from the system by giving group support toward his leaving.

We have defined morale as group self-esteem, *esprit de corps*. Stuart Klein, in the book *Essentials of Management* (1971), has pointed out that "group membership...may be particularly important in the context of jobs which have no intrinsic satisfaction...groups may afford consolation or comfort...or...may strengthen the individual member when he himself opposes... (some)...source of frustration."

Protective services work is not totally devoid of "intrinsic satisfaction"; however, it's not without its hassles. We believe that group feeling, or good morale, can have a positive effect on the individual, work-related problems of staff members. Family Resource Center has developed an agency structure and leadership style that actively promote group participation, group cohesiveness, communication, and *esprit de corps*. We have a system that generates and maintains group self-esteem—good morale. We have low absenteeism, turnover, and burn-out rates.

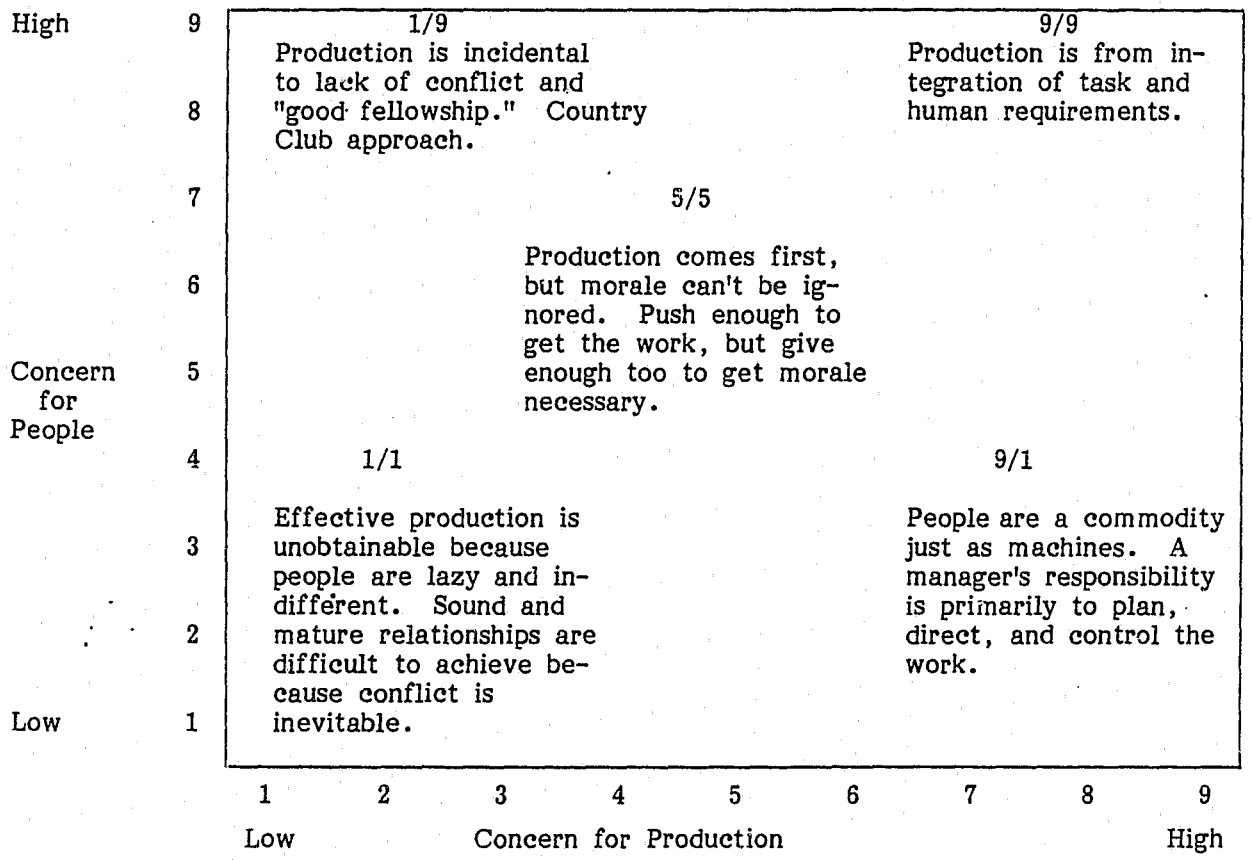
CONCEPTUAL FRAMEWORK

After conceptualizing our system and feeling smug about our "uniqueness," we turned to the experts and discovered that we were not so unique in theory as in application. Our discovery started when we decided to scan the literature to see if the experts supported or contradicted our experience. A review showed that each theorist seemed to contradict the other. There was no proven best theory of management or proven qualities as to what makes a good leader.

At this point, we gave up trying to find the "truth" and turned to finding support for our bias. What we found was a management model called the Managerial Grid, developed by Robert Blake and Jane Mouton (1964).

Figure 1

THE MANAGERIAL GRID
Robert R. Blake and Jane S. Mouton



Basically, the Managerial Grid is an attitudinal model which provides a basis for comparing various theories of management and examining an individual manager's approach. The individual manager is examined along two independent dimensions (1) concern for production and (2) concern for people. Blake and Mouton believe the most effective managers are those who score high on both of these dimensions—referred to as the 9/9 position. This position, also referred to as Team Management, is described as "interdependence through a common stake in organizational purpose which leads to relationships of trust and respect". In this approach, the manager's basic task is leadership rather than "pushing and controlling". His basic unit is the team rather than the individual and it is his task to enhance effective team work.

The basic assumption underlying team management is that "people want to do meaningful work" and that "participation in and responsibility for planning and directing work can make any job meaningful".

In addition, emphasis is placed on improving the communication structure of the organization, confronting conflicts, and assuming responsibility for oneself while encouraging and allowing others to do the same. Our experience at FRC shows that the team management position is an effective style of management in a protective services setting.

In a study of the phenomenon of burn-out in human service professionals (Maslach, 1976), the experience of detachment appeared to be a significant factor. This appeared to be true both

where burn-out was handled well and where it was handled poorly. Depending on how detachment is experienced, it can either contribute to more burn-out or to more effective coping with the very real stresses felt by human service professionals—especially those working with abusing and neglecting families.

When detachment is experienced in a negative fashion, it sometimes takes the form of dehumanizing clients, such as by referring to them as animals or "scum". While the worker may not consciously show his client this attitude, sooner or later he will be unable to successfully conceal it. The danger in this type of negative detachment is that it creates a significant separation between professional and client. This separation comes across in terms of human value—a dangerous position for a professional working in this sensitive area to maintain.

Detachment can be more effectively experienced through positive communication. Instead of the worker having a negative relationship (at least in his own mind) with his client, it is philosophically and practically better for him to take a positive approach. This can be best accomplished when he is able to form a strong group identity with his colleagues. This helps him to remain more open and receptive to the difficult clientele he seeks to help.

There are at least five elements of group support that seem to promote a positive group identity. Although these would probably be beneficial to any group, we are only concerned here with protective services professionals.

The first area is that of informal staff access. Specifically this would include the comfortable feeling that workers can go to each other to get advice, to bitch, or maybe to just sit. The important element here is not what they do when they get together but that they feel comfortable in doing so. The actual exercise of this support in terms of conversation or time spent may be minimal, but the feeling that it is accepted is essential.

A second area is diffusion of responsibility. Because child protective services is emotionally demanding and the worker often finds himself assaulted in many ways from many sides, diffusing responsibility in both decision-making and providing services can not only help to promote a strong group identity but also bring some relief to the individual worker.

Several things can contribute to this diffusion of responsibility. One primary method is for the worker to continually keep in mind that, although he may be the one with consistent direct contact with the client, he is only a representative of the agency mandated to provide the service and therefore is not personally responsible. A more sophisticated method would be to have a system where the serious decisions such as development of a service plan or the removal or return of a child are made by a group of people with differing philosophies, backgrounds, and expertise. The individual worker then is not deciding on his own but is only one contributor to the decision and carries out the ideas of the group. If one's agency is not set up to act in that way it is often possible for a worker to take another worker or supervisor with him when he anticipates a difficult interview or will need another observer or point of view.

A third area of group support is that of humor. Humor is a part of life—and not just one's life at home. Humor can be an effective way of relieving tension and of making situations appear less overwhelming.

Another way in which a worker can experience support is in having the freedom to take sanctioned time-outs when needed. This is not the same thing as the fifteen minute coffee break. It may be a time when several staff members informally get together to talk about a case or maybe to discuss the intricacies of making popcorn or Little Orphan Annie's sex life. The value here is in management's recognition of the fact that productivity in human service professions cannot be measured only in terms of time spent with the clients or recording in case files, but also in terms of the human development of the personnel who are expected to perform sensitive human services.

A final area of support is that of group communication. This is a more formal type of communication than suggested above. Two types of group communication stand out. First there is in-service training. Even well-trained professionals can find up-dating refreshing and helpful. This type of gathering for professional purposes can enhance a sense of group self-esteem and therefore morale.

Another form of group communication is the formation of support groups. These are somewhat formalized groups usually made up of workers in similar job functions who discuss job related problems and their feelings about the work they do. Bandoli (1977) gives an account of how one protective services agency experienced support groups.

Many of the above-mentioned positive forms of detachment can be organized and promoted by individual workers who have common concerns. They need not always be organized by the agency itself. However, if the agency encourages these and other forms of positive

detachment, its workers will feel that the agency is truly concerned about the enhancement of the human life of its own people as well as that of its clientele.

Two other ingredients that seem important in a systems approach to control of burn-out are flexibility and commonality of purpose. Christina Maslach stresses flexible work policies and a variety of job tasks to reduce burn-out. This prevents a worker from feeling in a rut and promotes professional growth. Flexibility does not mean structurelessness. Quite the contrary is true. A dynamic structure must be set wherein workers are able to move freely yet with purpose and choice. Lack of structure prohibits flexibility because it creates confusion and inhibits freedom derived from clarity.

Commonality of purpose or having "A Piece of the Rock" is our way of identifying what Blake and Mouton call "a common stake in organizational purpose". This sense of ownership is also related to propositions developed by a number of researchers which suggest that members of groups implicitly or explicitly demand conformity because it helps maintain a group that is attractive to them. In our system an individual either buys into the system or is pushed out.

THE FAMILY RESOURCE CENTER

Management

It is common for people to believe that child abuse professionals do not feel "miserable". The truth is the professionals struggle daily with miserable feelings and this can lead to burn-out. The Family Resource Center is a comprehensive evaluation and treatment program aimed at preventing and reducing child abuse. As a delivery system it is very special, however, since the Family Resource Center was also designed specifically to address the problems that workers face personally in serving abusive families.

What are the problems? What is burn-out? Burn-out is the effect of the job on the worker. It is what happens to the worker as a result of the continual pressure, stress, or boredom he experiences. Defining it is not easy. But seeing is believing: depression, apathy, dislike for clients, colleague problems, lack of creativity, incessant complaining, absence, bitterness, anger, and so on. Not just occasionally, either.

Recognizing the rigors of the job, FRC is a system designed to support the staff member and to counteract forces which undermine him. In any agency, the organization, administration, and structure should act to support and enhance the staff. Often this is not true; the staff supports the agency. At the FRC the staff is pivotal and is viewed as the main asset. There have been positive pay-offs in morale and controlled burn-out.

The strategy for dealing with staff morale and problems includes four components:

1. Management style.
2. Delivery system.
3. Staff development.
4 Atmosphere.

The management style is one of collective democracy or participatory management. Everyone is expected to participate in the management decision-making process, and does so. This requires open and active communication which demonstrates trust, worth, and value to the staff.

At FRC there are no supervisors; only the coordinator has administrative authority. Management is through the team by way of shared responsibility and leadership. The organizational structure is flat or horizontal. A multidisciplinary staff provides for variation of thought and approach in a non-hierarchical setting. Each staff member is viewed as a vital force in the whole system. Functionally the secretary is as important as the physician. Maintenance of the system requires support by and of each staff member.

The methods used to encourage participation are not profound or new. The important ingredient is the administrative attitude. A conscious effort has been made not just to include the staff but to force them to become responsible for themselves within the system. This is accomplished in many ways:

a. Major decisions are brought to general staff meetings.
b. On-going consultation with staff is necessary.
c. Ad-hoc committees and task forces insure staff involvement and save time.

d. Staff retreats allow for lengthy, undisturbed, concentrated time for staff to struggle with problems and consider functioning of the system.
e. An administrative expectation that it is okay and actually necessary for staff to have time out when nothing is done is a supportive measure.
f. Accessibility to management is necessary.

Flexibility, patience, and confidence in management are critical. Are job definitions rigid? Is there room for variety? For growth? Can management be openly criticized? Is the program set in stone? Can it change? Adjust? The Family Resource Center's approach to management has been successful in promoting morale and involvement and in administrative accountability. The results have been efficiency, commitment, pride of ownership, productivity, and a high level of services.

Delivery System

The purpose of delivery systems in protective services is to ensure that effective human services are being provided for human beings. If we are to encourage mature and sensitive behavior in our clients, we must expect the same of each other. The FRC delivery system has evolved in various directions at various times—not unlike the evolving of the human lives we seek to enhance. Although the members of the team represent different levels of training, all are expected to participate as much as possible in trying to work out effective services for our clients. The multiplicity of services offered through the center encourages the teams to offer the most comprehensive service plan possible.

While a team system is designed to effect beneficial changes in the lives of the families it deals with, it must be equally concerned about its own life. At the FRC this is done in several ways:

a. First, it recognizes that an individual worker does not "carry" a case but that the team is responsible for what happens with a given family. One worker will be assigned the job of being the primary contact for the family or may coordinate several services, but the responsibility for the success or failure of the center's intervention lies with the team. This often includes having three or more team members working with the family at the same time—each performing a specialized task.
b. The burden of serious decisions—such as removal or replacement—falls not on the individual worker or supervisor but on the whole team. The worker in the field or the courtroom speaks on behalf of the team and is not expected to be held individually responsible for a given plan or consequence of removal or return of a child.
c. The team system of service delivery at the FRC is horizontal in its line of authority. No single voice—even that of a psychiatrist or senior social worker—carries more weight than any other. The team, however, recognizes the specific expertise of those contributing to the staffing and uses it to formulate the plan.
d. FRC is a system in which each case is staffed by the entire team several times in the course of involvement with the family. The process is time-consuming and at times frustrating. Each team meets an average of four hours per week. We have found that well-thought-out plans tend not to foul up and save time in the long run.
e. The team serves as the supervisor. Leadership of the team is on a rotating basis with each member serving as team leader for one month.
f. One of the most significant functions of the team is that of support of the individual worker. The variety of personalities on a team make it possible for us to pick up early clues as to how a worker is doing and make adjustments as needed. A worker who is down today and is supported will be a supportive person to others when they need it.
g. A sense of celebration is also important to a team. We are quick to congratulate each other when a client seems to have responded and made positive strides. Likewise, when nothing we try with a client seems to make any difference, we can console a worker who feels some despair.

It has taken some time for our teams to develop as they have. The teams are not identical either in make-up or personality. Each has a life of its own. We feel we have to allow the teams to grow, expand, improve, and sometimes falter. Such intangibles as supportiveness, celebration,

and consolation cannot be legislated. They came about at the FRC by having mature workers and trusting them to find their way within a team framework and the demands of child protective services work.

Staff Development

At FRC, growth and change are important concepts for clients, the program, and the staff. Staff development is applied in the broadest sense, certainly not confined to training. The concern in a staff-supportive system is that each staff member should grow professionally and personally. Staff associations, learning opportunities, structure, and concentration of effort on management's part, all enable the worker to grow, change, and develop confidence and satisfaction in the job. This self-confidence and self improvement are results of:

a. Developing a broader knowledge base.
b. Opportunity and variety in experience.
c. Horizontal organization and feelings of equality.
d. Full participation through team approach and equalitarian management style.

All of this culminates in job satisfaction, good morale, and slower or controlled burn-out.

Many methods can be used in a staff development effort, the more the better. Obviously in-service training is of value. This should be weekly and works best if organized by staff members. Attendance, although encouraged, should be voluntary. The multidisciplinary team approach promotes sharing among professionals with a wide range of knowledge and experience. With the non-hierarchical approach teacher-pupil roles are dismissed and all are allowed to learn from each other. An attitude of mutual support "We're all in this together" encourages interdependence and individual consultation. Professionals and paraprofessionals work conjointly on many tasks.

Opportunities for experiences other than those specified in one's job classification are growth-producing and increase job versatility. Effort is made to provide outside training experiences at conferences, universities, workshops and so on.

Providing opportunities for staff to deal with their own interpersonal dynamics helps them stay in touch with their feelings, sensitizes them to each other, and helps actively work out relationship problems. For six months FRC staff participated in small interpersonal groups. Although these were not sensitivity groups, personal problems, concerns, and interactional problems were discussed. The approach for these groups included an educational component in terms of counseling techniques as well. One benefit of this activity came from staff being given time out to deal with their feelings and non-case-specific personal concerns. It was a protected time, almost sacred.

Staff retreats also allow growth-producing interpersonal exchange. FRC has had retreats annually for the purpose of addressing programmatic concerns and personal effectiveness in the system. The retreat is a weekend affair. Arrangements are made at some fairly secluded place away from Albuquerque. The staff plans the agenda and runs the meetings. Eating together, recreation, boogeying, and working hard bring the staff together, even though most are exhausted by the end.

Administrative action is a practical, necessary part of staff development. People should be properly classified and compensated for their work. Administration must continually address this problem. FRC upgraded eight positions in the first year of operation. Four positions are in the process of being upgraded. One extra meritorious increase is pending. Even if upgradings are nearly impossible to obtain, the act of trying is important and supportive to staff.

Staff development can take on many forms. It suggests that administration or the system is personally concerned about the individual staff member, his well-being and his growth. It is one way of controlling or slowing down burn-out.

Atmosphere

A person spending any time around an agency does not take long to pick up on its atmosphere. While specific determinants of an atmosphere may be elusive, the product is right out there for anyone to see. Atmosphere affects morale as much as any other single factor--including monetary compensation. At least this appears to be true at the FRC where social workers are paid less than public school teachers and grocery store checkers. Some factors affecting atmosphere are readily visible, such as carpets on the floor, a telephone for each worker, and the freedom to decorate one's office. Other "atmospheric conditions" have developed over the life of

the project. These seem to fall into four major categories: Ownership, humor, flexibility, and fellowship.

Probably the most significant factor in the life of the FRC so far has been the surprising evolution of a sense of group ownership of the project. In the early months of the project the staff was stumbling for an identity and some recognition. When it became apparent that they were embarking on a course of their own making, they began to take a personal responsibility for the center's development. A feeling of ownership of the project and throwing in one's lot surfaced, and from this a sense of pride has developed. Those coming into the system later found an agency already at work. However, they did not find that they would have to fit into a restrictive slot. Instead, they found opportunities to add their talents and interests to the development of the FRC. The system encourages incoming workers to use their expertise for the benefit of our clients and the enrichment of our staff. Those workers, thus seduced, have gained a sense of ownership of the project equal to that of the original staff. We have found that this sense of ownership is essential in each member of the staff. Over the life of the project a form of natural selection has developed and people who do not assimilate this feeling seem to be voluntarily bred out of the system. This "breeding out" is totally egalitarian; thus far, we have lost a receptionist and a psychiatrist in this manner.

Those who are familiar with both the horrifying nature of child abuse and the television show M*A*S*H can readily appreciate the need for humor in such an agency. A worker who has the wrenching experience of seeing battered babies; or who is facing the agonizing decision of removal or return of a child; or whose credibility or expertise is challenged in court; or who must face hostile, dangerous, and sometimes armed clients must have some acceptable form of release.

One of these is the use of humor. The humor often takes the form of mock criticism of a peer, self-deprecation, or the informal description of a client. Not a little of the humor is of a more personal and earthy nature. Sometimes the humor is done in a directly personal fashion as when a full-blown mock trial was held to impeach a team leader with the prosecution represented by an agency attorney and the defense throwing itself on the alleged mercy of a hanging judge. Other times the humor is found in memos written and distributed to the staff, or, more mischievious, writing to a state official on behalf of an unsuspecting worker and asking for approval for a trip to Israel--by motorcycle.

To an outsider, of course, the humor would seem frivolous, a waste of time and therefore of the taxpayers' money. What we know, however, is that this behavior is therapeutic rather than simply frivolous and that time for this must be informally built into the system. Without the opportunity for such humor and the understanding that at times it is necessary for the well-being of the staff, the FRC would lose a considerable amount of its ability to function effectively.

A third contributor to the atmosphere is the concept of flexibility. The FRC is organized such that, when the need arises, changes can be made by the total staff with a minimum of disruption of service to the client. When a certain lack of efficiency was noted in the original system of investigating referrals, the full staff debated a proposal and accepted it for a six-month trial period. The change was found to be so successful that no one on the staff asked for a review at the end of the trial period. This significant a change requires a great deal of flexibility in the structure of the agency. Organizations that are unable to allow for change stifle creativity, and productivity suffers. A worker who is expected to encourage self-reliance and self-respect in his clients must feel that his agency encourages the same in him. The FRC is such an agency.

The fourth major contributor to the FRC atmosphere is the old idea of fellowship. We do not have, nor do we seek, a paternalistic concept of "one big happy family". What seems to have developed, however, is a feeling of concern for each other. People are trusted to do their work and this trust is borne out in the product.

A feeling of inter-dependence and equality exists. It is a simple fact of life that we each must depend on others to carry out their respective responsibilities for the benefit of our clients. Some planned as well as serendipitous activities also seem to foster this feeling. Informal gatherings such as sharing popcorn, lunch hour, racquetball games, and succulent gossip sessions are helpful, as well as the more planned birthday parties or baby showers. What is important to remember is that all of the above is spontaneous. If it had been decreed by superiors that we would all like each other and we would have office parties, results would have been disastrous. By letting things happen at their own pace and as need arose, a genuine sense of non-maudlin fellowship took place. This could only have happened because the staff and administration wanted it to. In spite of the depressing mandate of the FRC, it is not a dreary place to work. On

the contrary, workers joining the staff from other states and private offices have found it to be a liberating agency which expects, encourages, and supports good work by offering respect and mutual concern.

It bears repeating that the beauty and success of a service delivery system based on a team management principle depends on human development. We must keep in mind that no matter how much we wish it were not so, we are a bureaucracy trying to make a dysfunctional family more human. In a sense, we are a machine directing people to be better people. This is a contradictory task and one that cannot succeed if the bureaucracy is not humanized to the greatest extent possible. We believe that a team based service delivery system, as developed at the FRC, has overcome that philosophical barrier. And, more importantly, it has found a way to give protective services workers the same consideration we seek to give our clients.

Validation

The Family Resource Center's success in controlling burn-out can be tested at least through assumption by three means: staff turnover rates, staff absenteeism rates and results of some research done at the center. The Appendix provides specific data regarding staff turnover, absenteeism and agency atmosphere.

SUMMARY

The formula at the Family Resource Center for controlling burn-out is rather simple: an increase in positive staff morale results in a decrease in burn-out effects. Burn-out is essentially dissatisfaction or unhappiness with one's job. It seems reasonable then to assume that if an agency can humanize itself to support, encourage, and involve the employee, that person will want to be there. Protective services work can be horrible and depressing, or exciting and challenging. The protective services agency can be bureaucratic, dehumanizing, and insensitive, or supportive, dynamic, and motivating. Which it will be depends to a large extent on how those with authority view protective services and what their responsibility is to provide an effective, capable program and delivery system.

The Family Resource Center has demonstrated that staff maintenance and growth are possible through leadership which integrates the agency's mission and staff requirements, through a management model which maximizes staff participation and involvement, through a comprehensive multidisciplinary service delivery system, and through a people-oriented agency atmosphere and staff development program.

If agencies are to be effective in managing child abuse and neglect problems, the well-being of staff members must be a consideration. This is necessary for humanistic reasons, for there must be consistency in our philosophy of help both to clients and staff. In addition, it is simply good management from a cost-benefit point of view to reduce and control absenteeism, turnover, and inefficiency in task completion.

Although FRC continues to struggle with many management and service delivery problems, it is clear that significant strides have been made in both areas. After only two years in existence the center has effectively dealt with the critical problem of staff maintenance and continues to grow in its ability to solve problems within the system and provide quality services to families and children.

Appendix 1:

Staff Turnover

— Estimated staff turnover for social services agency direct service staff (based on sample) - 25%
RRCCAN - HEW Region 6: September, 76.

— Bernalillo County Social Services Agency: protective service staff turnover, 1973 - 45%

— Baton Rouge Child Protection Center reported staff length of stay - 9 months
Child Protection Report

— FRC staff turnover first year - 9%

— FRC staff turnover second year - 13.6%

— FRC staff turnover directly attributed to burn-out:
First year - 0%
Second year - 9%

Appendix 2:

Staff Absenteeism
1/76 to 1/77

Annual Leave
Each staff member accrued 120 hours
Staff members took an average of 101.55 hours each
Staff members gained an average of 18.4 hours each
Leave has been taken predominantly on a planned basis

Sick Leave
Each staff member accrued 96 hours
Staff members took an average of 56.78 hours each
Staff members gained an average of 56.78 hours each

Appendix 3:

A Study of Communication and Atmosphere at FRC by
University of New Mexico Speech-Communication Department
Submitted October, 1976

1. Staff see themselves as working interdependently - 89%
2. Staff feel an atmosphere of candor and frankness prevails - 89%
3. "What are the major strengths?"
   A. Worker dedication - 80%.
   B. Worker competence - 45%.
   C. Quality of supervision - 50%.
   D. Openness and freedom of expression - 60%.
   E. Team decision making - 100%.
   F. Flat organization - 90%.
   G. Feedback and supportiveness of co-workers - 95%.
4. Regarding climate, staff felt:
   A. Trust was high.
   B. Participation by employees was high.
   C. Supportiveness was high.
   D. Openness in downward communication was high.
   E. Listening in upward communication was high.
   F. Concern for high performance was high.
5. Staff expressed satisfaction with:
   A. The work itself.
   B. The supervision.
   C. The co-workers.
   D. Team/decision-making.
   E. Flat organizational structure.
6. 65% of the effective communication incidents reported by FRC were in two categories:
   A. Supportive behavior
   B. Problem resolution

7. "The data indicate that on the climate inventory, the Family Resource group scored higher on every individual item, resulting in a composite score significantly higher than either of the other groups. The responses indicate, therefore, that the Family Resource group has a communication climate that is higher than expected...."

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Child Abuse: The Worker's Perspective

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Child abuse is defined by Andrew Schneider (1977) as:

> Any physical injury or injuries sustained by a child as a result of cruel or inhumane treatment or as a result of a malicious act by a parent, adoptive parent, or other person who has permanent or temporary care, custody, or responsibility for the supervision of a minor (p. 25).

As the awareness of child abuse becomes a growing national concern, most states pass laws making it mandatory to report families suspected of harming their children. As a result, more attention is focused on those social service agencies which are mandated to investigate cases of reported abuse and to provide services to these families.

Protective services in Tennessee are provided by the Department of Human Services. The department offers social services to families in which child abuse exists. The purpose of this service is prevention and rehabilitation in a nonpunitive atmosphere to maintain and strengthen family life.

One of the major difficulties in working with families who abuse children arises from the nonvoluntary nature of the intervention. In most social service agencies, the family makes the initial request for service; however, in a protective service investigation, the first contact is not solicited by the family but results from a complaint or the child's hospitalization with injuries.

> The initial interview with an abusing parent is an emotionally charged situation that demands great skill on the part of the social worker. The parent is upset, whether wracked by guilt for having injured his child, shame for having lost control of himself or embarrassment over having his "inadequacy" exposed. The parent fears the legal or psychiatric consequences of child abuse... (Goldberg, 1976, p. 274).

Good casework skills are required to establish a working relationship with such a family, especially when they have not requested service. In many instances, they may not recognize the need for assistance, or may view the worker as a threat and an intruder.

Several techniques can be used to facilitate the worker's approach to families resistant to intervention: use of a "low key" approach; nonconfrontive style; focus on verbal and nonverbal communication; empathetic, rather than deliberative, listening; and, inclusion of parents in decision making. These should be used in the initial interview and continued throughout the investigation. Social workers usually use these techniques, but they are most important in a protective service investigation because the worker frequently comes unannounced. The family is unprepared for the visit and must suddenly deal with the threat of an investigation. Consequently, the interview may provoke anxiety for the parents and the worker. The worker has little information about the family and does not know what their response to her will be. The parents may react by being extremely passive, extremely aggressive, frightened, or hostile.

Because of the sensitive nature of the interview, the worker should use a "low key" approach, especially in the initial interview. This approach should be courteous and nonthreatening so as not to arouse undue hostility, and thus create an atmosphere conducive to discussing the complaint. The worker should identify herself, the agency she represents, and the purpose of the visit. Initially, she can explain that concern about the parents' child has been expressed by someone in the community (in most states complaints are confidential), and she would like to discuss it with them. The worker must be supportive of the parents and not focus solely on the abuse.

It is essential the worker be nonjudgmental in the initial interview. She should not assume the parents are guilty of child abuse merely because it was reported, and should reassure the parents of this. Felix Biestek (1953) said that, "The function of social work is not to judge but this function is to preclude assigning guilt or innocence".

Because parents may be hostile, defensive, and unmotivated (unwilling to talk about the problem), it is very important that the worker heed both verbal and nonverbal communication. Empathetic rather than deliberative listening will help the worker better understand the parent. Charles Kelly (1970) compared empathetic and deliberative listeners as follows:

> Both listeners seek the same objective; accurate understanding of the communication from another...The empathetic listener lets his understanding of the speaker determine his modes of evaluation, which are automatic; the deliberative listener's understanding of the speaker is filtered through his predetermined modes of selective listening and actually spends less time as a communication receiver. The empathetic listener is more apt to be a consistent listener, and is less prone to his own or other distractions (p. 341).

This is especially important for workers who deal with abusive and resistant parents. It may be difficult for the worker not to "filter" the parents' communication through her knowledge that they are abusers.

During the interview, the worker listens closely to what the parents say. In approaching a family, the worker must anticipate several responses. Some parents may be angry and will express this anger toward her. Others may be very needy individuals who talk only of themselves while never expressing concern or feelings for the child. Others may deny they have problems with their parenting abilities even though the child is hospitalized with injuries and they tell inconsistent stories about how it happened. In some instances, parents may be so relieved someone has finally offered help, that they tell all. Annette Garrett (1942) stated:

> ...that in seeking to help people even in a very simple situation we need to listen not only to the objective requests but also to undertones which reveal their feelings and give us clues as to perhaps even more severe underlying problems. A person may not be able to verbalize the underlying problem or may not be aware it exists. A person who appears angry and belligerent may have no other way to express his hurt pride and guilt (pp. 23-24).

Just as it is important to identify what parents express through nonverbal communication, the worker should also be aware of what she is expressing nonverbally to the parents. The parents notice her facial expressions, tone of voice, apparel, posture, and gestures. Also, a worker can communicate to parents through the way she positions herself in an interview. To place the parents at ease, Gale Goldberg suggested the worker place her chair at a 60 degree angle to the parents' chairs to avoid forcing eye contact (pp. 276-277).

A fourth technique is the inclusion of parents in the decision making process, and helping parents exercise their rights of self-determination. This may be limited in a protective service investigation since the worker must first protect the child. The worker must clearly identify available alternatives and the consequences of each in seeking the parents' cooperation and help in decision making. The parents' method of self-determination may be refusal to cooperate even though they know the consequences.

Just as important as the worker's use of professional objectivity is consideration of the worker's emotional reaction toward abusive parents. A good protective service worker is one who is caring, giving, and sensitive to the needs of parents and children. The same qualities that make a good protective service worker also make her vulnerable to burnout. Burnout occurs when a worker's ability to feel or care for people gradually diminishes as, day after day, she gives of herself to others.

One factor contributing to burnout is internal. In investigating child abuse cases, the worker shares dual responsibility in feeling for child and parent. Feelings can become so painful that eventually the worker may attempt to deny them in an effort to endure her job.

Other factors that contribute to burnout come from external sources: the parent, the agency, and the community. This fragments the worker's energy and quickly tires her. Abusive parents are very needy and demanding, and can be a major source of pressure on the worker. The worker often must play the parent role for the parents by being available, setting limits, and serving as an outlet for their frustrations and anger.

Another source of worker burnout is the high expectations agencies, mandated to investigate child abuse, place on workers. The agency expects a thorough investigation of one case while the worker also handles several others. With present emphasis on accountability in

social service agencies, the worker has more paperwork and record-keeping responsibilities. Also, the agency may not only expect the worker to know the law and agency policy, but to interpret it skillfully and tactfully to parents as well as the community. So the agency, out of necessity, places high demands on the worker.

A third source of pressure is community demands that the child be protected. The community often does not understand how an agency conducts a protective service investigation. It takes much of the worker's energy to explain the procedures she, by law, must follow. Also, the worker must explain to the community that parents, even though they have harmed their child, still have rights. The community tends to stereotype child abusers as low-income parents, but in reality, child abuse touches persons in every socioeconomic class. The poor may more quickly lose custody of their children while high-income persons may retain custody of theirs. The worker must be careful not to stereotype the poor, or to allow parents of a higher economic level to intimidate her.

In conclusion, the above factors may result in burnout unless a worker receives adequate support from her peers, the agency, and immediate supervisor. The supervisor plays the major role in preventing burnout, because she is in a position to evaluate and detect its first signs. When she evidences burnout, certain techniques must be used to prevent its occurence. The supervisor can be supportive and assist in enhancing the skills of the worker.

The supervisory relationship involves knowing the worker and her capabilities. In order to to this the supervisor should have regular weekly conferences with a worker, read her records, and be available at her request for needed additional conferences. This enables the supervisor to learn of inappropriate worker attitudes toward clients. For example, the supervisor may observe a worker's feeling of punitiveness toward the parents or overidentification with the parents or child. This may prevent objectivity and/or appropriate intervention. The supervisor also should be aware of the cases the worker feels most competent to handle. Examples are cases in which the worker deals with specific ages of children, various types of abuse, or families of varying income levels. In being able to handle a particular case comfortably, the worker will be able to give better service to a family.

The supervisor must help the worker enhance several skills pertinent to a protective service investigation. A supervisor must aid a worker in planning her time efficiently. Effective and efficient planning is necessary due to the worker's many responsibilities, shortage of time, and need to meet agency expectations.

Another skill the supervisor must teach is how to assess a family accurately. This includes learning how to approach parents accused of abusing their child in a nonthreatening manner, and how to establish a working relationship. Another part of assessment is knowing what information is needed and how to obtain it quickly.

A third supervisory skill is to help the worker apply intervention appropriately. One way of doing this is to familiarize the worker with community and agency people and resources that can serve a family. The worker must also recognize at what point an intervention plan must be changed, and when and how to initiate court action to remove a child.

The supervisor must also help the worker recognize when to terminate a case. She must recognize signs that the family has stabilized to the point agency intervention is no longer needed.

A supervisor must also support the worker. A worker will often need to ventilate hostile, pent-up feelings to the supervisor and not feel her job threatened. Charlotte Towle (1963) discussed feelings and how workers may not realize their freedom to feel. She said:

> ...denial of feelings will desensitize a worker. It will constrict him in relating to people and lead to emotional shallowness. It is as he is free to feel that he becomes able to face and to regulate his feelings. It is as feelings are expressed and respected that he will be able to respect the feelings of others...

After a worker has experienced a difficult interview with a family, she may need to unwind. A worker must know she is not being judged as a negative person, but that the supervisor realizes she needs an outlet.

It is important the supervisor notice indicators of worker burnout. As stated earlier, one of the skills of a good protective service worker is empathetic, rather than deliberative, listening. I have seen a worker move from empathetic to deliberative listening as caseload demands increase and pressure grows due to lack of time. As pressure builds, so does the tendency to stereotype and lose professional objectivity. A change from empathetic to

deliberative listening is a "red flag" that a worker may be starting to burn out. Other indicators could be negative attitudes toward the supervisor, coworkers, and agency. Also, a supervisor may notice a worker losing compassion for her clients. The worker may take more sick days as a way to escape pressures.

A supervisor's warm, sympathetic, and understanding approach may also help prevent burnout. If the supervisor sees the worker having a difficult day, she may suggest the worker not make any field visits that day. The supervisor might find her a quiet place to work for several hours, away from the telephone and other interruptions. She must use care in assigning cases to prevent saturating a worker with only one type of case. Saturation could lead to burnout more quickly. A worker needs less demanding cases interspersed with those which are emotionally draining. This variety provides some relief for the worker. The supervisor may give a worker a week in which she receives no new cases if she begins feeling overwhelmed. If the supervisor is sensitive to and aware of the needs of the worker, the high job mortality often found in protective service units can be prevented.

Nationally, the concern about child abuse has focused on children and parents with little attention given to the worker who must deal directly with them. These workers are a valuable resource to an agency because of the unique skills they have for dealing with families in crisis. This work takes an emotional toll often leading to the worker's frustration and burnout. As a result, agencies lose this valuable resource due to high turnover rate.

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How Can We Avoid Burn-Out?

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> This book, being about work, is by its very nature about violence to the spirit as well as to the body. It is about ulcers as well as accidents, about shouting matches as well as fist fights, about nervous breakdowns as well as kicking the dog around. It is, above (or beneath) all, about daily humiliations. To survive the day is triumph enough for the walking wounded among the great many of us.
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> It is about a search, too, for the daily meaning as well as daily bread, for recognition as well as cash, for astonishment rather than torpor; in short, for a sort of life rather than a Monday through Friday sort of dying. Perhaps immortality, too, is part of the quest. To be remembered was the wish, spoken and unspoken, of the heroes and heroines of this book (Studs Terkel, *Working*).

Studs Terkel learned in his travels across the country that individuals are looking for meaning and fulfillment in their jobs. When this need is not met, anger, frustration, apathy, and then deadness follow. The problem portrayed in his book is not uniquely a blue collar crisis, but commonly exists in human service industries, among which are universities, protective service agencies, mental health clinics, and federal demonstration projects. Professionals, like secretaries and janitors, share the quest for meaningful employment. If, as the book suggests, when people's jobs do not meet their needs, their dissatisfactions are expressed by anger, hostility, resentment, and physical ill health, we in the human service field, which seeks to assist and serve people, have reason to be concerned.

Evidence of this problem is the high turnover rate and absenteeism experienced by most social agencies. The average social worker changes jobs every two years. Others, who no longer find satisfaction in their current jobs but either out of security needs or the limited job market do not leave, often experience the deadness and ill health characteristic of burn-out; individual performance is hampered, and client services are sacrificed. I have been interested in the problem of burn-out for some time. I reviewed the literature and talked with people who have experienced the problem, but it wasn't until recently that a personal experience crystallized for me the full impact of this burn-out problem on worker performance and client services. My father died a year ago after a long illness; he and my mother had been living on a small disability pension from his employment. When he died my mother received a small insurance benefit of $5000, but unfortunately my father's retirement pension stopped when he died. Based upon the conditions of my father's pension, the Social Security Administration was supposed to take over financial support of my mother upon his death. A year has elapsed and still my mother is completing forms and being examined by doctors. During this year I have been trying to navigate this system to help my mother receive the benefits to which she is entitled. My first contact with a worker in the Social Security Administration was a shock. My questions were calm enough—what has been the problem in providing my mother with the benefits for which she is eligible? What can we do to speed up the process? I also made some attempt to convey to the worker my mother's fears and feelings, to share with her what my mother was experiencing because of this extended delay and no information. The retort was defensive and blaming; every expression I had used to explain my mother's feelings had been interpreted by this worker as attempts to cheat the government. I felt that my intent had never been heard; my questions never received direct answers. Rather, judgments had been made about me because I was demanding services. Worse, I felt guilty and over-wrought, and found myself self-reproachful. Was I wrong? Was I neglecting my duty? Maybe my mother didn't deserve my father's pension, etc. After some reflection about what had happened to me, I realized that I had just experienced depersonalization, a prime symptom accompanying burn-out. I, as a client, was made to feel wrong or unreasonable; my self-esteem suffered because a worker could not accept my problem as unique or affecting my life any differently than the hundreds of others who have complaints.

Burn-out is not just a problem in social services and welfare; it also exists in protective service agencies who have the mandate to protect the welfare of children. As I began to interview workers in this area, I often heard them express fear of knocking on one more door, driving around the block several times trying to get psyched up. After a year on the job one

worker reported that he found himself creating distance between himself and his clients. He began to refer to clients as "they," feeling "Oh no, there goes the same old story."

The type of experience just described is devastating for all concerned. The client not only has not received what he needed, but has also been made to feel inadequate or inept because he creates the problems for the worker. The experience is just as damaging for the worker. In the process of delivering services day in and day out to many clients with numerous problems, the worker has somehow become disassociated from a prior commitment to extend himself and be helpful to other people. An original need or desire to be helpful to others has been altered and a gulf has been created between the client and the worker at a great cost to both parties. The client doesn't receive good services, the worker becomes sick, leaves the job, or translates this sense of failure into cynicism, apathy, and alienation. This is the experience of burn-out.

My hypothesis is that burn-out doesn't have to happen. To understand what happens to move a worker from commitment to improving the human condition and relieving suffering to rote compliance with organizational rules and regulations, one has to study three major interacting systems present in the operation of social agencies: personnel characteristics, management processes, and organizational structure. While the client is a factor in burn-out, I am assuming that burn-out occurs with all types of clients and is more a function of system characteristics. Further, since my intent is to intervene in the problem of burnout, I assume that the systems are more amenable to intervention.

Let me briefly define personnel characteristics, management process, and organizational structure. Workers have important differences, e.g., work motivation, attitudes, education, age, interests, and skills. These differences suggest that some individuals may be more susceptible than others to burn-out.

Organizational structure is the framework for operating within an agency, the blueprint describing how personnel are arranged in relation to each other and to the task. The most common organizational characteristics are complexity, formalization, centralization, and size.

Management processes are those integrative functions that blend human characteristics and organizational structure into a working agency. The functions that create a positive work climate are leadership, communication/coordination, job design, supervision and decision making.

I have been studying worker burn-out intensively for the past year. My work has been conducted in conjunction with a three-year evaluation of the Joint OCD/SRS National Demonstration Program in Child Abuse and Neglect being carried out by Berkeley Planning Associates (BPA). In this demonstration effort, eleven communities across the country received three-year grants to test alternative strategies for treating child abuse and neglect. The primary focus of the evaluation has been to understand the relative effectiveness of these alternative treatment strategies. The evaluation has, however, gone beyond the narrow concern of treatment effectiveness and has been more broadly concerned with the question of what makes programs effective.

As part of BPA's evaluation of the eleven demonstration projects, I have been looking at job satisfaction and worker burn-out in the projects, looking carefully at factors among the personnel, management, and organizational characteristics that were associated with burn-out. Data were collected through questionnaires and interviews with most of the staff in the projects, including workers who had left the project and personnel from every level within the organization. The findings were generated from the study of 11 demonstration projects and a survey of 162 workers.

FINDINGS

Burn-out Symptoms

I found the conditions of burn-out to be present both among those who had left the projects and those who were currently working for the projects. As people shared with me the behaviors that tended to accompany burn-out, some consistent and specific indicators of burn-out emerged. These are:

1. High resistance to going to work every day (dragging your feet);
2. Somatic symptoms, the nagging cold, frequent bouts with a virus or flu;
3. Feeling tired and exhausted all day, frequent clock watching to see how late it is, usually accompanied by tiredness after work;
4. Postponing client contacts, resisting client phone calls and office visits;
5. Stereotyping clients, "Here goes the same old story";
6. An inability to concentrate or listen to what the client is saying;

7. Feeling intolerant of client's anger, an inability to understand and interpret client anger;
8. Driving the long way to a client's home, driving around the block before entering the client's home;
9. Feeling immobilized, "There is nothing I can do to help these people";
10. Excessive anxiety about investigating a new client referral or making a home visit;
11. Frequently walking through K-Mart in the afternoon in between home visits;
12. Problems sleeping at night, tossing and turning, feeling restless;
13. Cynicism regarding clients, an emerging blaming attitude of "These clients create their own problems".

All of us experience these symptoms in varying degrees at various times; the burned-out worker feels a constellation of them a lot, and finds it more and more difficult to cope with case management responsibilities.

Personnel Characteristics

Personnel characteristics give us some important clues about burn-out, and also suggest ways of lessening the problem. People are different. Some are always happy, others tend to be solemn or even sour. Some people are energetic, even hyperactive, while others are low-keyed, slower and more methodical. Some people like crisis and highly complex tasks, others like things to be simple and straightforward. Some like to work all the time, others like to work only a part of the time, saving energy and time for personal interests and hobbies. These variations among people make a difference when working with child abuse and neglect clients, who demand a lot of energy, long work hours, and great patience. The system that deals with child abuse also demands perseverance and aggressiveness in getting needed services for clients. Those whose personal styles make them uncomfortable with these demands tend to burn-out earlier than those whose styles are more compatible with these conditions. Recruitment and selection of staff can be improved by a knowledge of the personality characteristics demanded by the job.

Education is another important characteristic that tends to be associated with turnover and burn-out. Those who are highly educated tend to change jobs more often than their less educated peers. The explanation for this phenomenon involves the type of education that students receive in social work Masters programs. Many social workers are trained to define problems within a psychoanalytic framework; others are trained in various other theories of human behavior, with an emphasis on therapeutic techniques. When working with abuse and neglect clients, workers so trained quickly become disillusioned with both the agency and themselves. Contrary to their expectations, abuse/neglect families' primary needs require workers to focus on getting food, solving housing problems, and advocating with other agencies on the families' behalf. These efforts require different kinds of skills. Most social workers want to do therapy, but most protective service agencies can't afford that luxury; there are too many clients to allow "one-to-one" contact. Furthermore, clients often don't make great leaps in self awareness or drastically change their life patterns. In fact, clients often resent the social worker's intrusion into their lives. Progress is slow and often unappreciated by a worker who has higher expectations. The highly motivated client must often be ignored when other clients with crises demand attention. Professionals find themselves in conflict with the organization over smaller caseloads, more therapeutic job responsibilities, and opportunities to work with motivated clients, and they tend to burn-out when these demands are not met.

An ironic aspect of this education problem is that social workers with BA degrees leave agencies to return to school to learn skills that will make them more effective with clients. They return to school to become trained like their MSW counterparts but return with skills that are incompatible with the job. Masters programs rarely emphasize the skills necessary to cope with and work with multi-problem families and the environmental conditions found in protective service caseloads.

Because education is a key variable in job satisfaction, burn-out, and turnover, graduate education must be re-examined and made more relevant to real world needs. Agencies should also give more attention to developing the skills of the BA level worker through in-service training. MSW workers need to be redirected to a more productive use of skills. There are MSWs who enjoy the front line experience and could be valuable resources if other organizational and management problems, to be discussed later, were resolved. Education isn't an irreconcilable problem, but it requires some attention.

The need for personal growth varies with individuals. Many workers reported that they left a project because their personal growth needs were ignored by project administration. They

reported a depression with their daily routine and a personal stagnation. If some workers leave the agency when personal growth is blocked, others, due to limited job markets, just become apathetic and burned-out and stay on the job.

There are workers who are more interested in policy and planning or community organization than in serving clients. Others want to work with groups or primarily with children. These people stumbled into their current jobs from a variety of paths, and want out. They find the clients intolerable and the job exhausting, and strongly resent doing something that is not their primary interest.

Other people find themselves promoted into jobs that are not compatible with their personalities or training. For example, supervisors often report that they do not enjoy the stress and demands that workers place on them. Their responsibilities are overwhelming and they feel ill-suited for their jobs. It is not easy to turn down a supervisory position, because it often means a promotion and more money. So they become burdened with the haunting feeling of failure and self reproach. Other individuals, however, who were burned out as workers, report that they thrived on the promotion to supervision and recovered an enthusiasm for the job.

Differences in individual education, growth needs, job interests, and personalities demand that more attention be paid to the recruiting and selection of social workers. Job responsibilities should be clearly spelled out. Potential employees should have exposure to two or more days of working with clients in this agency. Staff training and opportunities for growth must be provided on an ongoing basis with more attention given to providing training directly related to the job.

Management Process

Personnel characteristics are very important in contributing to burn-out, and there are psychologists who spend a great deal of time thinking about the worker-client relationship, individual personality differences, and how one should intervene. It is exciting to see the progress that has been made in better understanding this dynamic, but I am primarily interested in how organizational structure and management processes contribute to burn-out, turnover, and performance. My fear is that by focusing exclusively on personnel characteristics, those other conditions will be ignored. It is my hypothesis that much burn-out can be effectively dealt with by re-examining how projects or agencies are managed and organized.

In a study of 12 public welfare agencies, 16 private welfare agencies, and 10 public rehab agencies (Olmstead, 1974), the findings suggested that organizational competence and worker satisfaction are highly correlated with agency climate, i.e., realistic program goals and policies, adequate supervision, and effective communication. Satisfaction tends to increase when:

1. Goals are realistic, that is, they can be accomplished with human effort;
2. Goals are clearly understood;
3. Policies are clearly understood and there is clarity of work roles;
4. Supervision is effective;
5. Agency constraints and controls are moderate;
6. Work environment is stable and secure;
7. Communication within the agency is adequate and effective.

Management processes are those integrative activities that interface the organizational structure and personnel characteristics. The research in the eleven child abuse agencies pointed out some specific problem areas in management that contribute to the burn-out syndrome: project leadership, communication/coordination, supervision (accountability and support), and job design.

Leadership: Workers feel that problems created by inept or inexperienced leaders are significant factors in their satisfaction and performance. They believe that an inexperienced director takes longer to do a job, creates unnecessary conflicts with the host agency and between the director and workers, and allows the project to become disorganized, operating from crisis to crisis. Workers in these situations beg for a more planful approach to project operation.

Others complained that their director did not know how to cope with workers' anger or handle stressful situations in an orderly fashion. A director who is unable to set priorities causes problems for workers. Such a director may spend all his time putting out fires in the community and building community relations, while ignoring internal management and morale problems. Other directors demand that everything get done, even when "everything" is clearly beyond human effort. The pressure created is unsettling to the work environment, and people feel unproductive and harried.

Another common problem is project directors' inability to handle authority. Problems can occur if a director is passive and nondirective, or authoritarian and controlling. Passive directors create a tentative, confusing work situation. Controlling directors are antagonistic and have conflicts with professional social workers who have definite wishes to be included and consulted in program decisions. The most successful directors are those who provide structure and direction, but include everyone in decision-making related to project operation. In these situations, workers feel valued because their ideas are considered and incorporated into program plans.

In projects where the work climate is positive, the workers explain that much of their satisfaction is due to an existing trusting atmosphere. Serious problems are created when workers feel that they are not trusted. Some directors feel an overwhelming necessity to do a perfect job, and fear that if they do not watch carefully the job won't get done. Some directors never delegate responsibility. Others do, but oversee the performance in a nagging, critical tone. These attitudes imply to workers that they cannot be trusted, which undermines staff performance and morale. People need to feel trusted in order to feel comfortable supervising and managing clients' lives and protecting children. Trust is the most basic feeling and need; if it is not present, workers feel anger and resentment.

While experience, skills in coping with stress and anger, confidence, non-authoritarian attitude, and trust are very important in a director, the critical characteristic that a leader must have to improve worker performance and prevent burn-out is an ability to be supportive and give liberal positive feedback. Workers who left jobs with child abuse projects reported over and over, "I was never told that I did a good job." Some said, "My supervisor was supportive, but the administration never cared or gave us support." Others said, "No one appreciates that we are the ones working daily with clients; no one tells us that we are important, or tries to make us happy."

There are several reasons for this lack of support, but the critical one is that directors aren't trained in administration. They are often promoted into the leadership slot because they have been outstanding supervisors or therapists, or because they are experts in the speciality area. Individuals find themselves promoted into administrative positions without having thought through whether they are personally suited for the duties and responsibilities of project management. I am not advocating hiring business administration majors, but rather providing training in administration and management theory prior to promotion. For some people this may mean a year of training; for others less time is needed. I am also suggesting that a particular kind of training is needed, i.e., a human resource model that focuses on developing worker potential and uses facilitation as its primary skill in improving worker performance and structuring programs. A human resource model would be concerned with creating an atmosphere that nurtures workers, allowing them to nurture and serve clients effectively. If training cannot occur prior to assumption of an administration position, incentives should be used to encourage the acquisition of these skills while employed in the job.

Communication: As in the Olmstead study, I found communication to be a significant problem in project management. Most projects have scheduled staff meetings, but because of emergencies or scheduling problems, meetings are frequently cancelled. When staff meetings do occur, relevant information is often not discussed. Frequently, due to strong personality conflicts between key people in the project, communication is distorted or misinterpreted. In other situations, the person most affected by the information is the last to know. A number of workers wrote me, "My job was redefined and I was never consulted," or "One day, after working for 1½ years, I was told that I had to resign, becuase I lacked a college education." In large protective service agencies a typical complaint was, "I spent four hours completing the necessary paperwork so my client could receive day care, only to learn that the rules had changed two weeks ago and the forms would have to be redone; I thought twice before suggesting day care to the next client."

Bad communication creates many problems for workers. Valuable time is wasted. A worker feels unproductive and unappreciated. People spend a lot of energy being angry and resentful. In many agencies, workers turn to other workers to vent their anger and gain some needed support. Consequently, problems multiply and grow out of proportion. Schisms are created in the organization and workers congregate in each other's offices venting anger about the most recent frustration.

Good communication is difficult, even for social workers. Often communication doesn't happen because formal communication patterns are not established early in the project's life to assure that information is transmitted. Sixty-three percent of the workers claimed that their best source of information was through informal communication. Informal communication works

fine in a small organization with fewer than five people, or if one happens to be in the "in-crowd." Otherwise, it is inadequate as the sole information system and produces great stress and anger among isolated or neglected workers.

It is not easy to give blanket recommendations for improving communication. However, here are some guidelines. There should be regularly scheduled staff meetings. All staff should be involved in discussions that directly affect them. Individuals must take personal responsibility for resolving conflicts with anyone who has intruded into their program area, neglected to give necessary information, or hurt their feelings. Workers should assume the initiative in making management accountable for good communication habits, and should resolve to stop all third party communications (conversations, usually negative, about someone who is not present which are not meant to be helpful).

Supervision: Supervision has a long tradition in the social work profession. Recently, many have questioned its function and have advocated that social workers leave the womb of supervision and function as autonomous professionals. Nevertheless, in the eleven projects and in Olmstead's agencies, inadequate or non-existent supervision was strongly associated with burn-out.

One worker told me of her experience with a poorly trained supervisor in a protective service agency:

> "I had just completed my home visit with an extremely angry, hostile mother. She was angry with me because I had had to remove her child some time ago and still did not feel she was ready to assume her maternal responsibilities. I had endured her curses and hysterics; now, as I left her home I was trembling and angry. But I was also filled with self-doubt. Was I doing the right thing? Maybe there was something I should have done differently or might do now so that mother and child could be reunited? I returned to the office absorbed with the incessant dialogue taking place in my mind and proceeded to my supervisor's office. As she looked up, I blurted 'I am so angry with Mrs. S__.' Before I could finish my story we had several interruptions and then the phone rang. After the phone conversation, she said, 'What is it you were saying?' 'Nothing,' and sulking, I stalked out of her office. I was frustrated all afternoon."

Good supervision is crucial to workers' performance and satisfaction. Workers expect a supervisor to know what they do and to hold them accountable for the quality of work, giving feedback about performance with clients. Supervision can be done by one person or by a group. Peer supervision has been very successful in several projects.

Good supervision is important because social workers are called upon to make crucial decisions each day--removing a child from a home, taking a mother to court, struggling with sexual abuse cases. A worker feels alone, the system is complex and often insensitive, and there is a tremendous sense of self doubt and failure. In these situations a worker should proceed planfully and carefully, sharing the decision-making process with someone more objective.

Unfortunately, supervision often consists of monitoring a unit's paperwork, handling other bureaucratic red tape, assigning new cases to workers and becoming involved with workers and clients in crisis situations, especially when a case has earned the agency unfavorable publicity.

A redefinition of a supervisor's function is needed. The worker needs an advocate with the system, on his behalf and on the behalf of his clients, to improve the agencies' responsiveness and increase service resources to clients. When a worker can speedily provide relevant services to clients, he has greater satisfaction with the job he has done. Another important role of supervision should be to assist the workers in developing community resource networks. Very often a worker is too busy in the daily maintenance of caseloads to do the energetic legwork required to keep informed of new services and open up referral channels with local agencies. Yet resource networks are necessary to get clients services.

But, most important of all, social workers need someone who can give support and positive feedback about specific areas of accomplishment or progress with clients. When workers are absorbed with the mundane tasks of improving a client's environmental conditions, they often can't appreciate the progress that has been made. A supervisor can monitor a worker's performance and give the kind of case-specific feedback and support that a worker needs.

Why isn't supervision like this? It became clear in interviews with supervisors that many of them had been burned-out workers before their promotions. In other cases supervisors had demonstrated exceptional ability as caseworkers, but often had not had a model of good supervision. More importantly, neither of these types of supervisors had received training in

supervision before or after the promotion. Whether a supervisor is a burned-out social worker or an exceptional social worker, before he can become effective he needs training and ongoing consultation in the performance of his duties.

One supervisor, feeling his inadequacy, purchased supervision from a private consultant and saw immediate benefits from his efforts. Agencies must learn how to prepare supervisors for their very important task and must develop training programs for workers with supervisory potential. This training should be specifically focused on the development of skills in advocacy, community resource development, communication, accountability (case monitoring), and giving support and feedback.

Job Design: Research indicates that job design is another important factor in worker satisfaction and performance. A successful job design has the following characteristics: variety, using several different skills; task identity, feeling that the results of his work are meaningful, that there are results; autonomy, personal responsibility for performance; and feedback, positive and negative assessment of performance (one must note here that not everyone has the same needs or desires: Therefore, workers who have a great need for any particular dimension will be dissatisfied with anything less).

My first impression was that social work jobs have all of these characteristics. Closer scrutiny reveals that social workers who report being burned out have very narrow jobs. Many workers feel stuck in a pure casework job. While it is true that every client is unique and presents different challenges, many workers want and need opportunities to develop skills in training, education, community organizing, and group work. In several projects where workers were given a variety of job opportunities they reported higher satisfaction. Some reported that through public speaking engagements they were given positive feedback about their accomplishments, and were consequently able to integrate their experiences and feel renewed enthusiasm for their work with clients. In one situation a good job design compensated for deficiencies in other project management processes.

Workers must also feel that through their jobs they make an important and meaningful contribution, that they have accomplished something. In work with abuse and neglect families, some workers do not perceive that they are successful or that their efforts have been meaningful. These workers report high burn-out. The intake job is a classic example of this. Intake workers work with clients, completing investigations and beginning only tentative treatment planning before referring clients on to other workers. Rarely do they hear what has happened with the client. With this lack of visible results, intake workers often do not feel that they have been helpful to the families they investigate. I think this same need explains why workers become so angry with agencies to whom they have referred their clients when these agencies fail to give progress updates.

Because task identity is so important and may be a chief factor in burn-out, and because social workers, unlike artists, don't always have masterpieces as evidence of their efforts, feedback is very important. We mentioned its importance when discussing leadership, communication, supervision, accountability, and support. A frequently encountered problem is that many people resist feedback because of the way it is often given; therefore, feedback should be direct, specific, and positive-oriented.

The last aspect of job design is autonomy. This can be a tricky concept because it has to do with flexibility, self governance, and a worker's need for supervision and accountability. An example helps illustrate the point. I interviewed a highly successful, seasoned worker, who had worked in protective services for six years, one of the few senior employees in the agency. Granted, one of the reasons she had been able to keep up the grueling pace was that she thrived on difficult, complex cases. But she told me she had not burned-out because her supervisor had always trusted her and given her freedom to set her own hours and schedules, pick her own clients, and work in her own style. She felt free to work 50 hours one week and take off two days to sleep and recoup whenever she felt drained. This example contrasts with another worker who had burned-out and terminated with the agency before I talked with her. This worker had found herself overwhelmed with overtime, working late three and four nights a week. Feeling desperate because her job was beginning to intrude on her marital relationship, she asked her project director for permission to work four days a week, ten hours a day, and have a three day weekend to recover. The director refused because this was contrary to agency procedures and requirements. The worker, unable to sustain the job strain, left the agency. In a job as personally demanding as working with abuse and neglect, it is important that workers have permission to work in their own style and freedom to take appropriate measures to nurture and revitalize themselves.

Organizational Structure

In addition to these management processes we have to consider the impact of organizational structure—the way personnel are arranged in relation to each other and the task. Common measures of organizational structure are complexity (the number of different disciplines in an organization, the number of different roles and jobs), formalization (are there rules, policies, or procedures? written or unwritten? enforced consistently or haphazardly?), centralization (are decisions in the organization made at the top, in the middle, or does everyone participate?) and finally, size (large, small, large budget, small budget).

Organizational structure influences job performance and satisfaction, and is a main determinant of worker burn-out. In fact, large agencies like protective service organizations that are highly formalized, centralized in decision making, and hierarchical tend to have high turnover, low job satisfaction, and fast burn-out rates.

In the social service field, research that describes the impact of organizational characteristics on satisfaction, turnover, and burn-out, while also looking at management process, is scarce, but there is research (Tannenbaum, 1968 and Olmstead, 1974) that indicates that organizational structure is directly related to effectiveness of management processes and indirectly related to performance, staff morale and burn-out. Findings indicate that larger agencies are generally less effective than smaller ones. There are, of course, exceptions. Workers in one small agency reported that they were always struggling to get organized; this agency had high burn-out. In contrast, one highly bureaucratic protective service agency reported high staff morale and exceptional performance in serving clients.

In large bureaucracies, communication is more likely to be delayed and distorted than in smaller agencies. Decision making is often layers removed from the worker; no one has solicited his input and he is likely to be the last to hear of organizational changes. Also, in bureaucracies jobs are designed to fit the organization's purpose and to control variance. These job descriptions do not always fit the individual style and needs of all the workers. Consequently, workers may feel locked into rigid jobs and report a need for greater automomy.

Workers in large bureaucracies have some very specific criticisms that are not reported in smaller, less formalized, and more decentralized agencies. For example, workers in protective service agencies report that hassling "red tape" on behalf of their clients depletes their energy. One worker told me that he felt like giving up after fighting for two days to get emergency funds for a mother with three children and no food. He had completed the necessary forms, but had experienced numerous delays at various hierarchical levels before receiving final approval. Frustration occurs because the "right" people are never available, rules are unclear, it takes too long, and one is always on the defensive.

Large caseloads is the greatest problem in many agencies, the one most responsible for burn-out and poor performance. In order to cope with this problem, many workers control their caseload size by maintaining cases open on paper that they have functionally closed. While workers must do what is necessary to survive, the disadvantages of this subtle sabotage are that other workers assume a disproportionate burden and the system is neither changed nor confronted with the destructive condition that interferes with service effectiveness and results in worker burn-out.

Workers currently spend two to three days out of the five day week in the office completing paperwork. This means that clients are not visited as often as is mandated by state requirements and further, that workers spend half of their time doing work that is meaningless to them. Rarely are workers told the purpose of their paperwork or how this information improves services. Very often these management information systems are not designed to assist the worker in improving the case management of clients. Because management information systems are overwhelming and not informative to the front line worker and his supervisor, workers report that they tend to think twice about clients' need for day care before completing Title XX forms.

Even if a worker is speedy in completing paperwork (one worker I know estimates her answers and is able to complete most paperwork in a half day), they often cannot visit clients more frequently due to state requirements that workers use state cars to transport clients. State cars are rarely available more than two days a week for each worker to make home visits. In addition, there are innumerable problems in scheduling cars and maintaining the operation of available cars. Delay in reimbursements for personal use of one's own car is also a common disincentive to home visits.

Too often, because of these organizational constraints, the worker is caught between the bureaucracy and a hostile, angry, needy client. More frustrating still is working with a motivated

client but being unable to get the necessary resources to help the client because of bureaucratic red tape and paperwork.

Bureaucracies, unlike other agency organizational models, report problems with civil service and personnel hiring practices. Often directors cannot hire highly qualified workers because of these constraints. It is even more difficult to terminate a destructive or ineffectual staff member. The inability to control recruiting, hiring, and termination, which influence the ability of the agency to do a good job, is largely responsible for directors' burn-out and turnover.

Workers who have attended professional schools of social work, psychology, etc. find bureaucratic control systems contrary to their values and educational training. They engage in a constant value struggle with bureaucratic rules that diverts their energy from working with clients to fighting the agency. While the system needs to be confronted, these conflicts often become Kafkaesque as workers find themselves sparring with unknown adversaries. Because individual workers, fighting isolated battles with organizational controls, are often unsuccessful, they become discouraged, and, exhausted, employment in more pleasant, professionally oriented agencies. When this happens the worker may feel relieved to be in a better environment, but he also feels as if he has given up and failed to make a difference.

The impact that these problems have on a worker's performance and burn-out cannot be minimized. In order to deal with the problem, Olmstead states that we should pay less attention to reorganization of the structure and more attention to developing management processes that successfuly cope with the structural limitations mentioned. Clearly, attention to both organization and managers are needed, since there is evidence in the eleven projects studied that organizational characteristics act as disincentives to providing services and are a constant source of frustration to workers. Until we deal directly with the "red tape," paperwork, large caseloads, and transportation limitations, management processes cannot be depended on to compensate for the amount of burn-out and the negative effect of organizational disincentives in the delivery of services to clients.

SUMMARY

It is rare that any one factor produces worker burn-out or poor performance. Rather, a constellation of the factors that we have mentioned (personal characteristics, management processes, and organizational structure) creates a negative work environment. This model examines what conditions presently exist in social agencies, and makes solutions to the problems of worker burn-out more visible.

More careful manpower planning and recruitment are needed. Helping applicants to be more explicit about their goals, expectations, training background, and capabilities to do the job would help reduce the disillusionment.

In order to deal with management processes we need a human resource model of management theory. In this model, the director or leadership structure of the agency becomes an integrator of organizational characteristics and personnel qualities to perform the task of serving clients. As a facilitator, the director is concerned with the development and enhancement of human resources and creation of an environment that promotes performance and high morale.

Further, organizational structure should be more compatible with the task of delivering human services. More flexible, adaptive structures are needed to respond to the swampy conditions we find our clients living in.

One approach to the problem of burn-out is to suggest that workers improve their mental health and offer helpful suggestions for worker revitalization. In addition to this, workers should demand that management processes and organizational structures be consistent with the demands of the task, because in addition to contributing to worker burn-out, these processes and structures influence the quality of services to clients. Neither of these options is easy for workers to achieve, but in work environments in which management processes and organizational structures are facilitative and supportive to the worker in accomplishing his job, workers refuse to settle for less.

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Burn-Out in Mental Health Professionals

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Many health and social service professions require the individual to work very intensely and intimately with other people over an extended period of time. Such professional interactions often arouse very strong emotional feelings within the staff member, and can be extremely stressful. Yet, the traditional orientation in most humane professions has always been client/patient centered, with little attention given in literature, research, or training to the many stresses experienced by the professional. These stresses, when not acknowledged and adequately dealt with, can result in burn-out, characterized by physical and emotional exhaustion, negative self-concept and job attitudes as well as loss of concern and emotional feeling for the people the professional works with. According to our preliminary research in this area (Maslach and Zimbardo, 1973; Maslach and Pines, 1977), the incidence of burn-out is very high in many health and social service professions, and is a major factor in low worker morale, absenteeism, high job turnover, and other indices of job stress. In addition, it may be a factor in the poor quality of many health and welfare services.

In a series of studies, we tried to discover the social and psychological dimensions of burn-out. We wanted to identify the interpersonal stress professionals faced; what, if any, preparation they received for coping with stress; what specific techniques they used to combat burn-out; and what personal effects resulted from using such techniques. In addition to making field observations of professionals at work, we conducted extensive questionnaire studies and in-depth interviews. Our initial samples consisted of social welfare workers, psychiatric nurses, poverty lawyers, some prison personnel, and child care workers.

On the basis of the results from these studies, we developed a working model of the burn-out process. Much of our data revealed a similar pattern of responses for the majority of our subjects in a variety of occupations. These findings suggest that burn-out is far more general than previously thought, and is a fairly common pattern of behavior. Child care workers, social welfare workers, psychiatric nurses, poverty lawyers, and others report similar changes in themselves and in the perception of their clients/patients and their feelings toward them. Also, they report using a comparable set of techniques to combat their burn-out. Such techniques included the following:

(1) Detached concern: In order to perform efficiently in stressful situations, professionals shielded themselves against disruptive emotions through various techniques of detachment. By treating clients in a more objective, detached fashion, it became easier to perform the necessary interviews, tests, or therapy without suffering strong psychological discomfort. Within some professions, this process is called "detached concern," a term which better conveys the difficult, and almost paradoxical, position of having to distance oneself from others in order to help or cure them; (2) Intellectualization: Professionals tried to "objectify" the situation by recasting it in more intellectual and consequently less personal terms; (3) Compartmentalization: Professionals often made sharp distinction between their job and personal life, by leaving their work at the office. In this way they could confine the emotional stress to a smaller part of their lives; (4) Withdrawal: Professionals tried to minimize their involvement in stressful interpersonal interactions in several ways: spending less time with others, communicating in more impersonal ways, interacting with other staff rather than patients/clients, etc., and (5) Social techniques: Professionals experiencing stress often turned to others for advice, comfort, tension reduction, help in achieving distance from the situation or intellectualizing it, and a sense of diffusion of responsibility.

Our data also allowed us to compare different work environments within the same profession, and based on these findings we developed several hypotheses about important social variables in the burn-out process, including: (1) Analysis of personal feelings: Since the arousal of strong emotional reactions is a common feature of these professions, institutional mechanisms should be established to allow staff to express their feelings, receive feedback and support from others, and to develop new goals and understanding of their relationship with their patients/clients; (2) Positive basis for interaction with patient/client: Particularly in social service professions, the practitioner only deals with the negative problems in the client's life, since too

many "good" things can lead to denial of aid. This promotes a negative perception of the client and makes it more difficult for the professional to interact with him or her in a more human, dignified way; (3) Shared work roles: If more of the work responsibilities were shared among professionals (e.g., peer consultation, shared caseloads, teamwork), there would be less personal stress on each. The nature of the professionals' relationship to their supervisors also affects their ability to combat burn-out; and (4) Withdrawal opportunities: The types of withdrawal used by professionals varied greatly in their effectiveness as a coping strategy and in their impact on the patients or clients. The most positive form of withdrawal was a "time-out," in which the professional could voluntarily do some other, less stressful work (e.g., doing paperwork, dispensing medications), while other staff took over his or her responsibilities with clients/patients. In contrast, negative forms of withdrawals were "escapes," in which the professional's decision to break from work always came at the expense of clients, since no other staff could take over his or her duties. The use of sanctioned "time-outs" vs. guilt-arousing "escapes" seems to be determined primarily by the social structure of the particular work situation.

METHOD

In trying to obtain further information on these and related issues, we conducted a more extensive questionnaire and interview study with the staff of various mental health institutions in the San Francisco Bay area. Although most previous research and literature on mental health institutions focused on patients rather than staff members, we believe a clearer understanding of the stresses which clinical personnel face, and a more complete delineation of the methods used in the coping process, are critically important for ensuring high quality care and therapy.

In the current study, 76 staff members of several different mental health institutions were surveyed, including: psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, attendants, and even volunteers. Our sample included a large state hospital, an army hospital, a county hospital where hospitalization is restricted to two weeks, a few halfway houses, and a house patterned after R. D. Laing's Kingsley Hall. These institutions varied in several dimensions identified in our earlier research as important variables in the development of burn-out. Two of these dimensions were the size of the institution and, more important, the institution's staff-patient ratio. In our earlier work, we found that the more people a staff person was responsible for, the more likely he or she would be to perceive them negatively, have less empathy for them, engage in more "escapes," and exhibit signs of emotional stress.

Another relevant dimension was the severity of the patient illness, as reflected by the percentage of schizophrenics in the patient population. It was assumed that the more serious the condition of the patient, the more emotionally stressful the staff member's job would be, and thus the greater the chance for developing burn-out.

Within the institutions, the staff varied in the number of hours they worked and the number of hours spent directly with patients. The institutions also varied in their therapeutic orientation and attitudes toward medication, ranging from strong approval and frequent use to strong disapproval and very limited use of any pharmacological intervention. Finally, the institutions varied on numerous ancillary working conditions thought to be important factors in the burn-out process. These included the number of staff meetings (important as a place to escape from stressful interaction with patients and to receive social support) and the opportunity for temporary withdrawals or "time-outs."

In addition to these and other institution-related variables, the present study examined several personal variables. Biographical data included items such as formal education, rank, and length of time spent in mental health work. Self-perception data were based on a 23-item, semantic differential adjective check list on which the staff members described themselves. Each item consisted of a bipolar, 5-point scale, such as "warm/cold," "valuable/worthless," "friendly/unfriendly," "intimate/distant," etc. We also collected attitudinal data. The staff member's attitude towards mental illness was assessed by the Custodial Mental Illness Ideology scale (Greenblatt, Levinson, and Williams, 1957) and by questions about the nature of schizophrenia. In addition, staff members rated the average schizophrenic patient on the same 23-item scale used to rate themselves. Finally, a battery of questions was used to tap the staff's attitude toward various aspects of their jobs.

RESULTS

This study generated a large amount of data which cannot be adequately detailed in a brief report such as this. Therefore, we will present only the major findings in summary form, without

including actual statistical analyses. However, note that all results are highly significant according to standard statistical tests.

Institutional variables: As a result of different work conditions in various mental health settings, staff members expressed different attitudes toward their job, patients, and mental health in general: (1) Ratio: The larger the ratio of patients to staff the less staff members liked their job and the more they tried to separate it from their personal lives. They said they would change their job if only given a chance, and did not seek in it self-fulfillment or social interaction. They saw job conditions (e.g., salary) as the best thing about the job and limited their after-hours involvement with the institutions or patients only to emergency cases; (2) Patient population: The higher the percentage of schizophrenics in the patient population, the less job satisfaction staff members expressed. They liked their work less, were less likely to view it as ideal, and were less conscious of their goal in their work. Staff members with a higher percentage of schizophrenic patients also spent more time in administrative duties and recommended pharmacological intervention, rather than psychological treatment, for problems such as suicidal attempts; (3) Work relationships: Work relationships were affected by certain work conditions, and were also related to staff members' attitudes toward their work, the institution, and the patients. Work relationships improved where there were fewer seriously ill patients and fewer work hours. When work relationships were good, staff members were more likely to confer with each other when having a problem with a patient, express more positive attitudes toward the institution as a whole, enjoy their work, and feel successful in it. They also rated the institution more highly and described the reason for being in mental health as self-fulfillment. When work relationships were good, staff members reported many "good days" and few "bad days." They felt free to express themselves on the job, and spent less time with other staff members or in administrative work. Most important, however, they described the average schizophrenic patient in more positive terms—as more warm, reliable, powerful, strong, even-tempered and intimate—than did staff with poor work relationships; (4) Staff-patient relations: The quality of interaction between staff and patients was related to staff members' perceptions of the institution, other staff members, their work, and the patients. When interaction was good, staff members liked their work, felt successful, and found self-fulfillment. They learned to appreciate other staff members and conferred with them more often when having problems with a patient. They also rated the institution more highly, described patients very positively, and stayed involved with both the institution and the patients even after work hours; (5) Frequency of staff meetings: High frequency of staff meetings was correlated with very negative, dehumanizing attitudes toward patients. It also correlated highly with age, rank, avoidance of direct contact with patients, and with viewing the average schizophrenic patient as more bizarre, cruel, cold, insane, uncaring, and not understanding. Staff members who participated in more staff meetings gave more weight to information about the patient which came from the patient's family or the psychiatric interview, than information which came directly from the patient. They saw less chance of curing schizophrenics and tended to have job oriented goals in their work (rather than self or patient oriented goals); (6) "Time-outs": Staff members who could afford "time-outs" when, for some reason, they did not feel like working directly with patients, exhibited more favorable attitudes toward patients. They described the average schizophrenic patient as more kind, sane, reliable, caring, and understanding than did staff members who did not have the option of detaching themselves during periods of stress. They also saw more chance of curing schizophrenia and expected patients' behavior toward outsiders to be normal most of the time; (7) Work schedule: Longer work hours were correlated with more stress and negative feelings on the part of staff members. The more hours a day one worked, the less one liked the job, the less responsible one felt for patients, and the less control one felt over the patient's life in the institution. In addition, staff members described themselves as more bizarre and intolerant; (8) Time spent in direct contact with patients: The lower ranking staff members (volunteers, attendants, etc.) spent more time in direct contact with patients than higher-ranking staff (psychiatrists, psychologists). Also, the more time staff members formerly had spent working with schizophrenic patients, the less direct contact they currently had with patients. As might be expected, staff who had less direct contact with patients were more likely to spend their time in administrative duties and staff meetings; (9) Time spent with other staff members: Staff members who spent more time with other staff described themselves as more apathetic, irresponsible, and tense. They said they felt they were failures on the job, with patients, and in achieving their goals; (10) Time spent in administrative duties: Higher-ranking staff members spent more time in administrative duties, as did staff members who worked with a higher percentage of schizophrenic patients. Spending time in administrative duties was correlated with

some negative attitudes toward the job and the patients. Staff members who spent a great deal of time in administration liked their job and patients less. Gradually, they developed negative attitudes toward patients and spent less time with them. These staff members said their original reason for entering mental health was job conditions (rather than self-fulfillment or interaction with patients), and that their attitudes toward the patient as well as other mental health workers had changed negatively. They also described themselves as less tolerant; (11) Work sharing: Work was perceived as less stressful if the work load was shared. Sharing of work was also related to an increase in freedom of expression, a feeling of having input into the institution's policies, and a feeling of personal power.

Staff variables: Various personal characteristics of the staff were highly related to their perception of the job, patients, and mental health: (1) Formal education: For staff members with a higher education, the original reason for entering mental health work tended to be self-fulfillment (rather than job conditions). Usually, however, their attitudes toward patients changed negatively over time. It seems they entered the mental health profession with high expectations but became more disappointed over time and began viewing patients as more weak, apathetic, and powerless. They were pessimistic about the possible effect of their work, seeing little chance of curing schizophrenia. When asked to describe themselves, staff with a higher education said they were more tense, distant, and introverted; (2) Rank: Higher ranking staff usually spent less time in direct contact with patients and more time in administrative work. Their attitudes toward patients changed negatively over time as had their attitudes toward mental health. They listed internal causes as the main reason most patients became schizophrenic, approved the use of pharmacological intervention, and saw little chance of curing schizophrenia.

Lower ranking staff had more direct contact with patients, and their attitudes toward them were less dehumanizing. When asked about the rules governing staff-patient interaction, lower ranking staff more frequently viewed these rules as explicit, both for themselves and patients; (3) Time in mental health work: The longer one worked in the mental health profession, the less one enjoyed working with patients, the less successful one felt with patients, and the more custodial became one's attitude toward mental health. One stopped looking for self-fulfillment at work, "good days" became very infrequent, and the only good thing about work was the job conditions; (4) Sense of success and control: Staff members who felt they had input into the institution's policies, and who felt free to express themselves on the job, had a much more positive view of themselves and patients. They were self-confident, felt they had greater control and authority, and also felt better about their work and themselves on the job. Staff members who felt successful on the job and with patients had an extremely positive perception of themselves. They liked their job, liked working with patients, had many "good days," and felt successful in achieving their goals. Yet, they did not express humanistic attitudes or a particularly positive view of patients; (5) Relationship with patients: Staff members who described their relationship with most patients as close spent more time in direct contact with them and less time with other staff members or administrative work. They liked their job, liked working with patients, and felt successful in both. They were optimistic about their effectiveness in their work and saw a greater chance to cure schizophrenia. They also expressed very positive attitudes toward themselves and the patients; (6) Job attitudes: Job attitudes were related to some work conditions and to staff members' attitudes toward other staff members and themselves. Staff members who liked their work very much had a smaller percentage of schizophrenic patients, worked fewer hours a day, and spent less of their time in administrative duties. They liked working with patients, liked themselves very much, found self-fulfillment in their work, considered it the ideal job, and felt successful. They also tended to have positive attitudes toward other staff members, saw a good chance of curing schizophrenia, and rated their institution more highly. In addition, they did not report becoming as tired and exhausted during work; and (7) Mental health attitudes: Humanistic, rather than custodial, attitudes toward mental health were more characteristic of staff members who had not worked long in mental health, who viewed their work as overlapping with their personal life, and who expected patients' behavior to be normal most of the time. These staff members gave more weight to information provided by the patient than that coming from the patient's psychiatrist. They strongly disapproved of the use of medication during a crisis situation.

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS: HOW TO COMBAT BURN-OUT

Much like our earlier samples of health and social service professionals, mental health workers experienced personal stress due to working closely and intensively with patients over an extended

time. There are several factors, physical and social, in the mental health institution which can either reduce the amount of stress and/or aid the staff member in successfully coping with it. Stress is reduced by such factors as a smaller staff-patient ratio, fewer working hours, and sharing the load of the more severely ill patients. Coping techniques include opportunities for temporary "time-outs," job rotation, and greater support from other staff. Such techniques temporarily remove the staff member from stressful interactions, limit stress to a definite time, or provide opportunities for expressing personal feelings and getting help and support from others. One can argue that the use of medication during crisis situations is also a coping technique, since it helps separate the worker from stressful interactions with patients and tends to make the patients more passive and manageable. However, if such a practice is conducted for the staff's benefit, rather than any belief in its value for the patient, then it must be viewed as a negative coping strategy since it occurs at the patient's expense. The coping techniques we propose are characterized by their lack of such detrimental side effects. They allow the staff member to deal effectively with his or her personal stress while continuing to provide high quality care and therapy.

Thus, our findings converge into recommendations which primarily emphasize the following changes: (1) Smaller staff-patient ratio: The quality of interaction between staff members and patients is greatly affected by the number of patients for whom the staff member provides care. As this number increases, the staff member may experience cognitive, emotional, and sensory overload, while as the ratio decreases the quality of patient care improves. This finding has been noted in other studies as well (Ullman, 1967; Moos, 1976); (2) Shorter work hours: Fewer work hours mean less job stress for the working staff, and as a result they like their jobs better. This recommendation can be implemented by initiating shorter work shifts and more breaks, or by establishing part-time positions which are especially important for women professionals who also carry the burden of their own families; (3) More opportunities for "time-outs": Such temporary withdrawals could involve either non-patient-related work (preparing medications, cleaning, doing paper and administrative work), or simply rest and relaxation. In all cases, such "time-outs" should not come at the patients' expense. The institutional structure should be flexible enough to allow other staff to handle the necessary activities while a staff member recoups; (4) Sharing the patient load: Staff members working only with the more seriously ill patients seem to burn out more easily. Sharing the load of the difficult patient population via rotation between wards and work sharing are two suggested ways of easing some of the pressure from the individual staff member. It also helps make the job more varied, interesting, and stimulating. These suggestions are supported by one of the current study's findings--more work sharing results in less personal job stress and more positive staff attitudes toward patients. In a job with greater variety, there is less stress in each of its elements. Staff members who see patients, interact with other staff, and do paper as well as administrative work seem more satisfied with each of those tasks, much more than those whose work limits them to only one aspect. The recommendations of this finding can be far-reaching in terms of job definitions (e.g., let administrators see some patients, and clinicians do administrative work, etc.). (5) Giving new meaning to staff meetings: In other health and social service professions we studied, staff meetings served several important functions. They enabled the staff to socialize informally, give each other support, confer about problems in their work, clarify their goals, and exert some direct influence on the policies of the particular institution. In these professions, frequency of staff meetings was negatively correlated to burn-out. Unlike these findings, taking part in several formal staff meetings in mental institutions seems to be positively correlated with burn-out. Based on interviews we conducted with staff members, we believe the reason for this outcome is that most staff meetings center around case presentations in which a staff member uses psychological jargon to describe a patient in terms of his or her mental illness, thereby placing greater distance between the staff member and the patient, who is reduced to an example of some abstract concept such as "schizophrenic." Thus, staff meetings detach the staff member from the patient. They very rarely, if ever, center around problems experienced by staff members.

Staff meetings should provide the staff with opportunities to express themselves and have input into institutional policies. Not only would this allow staff to exert some control over their work, it would also give them greater sense of involvement in, and commitment to, the institution. Furthermore, staff meetings should change from a place to discuss patients in a detached, intellectualized way, to one where the staff members are provided emotional and social support, and can confer with other staff members about themselves and their patients.

Only when the emotional needs of staff members are fulfilled will staff meetings help prevent burn-out.

(6) Improving work relationships: One of the interesting but sad outcomes of this study was that some workers began spending more time with other staff members as a means to detach themselves from their patients. This often indicated burn-out. Rather than giving each other support and conferring about problems with patients, staff members seemed to gather in order to avoid patients.

One of our strongest recommendations is to create support systems and improve the social milieu in the institution by improving work relationships among staff members and between patients and staff. This important goal can be achieved by changing or modifying the function of staff meetings, as previously discussed, or by establishing some other institutional mechanism which will allow staff members to openly express their feelings and receive feedback, support, and consultation from others. Regular encounter group sessions could help, as well as staff peer counseling, team work, and work sharing. In addition, social activities such as parties, picnics, and outings (in which staff and patients interact naturally and express their more positive, healthy, and human sides) can help. Conferences in which staff gather outside the institution in order to grow, develop, and receive ongoing education are another suggestion. (7) Education in the process of detached concern: Our results indicate that staff members with high education enter mental health work in search of self-fulfillment. They come with very high expectations of themselves, their job, and the patients. They appear to burn out and, at times, do so by climbing the administration ladder. They develop negative attitudes toward patients, and become very pessimistic about the possible effectiveness of their work. These findings corroborate Seymour Sarason's (1976) description of the obstacles to job satisfaction in community mental health work. According to Sarason, advanced education in psychology, and particularly mental health work, created high expectations in students, some of which never come true. Such education emphasizes the need for self-expression, authenticity, and the expression of the humanistic potential in everyone. Education in psychology also emphasizes the value of the experiential, the new, the exciting, the intriguing, and the continuous search for the "big happening" in life. These great expectations are frustrated when the professional finds him or herself a small part in the bureaucratic machine, and in a mundane and uneventful career which almost totally lacks authenticity, self-expression, and excitement.

Thus, we think it crucial to include, as part of any advanced clinical or psychiatric training, at least one course that prepares graduate students and prospective mental health workers for the stresses and tremendous emotional pressures they will encounter in their future work.

(8) Retreats for staff members: One of our most consistent findings, coming from this and other research on people in the health and social services, is the high correlation between years in practice and degree of burn-out. As a way of combating or slowing this process, which adversely affects staff and patients, we strongly recommend that staff retreats, conferences, and workshops be established. These retreats would provide experienced workers who begin to burn out an opportunity to leave their work and discuss their feelings about themselves, patients and the institution. They could also clarify and restate their job goals along with other staff undergoing a similar process. In such workshops, formal presentation of theory and research findings related to the development of detached concern can be very important in helping the professional. (9) Recommendations for the individual staff member: Our list of recommendations is not limited to work conditions only, but also extends to the worker who must develop safeguards that will prevent emotional and physical exhaustion as well as the negative attitudes associated with burn-out. Staff members must be aware of work stresses, recognize danger signs of impending burn-out, acknowledge vulnerabilities, set reasonable limits on their work, set realistic, achievable goals, and most important, be willing and able to provide for themselves as well as for their patients. These recommendations, and the change of focus from the patient to the professional, are at first sight foreign to the traditional view of mental health work. However, our results indicate that focusing only on patients is self-defeating for both staff and patients and may contribute to burn-out.

This list of recommendations is not all-inclusive. However, it does reflect our best knowledge to date about the possible safeguards which can be instituted to prevent the emotional exhaustion and negative attitudes associated with staff burn-out.

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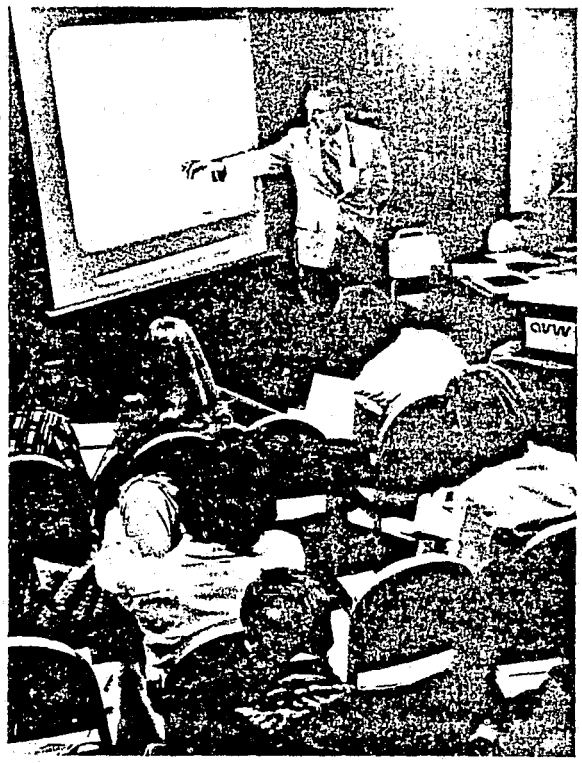

Workshop on group therapy: Blair Justice

Workshop discussion group

Workshop participant

INTERVENTION STRATEGIES

The process of intervention in child abuse and neglect situations can be approached from the entry point of individuals, groups, or total family systems, and by representatives of the disciplines of medicine, nursing, law, mental health, or social welfare. Ideally, it includes detailed assessment, comprehensive services, and evaluation.

The ability to make an accurate assessment of a family situation and to accurately predict the degree of risk to the child is crucial. Papers here offer a selection of self-report, behavioral, and observational techniques for evaluating a parent's potential to abuse a child. The variable of child abuse and neglect is correlated with marital problems, alcohol abuse, poor impulse control, family stress, and other problems and conditions.

The group of papers on *treatment* and evaluation of treatment presents a wide range of options. Most, however, stress the importance of involving the parent in treatment planning, the need to keep the family intact if at all possible, the provision of a wide range of services to reduce social and environmental stress on the family, and the accurate evaluation of the results of treatment. The number and diversity of direct treatment/intervention strategies should not suggest a need to choose the "one right method," but rather an opportunity to individualize interventions to meet the unique needs of unique families.

Client Assessment

Differentiating Abusing and Neglecting Parents by Direct Observation of Parent-Child Interaction

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The study of child abuse and neglect has suffered from the same sorts of developmental problems which have plagued most areas of behavioral and social science. Among these problems have been the tendencies to: (1) place more emphasis upon what people say about themselves than on what they do; (2) focus on the more obvious—if you will, the more colorful and easily noticed—aspects of behavior; (3) look for the causes of behavior within the psyches of the actors; (4) use lay definitions of behavior; and (5) rely upon impressionistic accounts of those behaviors.

Clearly, additional attention should be given to procuring data about what parents and children actually do. This requires, of course, the gathering of data of a direct observational nature. Moreover, such observations should, whenever possible, be made within the subjects' natural ecology, i.e., the home. It should be equally obvious that, where parent-child relationships are concerned, special attention must be given to the prevailing patterns of interaction within the family: interaction between the parents and their children, between the parents themselves in two-parent families, and between the child and his or her siblings when such are present. And, importantly, when we look at interaction we should pay attention to the reciprocal character of that interaction; e.g., behavior from the child to the parent as well as from the parent to the child.

Whichever behaviors we select for study, we should define them objectively and in such a manner as to minimize inferential or subjective judgments on the part of the observer. This latter requirement is important when we are dealing with phenomena as sensitive, subtle, and complex as social interaction; it is critical when we are attempting to measure these behaviors as they occur in their natural ecology.

Concern for these issues in the field of child development has been on the rise, especially for the past ten to twelve years. An excellent example of this kind of research can be found in the work of Gerald Patterson and his associates at the Oregon Research Institute in Eugene, Oregon. Their research has led, for example, to the conclusion that parents with problem children often direct few positive contacts to their children. Instead, these parents seem to rely upon punitive techniques, especially when they are disturbed by their children's behavior and are trying to control that behavior. Their studies also suggest that when such parents do respond positively they tend to do so inconsistently, with apparently little regard for the prevailing circumstances (Patterson and Reid, 1970; Johnson and Lobitz, 1974).

Other research by Alexander (1970), Duncan (1968), Mischler and Waxler (1968), Stuart (1968), and Winter and Ferreira (1969) indicates that families exhibiting various kinds of deviant behavior tend to be more silent, talk less equally, have fewer positive interruptions and, in general, are less active than normal families. In a similar fashion, Gordon and Kogan (1974) have discovered that mothers who find their children generally unrewarding tend to be rather negative in their interactions with their children. In contrast, mothers not experiencing these problems tend to give praise and attention contingent on their children's behavior, and the frequency of positive attention from mother to child is higher than in the problem families.

These lines of research converge on the notion that parents who resort to excessive corporal punishment or who seriously neglect their children may typically display similar behavior patterns. Moreover, such parents may actually possess limited behavior repertoires in social relations generally. These limitations are especially noticeable and a cause for social concern when they involve their own small children. These and related ideas were tested as part of a three-year project investigating the interaction patterns in a number of abusive, neglectful, and matched control families.

PROCEDURE

Sample. Three family types were selected for study: (1) those where one or more children were abused; (2) those where one or more children have been neglected; and (3) families where no official records of abuse or neglect exist but who are similar to the first two types on a number of dimensions such as age of parents and children, number of children, and income and educational levels of the parents. Families classified as abusive or neglectful were recruited through the Commonwealth of Pennsylvania's Department of Public Welfare. The matched control families were contacted by the Pennsylvania Field Research Laboratory. The families reside in a generally rural environment in central Pennsylvania. In general, a good match was obtained between problem and control families. In order to attract families as well as to assure their completion of research tasks, they were paid $40.00 at the end of their participation in the study. Data from twenty-five families in each of the three categories have now been obtained. Data from the first ten families in each category will be presented in this report.

Setting. In each case, the observers were scheduled to see the families in their houses for six hours during a given week. Approximately four hours of this time were spent in actual observation: a longer period for larger families, slightly less for smaller families. Each of the four observation sessions was broken down into three separate tasks: construction, skill, and discussion. These tasks were selected to encourage interaction in situations common to most families. There was a five minute break between tasks. Within each task a particular family member was focal subject twice for a minimum of one and one-half minutes each period. Thus, each family member was a focal subject for at least thirty-six minutes during the four observation sessions. The order of focal subjects was determined by a table of random numbers before a session began.

Response Definition. The principal dependent variable in this study was the observed pattern of interaction between family members. The observational code used was recorded through the Behavioral Observation Scoring System (BOSS). BOSS consists of a ten-digit keyboard, a stopwatch, and a specially modified cassette tape recorder. When a particular behavior occurs the observer depresses a key and an electrical impulse is transmitted onto a magnetic tape. Special computer programs decipher the impulses from the magnetic tape. The behavior code itself consists of five column entries:

1. Type of Interact. For any given one and one-half to two minute interval, during which a particular family member is the "focal" subject, he or she can direct a verbal response to another family member (verbal give = 1) or touch another family member (physical give = 3). On the other hand, the focal subject may be the recipient of another's verbalization (verbal receive = 2) or be the subject of another's physical response (physical receive = 4). These four categories exhaust the behavior possibilities for column 1.
2. Emotional affect of interact. Column 2 modifies the general interact entry by coding the emotional affect for that behavior (1 = neutral, 2 = positive, 3 = negative).

3&4. Columns 3 and 4 identify the other person who is interacting with the focal subject. In this way, we can record any and all interactions between the focal subject and the other members of the family.

5. To complete the code, column 5 indicates the occurrence of a command (prescriptive command = 1, proscriptive command = 2, comply = 3, refuse = 4, neither = 5).

Once a family has been observed, the cassette tapes are played through a special electronic interface which notes the events as they occurred as well as the passage of time between the data entries. The addition of a temporal dimension is possible because a cassette is recorded and played back in "real time" which allows for the computation of behavior rates, making comparisons within and across families possible.

Observer reliability. In an attempt to minimize observer bias, the observers were not informed until all observations were completed, whether the family they were observing was an abuse, neglect, or control family. In addition, immediately after observing a family, the research assistants involved were asked to guess in which family category this family belonged. Basically, they were poor guessers. In general, families were identified as neglecting less often than would be expected from their actual number. Families were most often hypothesized to be in the control category.

The observers operated in pairs which were shifted in composition every two or three weeks to prevent the development of unique definitions of the behavior codes. In order to check on observer reliability both observers coded family interaction over all sessions. One observer's tapes were randomly selected for complete analysis. Then a "probe" tape was randomly selected from the second observer's coding, one from each session, to compare with the data from the other observer. Observer reliability was estimated by computing correlation coefficients, slopes, and intercepts, using the rates of a particular behavior scored for each family member by the two observers. Two sources of error are taken into account; i.e., the actual frequency of a given behavior and the time involved in observation. If the correlation coefficient is high, the intercept close to zero and the slope approximately 1.00, agreement between the observers would be high. If the intercept either exceeds or is less than zero, a high correlation with a slope close to unity would suggest a persistent positive or negative bias in the data.

RESULTS

For the code as a whole observer agreement was quite high, the lowest coefficient being .96. Moreover, the slopes are all close to 1.00, the most disparate being .98. The intercepts are close to the expected value of zero with apparently random fluctuations ranging from -.04 to +.04.

Behavior Rates. Rates of behavior were the most appropriate unit of analysis rather than frequencies, since individual family members were not always observed for equivalent time periods due to absences and other confounding events. However, when rates (responses per minute) are examined, care should be taken not to forget that small rate differences can reflect large differences in total amounts of behavior. For example, if one family member directs verbal responses to an other at a rate of six per minute and another at a rate of five per minute, the first person will emit approximately 240 more verbal responses over the four-hour period of observation.

In all, over 12,000 verbalizations were recorded for each family type, with mean frequencies per family ranging from 1,254 to 1,430. Given the space available, we will only describe some of the more prominent and statistically significant differences in characteristic rates.

To begin with, differences between problem and control families were more sharply drawn for the abuse families, and in the abuse families the mothers were particularly distinctive.

1. For verbal behaviors, mothers in abuse families direct 20% fewer contacts to other family members than do mothers in the control families (.47 per minute compared to .59 per minute).
2. In addition to their lower rates of verbal behavior to begin with, mothers in abuse families allocate 18% fewer of their total verbal contacts to their children than do the mothers in the control families (.63 per minute compared to .77 per minute).
3. In contrast, these abuse mothers direct a 24% greater proportion of their total verbal gives to their spouses than do their matched controls (.25 compared to .19).
4. For combined physical and verbal behavior, mothers in abuse families direct 40% fewer positive contacts to other family members than do mothers in the control families (.22 compared to .38).
5. Mothers in abuse families also respond negatively to the rest of the family at a rate 50% higher than their matched controls (.16 compared to .08).
6. They also respond more negatively to their children. They direct negative contacts to their children at a rate 47% higher than the mothers in control families (.15 compared to .08).
7. Interestingly, abuse fathers behave negatively toward their children at a lower rate than their spouses and at a lower rate than fathers from the other family types. Unfortunately, we have no measure of the intensity of a response, positive or negative. It is, of course, possible that while the abuse fathers are reacting negatively at a lower rate than other parents, when they do respond negatively they do so at excessive intensities.
8. As was the case for verbal behavior, in general, fathers in abuse families stand out since they direct slightly more positive responses to their children than do their spouses, which is a reversal of the pattern found in the other family types.
9. On the other hand, children in abuse families are 28% more negative to one another than are their matched controls (.29 compared to .21).

10. In abuse families, wives comply with the commands or requests of their husbands only 20% of the time compared to 64% of the time in the control families.
11. A final distinctive characteristic of the abuse families is that the parents, together, direct 28% fewer (.71 compared to .95) physical contacts of any kind to their children. In turn, the children direct 27% fewer physical contacts to their parents. Moreover, the mothers direct 36% fewer physical behaviors to their spouses than do their matched controls.

So far as the neglect families are concerned, a few of the more distinctive differences in characteristic patterns of interaction include:

1. Neglect families, as a whole, direct positive contacts to each other 40% less often than their matched control families (.48 per minute compared to .82 per minute).
2. The neglect mothers, in particular, respond positively at a rate almost 60% below that of mothers in the matched control families (.13 compared to .31).
3. At the same time, neglect mothers direct negative contacts to other family members 54% more often than their matched controls (.24 compared to .11).
4. Taken together, the neglect parents give positively to their children 48% less often than do control parents.
5. Perhaps in response, the children in the neglect families direct 24% fewer verbal responses to their parents than do the children in control families (1.09 compared to 1.43) and they comply with their parents' requests and commands only 33% of the time. In control families, children complied with parental requests 41% of the time.

DISCUSSION

We have described some of the more striking differences between abusive, neglectful and control families. The picture drawn is coherent, if not surprising in every detail. In general, the abusive and neglectful families display some of the same characteristics which have been found for other problem families (Patterson and Reid, 1970; Gordon and Kogan, 1974). Overall, mothers in the abuse families tend to direct contacts to other family members at a low rate. When they do interact, either with their spouses or their children, they clearly accentuate the negative more than do their husbands and more than the parents in the control families with whom they have been matched.

Interestingly, the abusive parents, as a unit, tend not to interact on a physical level, whether it be positively (e.g., affectionately), negatively (e.g., hitting), or neutrally (e.g., in gaining one's attention). A compelling conclusion is that these adults, especially the mothers, are deficient in important supportive social skills. Finally, they seem to be passing on similar styles of interaction to their children.

A similar pattern emerges for the neglect families. Especially interesting is the fact that the mothers in the neglect families respond positively at a much lower rate than their matched controls and they direct considerably more negative responses to other family members. Thus, their low rate of positive responding is exacerbated by their higher rate of negative contacts.

Although we have reported here only differences in rates of interaction, we have analyzed our data in terms of more complex and subtle dimensions such as the degree of reciprocity among family members as well as their tendency to interact equitably or inequitably. Basically, the sorts of differences we have described in this report are mirrored in our analyses of reciprocity and equity. In general, the abuse and neglect families tend to be much less reciprocal in their dealings with each other. This is especially the case for physical interaction in the abuse families as a whole. For verbal behaviors, there is an especially low level of reciprocity among the children in abuse families. One provocative finding in this regard is that the older children in abuse families are apparently responding to their mothers' poor parenting skills by serving as surrogate parents to their younger siblings.

Neglect families deviate from reciprocity especially in parent-child relations. The lower degree of adult-child reciprocity in the neglect families appears to result from the 24 percent lower rate of child to adult verbal contacts found in these families compared to their matched controls. This finding is suggestive of a lack of contingent attention which is also consistent with the fact that neglect parents direct positive contacts to their children approximately one-half as often as do control parents.

We are in the process of examining these styles of interaction even more precisely by looking at behavioral sequences. In this regard, preliminary analysis suggests that adults in the abuse and neglect families display a greater tendency than control adults to behave in a coercive manner with each other. And, interestingly, this same pattern holds for children in the abuse families in their relationships with each other. Thus the pattern is continued.

The data described in this report must, of course, be interpreted with care. To begin with, the sample is small--only ten families in each of the three categories. Yet, in spite of the small sample size there were, as we have seen, a considerable number of statistically significant findings. This suggests that these results are statistically robust and highly likely to be sustained and strengthened when we consider our total sample of more than 75 families. The extent to which these interaction patterns are peculiar to our largely rural sample can only be determined by future research of a similar nature in urban settings.

There is reason to suspect that the differences in styles of interaction between problem and non-problem families which we have described are conservative estimates. The basis for this argument is that a considerable number of our control families were found to be at risk for potentially engaging in abusive acts as determined by their profiles on the Helfer-Schneider "Survey on Bringing up Children" (1974). This matter can be resolved by enlarging our control sample to include more parents with low scores on the Helfer-Schneider scale.

Finally, we are in the process of relating these interaction styles with other data which were collected simultaneously, such as measures of stress derived through the Schedule of Recent Experiences (SRE) questionnaire (Holmes and Masuda, 1973) and the health of the parents as determined by their responses to the Cornell Medical Index. Again, sharp differences emerge between the problem families and their matched controls. In each instance, the abuse families tended to show consistently more life change and greater physical and emotional disturbance than their control families. While some of the same differences were found to exist between neglectful parents and their controls, the differences were neither as consistent nor as statistically significant.

These data, as well as those currently being collected, will be used to design and implement an intervention program to teach and encourage more effective and humane patterns of parenting in particular, and social interaction in general. The important characteristic of this program is that it will be based upon a sizeable amount of carefully obtained baseline data.

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Prediction of Child Abuse and Neglect: Measures to Identify Parents' Potential

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INTRODUCTION AND PURPOSE

The importance of primary prevention of child abuse and neglect is obvious. An acceptable method of identifying parents who are at high risk for abuse or neglect must be developed so that effective intervention can take place before violence or neglect occurs. Research which would lead to a better understanding of the interplay of the causal factors of child abuse and neglect is necessary if we are to deal effectively with the problem.

The purpose of this study was to develop a battery of measures for early identification of parents with potential for abuse or neglect of a child. With such measures, early intervention and prevention can take place. The multidisciplinary staff was composed of nurses, a social worker, a psychologist, and a sociologist.

This paper will cover the characteristics of the sample, data collection procedures, a detailed description of the development of the child rearing attitude scales, ways parents handled irritating child behaviors, data analysis and findings, and validity findings.

CONCEPTUAL MODEL AND SAMPLE

The conceptual model was a path analysis model with nine variable blocks and arrows to show expected paths of influence. Figure 1 shows the nine independent variables: parents' background, personality, social network resources, ways of handling irritating child behaviors, child rearing attitudes, parent-child interaction patterns, antecedent to early attachment, general and specific physiological response to child related behaviors. Personality of the parent was expected to influence his social network resources, child rearing attitudes and general physiological response to stressful or pleasurable stimuli. Resources in the social network were expected to influence how the parent handled child behaviors he found irritating and patterns of interaction between the parent and child, with the variable of child rearing attitudes influencing parent-child interaction and physiological response to specific stimuli.

The sample for this study was composed of 109 families, 55 abusive or neglecting families and 54 controls. The abusive and neglecting families were on active caseloads of child protective services of the Department of Social and Health Services of the state of Washington. The caseworkers initially explained the project to the clients, giving them a written description and the voluntary consent forms to be mailed into the project by the family if they were interested. Project staff visited the family to fully explain the project, answer any questions and arrange for the family's participation. Protective service families were not included in the study if the caseworker's assessment indicated that the family would not be appropriate. Black and white families were selected for the study as being representative of the larger proportion of CPS cases. Selection was also based on the age of the child. The age ranges of the children were: (1) early infancy (0-4 months), largely dependent; (2) late infancy (6-12 months), early directed activity and focalization stage; (3) early toddler (1-1½ years), starting self-assertive stage; (4) late toddler (2-2½ years), independence and negativism stage.

The abusive and neglecting families were matched with control families on age of child; age, education, and race of the mother; and single versus couple status. The control subjects were recruited from well-child clinics, a nutritional supplement clinic and by radio and newspaper appeals. Controls were screened to rule out previous reporting for abuse and neglect.

There were 169 adult subjects, 60 male and 109 female. One hundred fifty-seven were white and twelve black. The mean age of the mothers was twenty years. About half had not graduated from high school. There were 84 controls and 33 abusive and 34 neglecting parents, with 18 spouses of abusers. In cases of neglect, both parents were considered to be neglectors, whereas in the abusive families, it was possible to identify which parent had inflicted abuse.

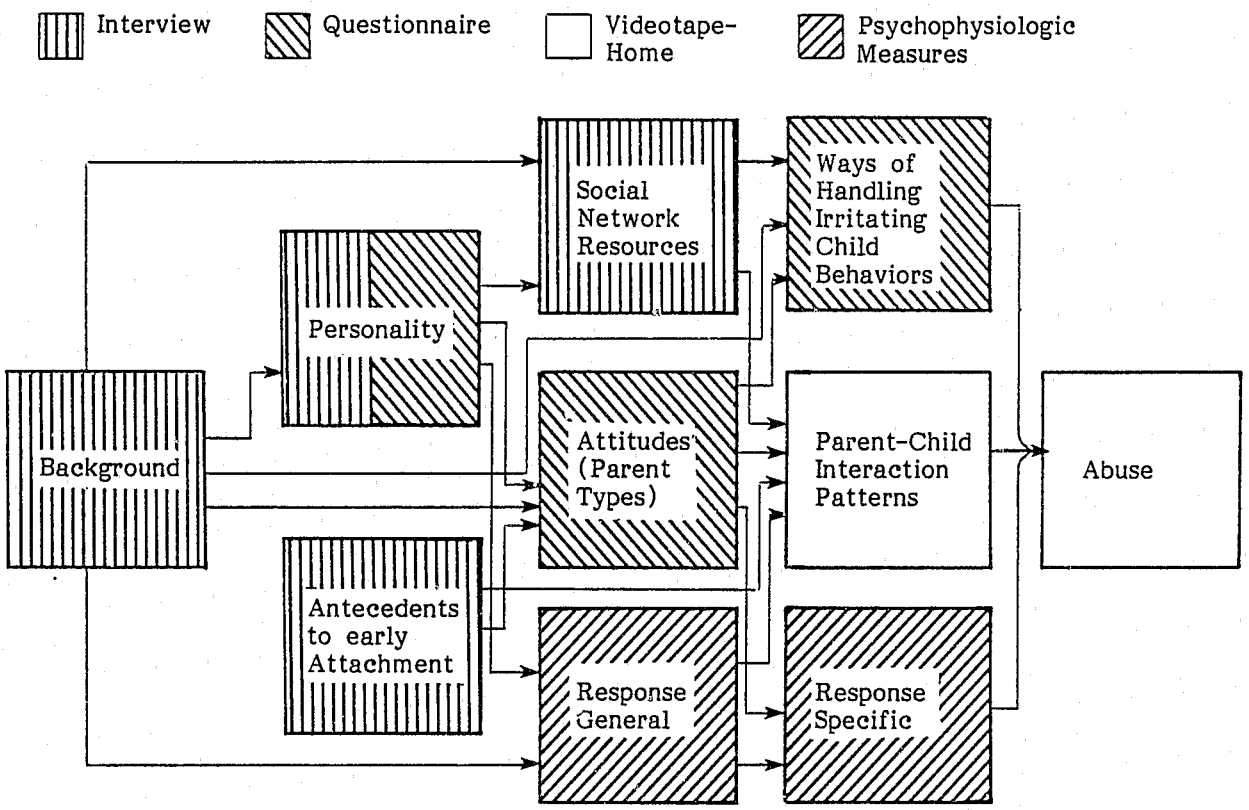


Figure 1. Path Analysis Model
Variables and Source of Data

PROCEDURES

Interviews, questionnaires, videotaped observations, and physiological measurements were used to collect data. Data collection was done both in the subject's home and at the University.

Parents were interviewed and videotaped during the home visits. The interviews covered the parents' childhood experiences, current relationships with others and the child, information about the pregnancy and newborn period, and their perceptions of themselves as parents.

Each parent was videotaped teaching the child two tasks, one appropriate to the child's age and another more difficult. The teaching tasks were to provide a parent-child interaction sequence. Fifteen parental scales developed by Barnard (Barnard et al, 1974) were used for analysis of the interaction.

At the beginning of each home visit, time was allowed to become acquainted and answer questions. The parents were asked if the video equipment could be brought into the house. While the equipment was being set up, staff interviewed one of the parents. Some of the parents were shy or ill at ease as the videotaping session began. As they became involved in the teaching task with their child, they seemed to forget the camera.

For the University visits, each parent was scheduled at his convenience, with transportation provided by the research staff. In most instances, the same staff member accompanied the parent and collected the data, to provide continuity, particularly for the abusive subjects. At the University, the parents completed the self-report questionnaires on child rearing attitudes, empathy (Mathews et al, 1976), Machiavellianism (Christie and Geis, 1970), and ways of handling irritating child behaviors.

The parents were given an opportunity to visit the physiological laboratory, look at the setting and equipment, and ask questions. The physiological measurement preparations consisted of having electrodes attached to fingers of both hands, the right wrist, and both ankles, and the respiration measuring device strapped around the chest. Physiological measurement included heart beat-to-beat intervals, continuous heart rate, left and right hand blood volume pulse, left and right electrodermal skin conductance level and response, skin temperature, and respiratory

rate. The recordings were made while the parent viewed stimulus videotapes depicting mother-father-child interaction in families of the same race as the subject with a child of the same age as the subject's child. Some scenes were stressful and some pleasant with neutral stimuli (a pastel color show) to separate the scenes and provide 15 minutes of baseline data. The stimulus tapes were made for the study in the closed circuit television studio at the University, using families recruited from the community.

A debriefing session after the physiological testing gave the parents an opportunity to express their reactions to the stimulus tapes and testing situation, and their feelings about the project in general. The home videotapes of the parent teaching the child a task were shown and permission requested to keep the tapes for the study purposes. The families enjoyed seeing themselves on television and frequently expressed an increased awareness of their interaction with their child. One parent said it was as if she was seeing herself with her child for the first time and another parent observed that she had not allowed her son to do anything for himself.

DEVELOPMENT OF CERTAIN INSTRUMENTS

Child Rearing Attitude Scales. The parental attitude scales were developed by the project staff after extensive review of the literature. Four major parental types were identified and Likert scales constructed for the four attitude constructs: role reversal, low boiling point, sadistic, and strict disciplinarian. For each construct, there are four versions of the scales, one for parents of each of the four age groups, making a total of 16 scales.

Role Reversal Parents

Definition based on the literature: The theme central to the concept of role reversal is, according to Morris and Gould (1963), "the reversal of dependency role, in which parents turn to their infants and small children for nurturing and protection". As a result of inadequate parenting, the socio-emotional development of the role-reversed parent is thought to be arrested at a very early stage.

Role reversal parents experience persistent fears of punishment and fears of losing those persons upon whom they depend for love and comfort. They are limited in their ability to see their child's needs and capabilities, demanding adult performance and behavior. When these parents view the dependency needs of their infant-child as attacks upon themselves, they retaliate through passive neglect or active battering of the child.

Behavioral patterns characterizing these persons include:

1. Reacting to the infant-child as though he were the original demanding, never-satisfied parent.
2. Attributing to the infant-child adult powers, motivations and judgment.
3. Playing the roles of his original parents and himself as the original child simultaneously.
4. Infantile, explosive, uncontrolled feelings and behavior.

Nominal Definition: Parents who use their infants and children to meet their own needs and who perceive the child's behavior as deliberate attempts to hurt the parent.

Dimensions: 1. Parent rights versus child rights.
2. Parent obligations versus child obligations.

Low Boiling Point Parents

Definition based on literature: A parent who has not learned to tolerate frustration, therefore, has a low threshold or tolerance of frustration and difficulty in coping with stress. Characterized as having an inability to delay gratification; impulsive behavior, intense emotional response to minor provocations. At other times, the parent is withdrawn, petulant, obstinate to the point of despondency and despair, seeming to invite mothering.

Low boiling point parents have feelings of inadequacy, vulnerability, helplessness, and intense anxiety. Their anger is poorly controlled, fueled by intense anxiety, which erupts easily. They have a life-long behavior pattern with a repetition of crisis stressful situations. When they are confronted with a stressful situation, their outbursts may be verbal with physical threats; at times, they may displace feelings of anger onto the child by physically abusing him.

Behavioral patterns of low boiling point parents include:

1. Difficulty in coping with stress and a low tolerance for frustration.
2. Impulsive activity with inability to delay gratification.
3. Feelings of being overburdened.
4. Lack of belief in themselves or anything else and feelings of inadequacy.
5. At times, uncontrolled anger.

Nominal Definition: Stressed parents who have difficulty with their stresses.
Dimensions: 1. Disorganized versus organized.
2. Emotional control versus rational control.

Strict Disciplinarian Parents

Definition based on the literature: Parents who are strict disciplinarians expect their child from early infancy to "show exemplary behavior and a respectful, submissive, thoughtful attitude toward adult authority and society" (Steele and Pollock, 1968, p. 110).

Rules defining acceptable behavior are established independent of the child's needs and feelings. Standards of behavior and the means of enforcing such standards are widely accepted in our culture. However, disciplinarians' standards are exaggerated and inappropriate for a child of a given age. These parents advocate the use of physical punishment and other punitive measures to control their child. There is a sense of righteousness in these parents. Justification for parental actions is based on the premise that "to spare the rod is to spoil the child".

Characteristics of strict disciplinarian parents include:

1. A strict, internalized moral code.
2. A cold, rigid personality.
3. Strong concern for the child which is focused more on supervision than caring.

Nominal Definition: Parents who advocate and use physical punishment measures—and do "not spare the rod".
Dimensions: 1. Sole (parental) control versus natural development.
2. Physical punishment versus other means of discipline.

Sadistic Parents

Definition based on the literature: Parents who use cruel and unusual forms of punishment. To them punishment is an end in itself, rather than discipline used as a means of controlling the child's behavior. The punishment is not the result of the parent's anger or lack of self-control, but planned and calculated, and of a tortuous nature. "Punishment divorced from discipline becomes a monstrosity. Yet it is precisely this separation that characterizes abusing parents" (Young, 1964, p. 45).

Sadistic parents have the following characteristics:

1. Absence of guilt feelings.
2. Enjoy inflicting pain.
3. A psychotic break with reality, live in a world of fantasies or delusions.
4. Utilize punishment that is long and drawn-out.
5. Plan disciplinary options which they rationalize as "fitting the child's crime".

Nominal Definition: Parents who utilize cruel and unusual forms of punishment, carefully planning disciplinary options which fit the child's crime.
Dimensions: 1. Pleasure versus discomfort.
2. Cruel and unusual versus ordinary treatment.

Examples of items for each of the four attitude scales for parents whose infants are newborn through four months of age appear below:

1. A baby should eat all the food his parents give him.
2. Parents normally are able to be patient even if their baby eats slowly.

3. A baby who won't cooperate while being fed deserves to go hungry.
4. God believes all babies should be punished.

1 = Role Reversal parents
2 = Low Boiling Point parents
3 = Strict Disciplinarian parents
4 = Sadistic parents

Ways of Handling Irritating Child Behaviors. This instrument is a modification of one developed by one of the authors for a previous study (Disbrow, 1969). The measure consists of a series of child behaviors that might be irritating to the parent, plus a series of parental handling options ranging from giving affection to use of verbal and physical punishment. This was a self report of the way (or ways) the parent had handled each situation. The eleven child behaviors included such items as "Won't cooperate, Won't stop crying, Bites or hits, Gets angry with me, Embarrasses me, Gets in my way, Screams, Soils diaper or pants, Breaks something of mine, Shows me he doesn't love me, Never lets me alone."

ANALYSIS OF DATA AND FINDINGS

Correlations. Correlation between indicators from each variable block and abuse were computed. Since most of the data were ordinal, Kendall's Tau was used to measure the strength of relationships. In Table 1 are listed the Tau coefficients of the indicators for all of the blocks except for the physiological measurement, which will be discussed in a separate section.

Table 1

Tau Coefficients Reflecting Relationships
Between Specific Variables and Abuse

Major Variables and Indicators	Tau Coefficients
Background	
Parent factor	-.21
Ways handled as a child	.26
Personality	
Machiavellianism	.11
Empathy	-.25
Self concept as a parent	-.19
Antecedents to Early Attachment	.21
Social Network Resources	
Getting away from children	.25
Close friends	-.30
Feelings about handling child rearing disagreements	-.22
Parent Child Rearing Attitudes	
Role Reversal	.37
Sadistic	.22
Low boiling point	.36
Strict disciplinarian	.30
Ways of Handling Irritating Child Behaviors	.44
Parent-Child Interactions	
Perceived communication between parent and child	-.31
Child's readiness to learn	-.18
Parent facilitating behavior	-.41

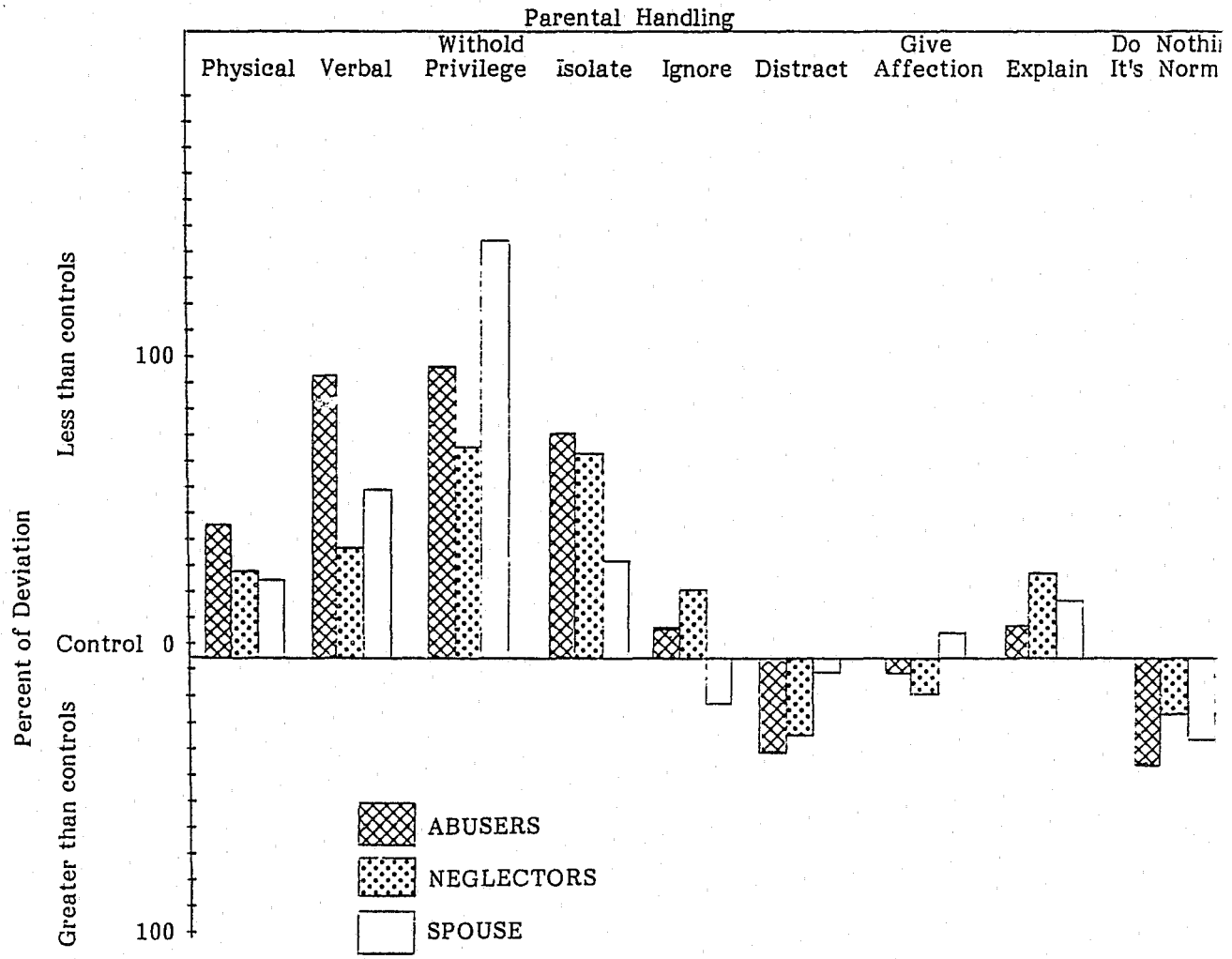
Abuse correlated inversely with some of the indicators. Abusive parents felt that their own background had been poor, that their parents did not understand them, and that they did not get along with their parents. They were lacking in empathy, had low self concepts, few close friends, were upset about the way child rearing disagreements were handled in the home, did not communicate with their children, lacked sensitivity to their children's cues, and their children had difficulties learning the tasks.

Other indicators correlated positively with abuse. Parents who abused their children were themselves abused as children. They scored high on the Machiavellianism scale, and on antecedents to early attachment (pregnancy unplanned, complications for mother and/or infant, and infant kept in hospital longer than the mother). Abusive parents wanted to get away from the childhood but felt trapped, and scored high on all four child rearing attitude scales.

Ways of Handling Irritating Child Behaviors. Figure 2 shows ratios of abusive to control subjects' response to the child behaviors. The responses of the control subjects were taken as the population norm. The percentage of the control group's total responses for each type of parental handling option became the common denominator. The percentage of the abusive, neglecting, and spouses of abusers groups' total responses for each option was divided by this common denominator. Figure 2 shows the percent of deviation (greater and lesser) from the control for each parental handling option.

Figure 2

WAYS OF HANDLING IRRITATING CHILD BEHAVIORS
RATIO OF ABUSIVE TO CONTROL SUBJECTS' RESPONSE



Parental handling options were divided into physical (hit with something, spank with hand, shake or shove), verbal (scold or nag, yell at child, shame or ridicule), withhold privilege, isolate, ignore, distract, give affection, explain, and do nothing: "it's normal".

Abusers, neglectors, and spouses all were more likely to use the parenting options of physical and verbal punishment, withholding a privilege, isolating, and explaining to the child, than controls.

Abusive subjects used 47 percent more physical ways of handling irritating child behaviors than did controls; neglectors used 27 percent more; and spouses used 26 percent more. For verbal handling option, abusers used 92 percent more, neglectors 37 percent, and spouses 50 percent.

For withholding and isolating, abusive subjects used 96 and 78 percent respectively, and neglectors used 76 and 72 percent. The difference in these categories was with spouses. Spouses used 111 percent more withholding than did controls, but only 30 percent more isolation. Abusers used 2 percent more explaining, neglectors 21 percent and spouses 10 percent.

For the parental handling options of distract and do nothing because the child's behavior was perceived as normal, all three groups used less of the options than did the controls. Abusers used 43 percent less distraction and 53 percent less of doing nothing. Neglectors used 39 percent less distracting and 35 percent less of doing nothing. Spouses used only 14 percent less distraction but used 46 percent of doing nothing.

On the remaining two options, the groups were split. Spouses were the only ones using less of ignoring (25 percent) and slightly more of giving affection (1 percent). Abusers and neglectors used ignoring slightly more (5 percent and 17 percent respectively) and giving affection less than controls (16 percent abusers, 22 percent neglectors). In general then, the abusers', neglectors' and spouses of abusers' deviations from controls were greater in the punitive options and less in the non-punitive options.

PHYSIOLOGICAL ANALYSIS AND FINDINGS

Analysis. The population includes 84 control subjects, 33 physical abuse subjects, 34 neglecting subjects and 18 mates of abusers, for a total of 169 subjects. While a few physiological data cells could not be filled because of isolated transducer and instrumentation problems, missing data for any one measure never exceeded six subjects for the controls, four for physical abusers, three for neglectors, and one for mates of abusers.

All data for each measure and each of the twelve stimulus periods were combined to yield summary descriptive statistics (mean, standard deviation, standard error of the mean) for each of the four experimental groups. Measures of association (Pearson's Product Moment r for comparison of physiological data, Kendall's Tau for comparison of physiological and psychological-behavioral data) were computed for controls versus physical abusers, controls versus neglectors, and physical abusers versus neglectors. Repeated measures analyses of variance were carried out for experimental group stimulus period effect. Stimulus period effects were analyzed for the twelve periods separately and combined for the three major stimulus groupings: neutral periods, pleasant stimulus scene periods, and unpleasant stimulus scene periods. Stimulus periods were also combined into 1st, 2nd, and 3rd thirds and analyzed for temporal trends.

Specific Finding

1. Heart Rate. Heart rate of control subjects differed significantly between pleasant and unpleasant scenes ($F1/166 = 18.8$, $p<.01$), while that of both abusive and neglecting subjects did not. The difference for controls was due to decrease of heart rate during pleasant scenes and increase during unpleasant ones. All three subject groups showed a significant difference between neutral and stimulus periods (controls $F1/415 = 92.8$, $p<.01$; abusers $F1/160 = 13.6$, $p<.01$; neglectors $F1/165 = 39.2$, $p<.01$), with the controls showing the largest effect. Controls also showed temporal habituation effects ($F2/498 = 9.0$, $p<.01$), with the heart rate decreasing over the course of the study. Abusers showed lesser, but still significant, habituation effects ($F2/192 = 3.7$, $p<.05$), while neglectors had no significant habituation effect.

It appears that both abusive and neglecting groups' heart rates were not as labile in physiological response to the environment as were those of controls. The neglectors were perhaps the most deviant group in that they showed no habituation over the course of time, possibly because of minimal initial reaction. The abusers, on the other hand, came to the experiment with a high heart rate (their average heart rate magnitude exceeded that of the other subject groups in 11 of the 12 stimulus periods), but showed some habituation over time.

2. Heart Rate Variability. While changing their heart rate in response to stimulus changes, control subjects were much less variable in their rate changes than abusers and

neglectors. Thus, there was no stimulus effect on heart rate variability for the controls, while physical abusers and neglectors showed strong significant effects ($F11/330 = 9.8$, $p<.01$ and $F11/341 = 13.2$, $p<.01$, respectively). Control subjects' variability did not change between neutral and stimulus periods, while that of abusers ($F1/150 = 43.0$, $p<.01$) and neglectors ($F1/155 = 23.3$, $p<.01$) did. Controls' variability did not change as a temporal function, while both abusers ($F2/180 = 8.1$, $p<.01$) and neglectors ($F2/186 = 12.0$, $p<.01$) showed such change.

In terms of absolute magnitude of heart rate variability, the neglector group's averages were the lowest for all subject groups for all 12 stimulus periods.

3. Blood Volume Pulse. On both right and left body sides, BVP's of controls and abusers showed a negative correlation ($r = .19$, $p<.02$) during the first stimulus block (% change from the first neutral scene to the first stimulus scene). It appears that the physical abusers maintained a high level of constriction at the onset of the stimulus period, while neglectors and controls did not. The effect disappeared during the course of the study, presumably as a function of habituation.

All groups showed a significant stimulus block effect (controls $F5/385 = 17.8$, $p<.01$; abusers $F5/145 = 3.2$, $p<.01$; neglectors $F5/155 = 7.9$, $p<.01$). While this suggests that habituation in this physiological system took place for all subjects, the significant group effect ($F3/765 = 3.6$, $p<.02$) suggests that habituation in the controls was more pronounced and regular than in the other groups.

4. Skin Conduction Level. On both left and right body sides, the control subjects and the neglectors showed a significant habituation effect over time (control-left $F2/474 = 10.9$, $p<.01$, control-right $F2/486 = 21.7$, $p<.01$; neglectors-left $F2/196 = 13.4$, $p<.01$, neglectors-right $F2/186 = 17.8$, $p<.01$). The abusers showed no such significant effect. The SCL differentiation of pleasant-unpleasant scenes also showed significant group differences. Controls approached a significant pleasant-unpleasant stimulus difference on the left body side ($F/158 = 3.1$, $p<.08$) and showed strong significant effect on the right side ($F1/162 = 11.6$, $p<.01$). Neither abusers nor neglectors differed significantly between these stimulus blocks.

In terms of absolute magnitude of skin conductance, the groups of neglectors, for both body sides, had the lowest average SCL magnitude for 12 of the 12 stimulus periods for the three groups. No such systematic difference was seen between controls and abusers.

5. GSR Half Life. The controls differentiated pleasant versus unpleasant stimulus scenes at a significant level (right half life, $F1/18 = 5.1$, $p<.05$). No such effort was seen in either abusers or neglectors. The difference was due to longer half life while viewing the unpleasant scenes (1.79 sec. versus 1.58 sec).

In terms of general findings, there was a significant positive association (average $r = .21$, $p<.05$) between heart rate and length of GSR half life for all stimulus periods of controls and abusers. The effect for neglectors was also significant but less pronounced (average $r = .17$, $p<.05$).

Summary. The data indicated strong differences among the physiological response patterns of control subjects, physically abusing subjects, and neglecting subjects. The control subject was more in tune with his environment. His physiological system differentiated between stimulus scenes, showed regular habituation patterns, operated within a limited range throughout a period, and showed no violent up or down swings. The neglector showed less interchange with his world. He came to the experiment with lower physiological levels than others and stayed low throughout. He showed little variability, and that often not related to stimulus input. He did not differentiate between stimulus scenes. The physical abuser was similar to the neglector in his relative independence from stimulus input. He, too, did not differentiate different types of stimulus, showed irregular habituation patterns and showed irregular swings in physiological response during the course of the experiment. However, the abuser came to the study with elevated physiological measures, particularly the cardiovascular measures, and stayed high throughout.

Future Analyses. Work is continuing to relate psychological predictors to physiological predictors, to analyze responses to common themes within the various stimulus periods, and to arrive at predictive clusters with factor-analytic methods.

VALIDITY

The predictive validity of a set of measures is the ultimate test of their usefulness. When sensitivity, the ability to correctly predict the anticipated problem, and specificity, the ability to correctly predict absence of the problem, are too low, many people are missed or falsely labeled as having the problem.

Many factors affect the predictive validity of a battery of measures: (1) the choice of the criterion measure and its validity, (2) the number of measures involved in the battery, (3) the steps taken to reduce error in developing or assembling the tests or measures, (4) the external validity of the measures, i.e., their utility with populations other than the one on which they were developed, and (5) the number of people in the population who manifest the problem to be predicted. Of the factors influencing predictive validity, factor one will be discussed alone, factors two and three will be combined under error and data reduction, and the factors four and five will be combined under future plans.

Recently there has been much discussion about whether society can afford to spend money on research to develop predictive batteries of tests if the results continue to yield such high percentages of inaccurate labeling, whether positive or negative. The question might better be: Can society afford not to spend money on research which attempts to produce valid measures? Many persons are attempting to predict, label, and intervene based on tests derived from small samples and from measures as vague as a person's perception that something might be true. The main emphasis in this study has been on the validity of the measures.

Criterion Measure for Abuse. For this study, abuse was defined as acts of those parents referred for physical abuse and neglect who were currently being carried as open cases with a child protective service. It was assumed that busy caseworkers would not keep open the cases of parents who had been erroneously referred or who did not prove to have serious problems.

Steps Taken to Reduce Error through Reduction of Number of Measures. The study being reported set about to systematically design and/or assemble measures to test the major areas identified as problem areas in abuse and neglect. In order to test concurrent validity, four types of data procedures were utilized: interview, questionnaire, videotaped parent-child interaction, and physiological measurement. This last procedure, physiological measurement, was seen as important because parents who are stressed enough to react by hurting their children should manifest this stress physiologically. It is also possible through physiological measurement to determine whether subjects take a short or long time to return to normal. This has implications for intervention or treatment.

In order to insure content validity, large numbers of indicators, attitude scale items, interview questions and physiological measures were constructed or selected. This large number of variables had to be reduced.

Internal consistency of attitude scale items was tested using standard Likert techniques. The original 800 parental child rearing attitude scale items were reduced to 320 through pretesting before the actual testing started. At the completion of the developmental stage of the study, after 169 adult subjects had been tested, further item reduction of the child rearing attitude items was done resulting in 120 items, 30 per child age group. The empathy attitude scale items were also reduced from 33 to 9 at the completion of this first phase of the research.

Factor analysis was utilized to determine which indicators of the variable blocks—background, social network resources and parent-child interactions—would form themselves into factors. Orthogonal factor analysis was rejected because this type of factor rotation assumes that underlying dimensions are independent (orthogonal). This may not be true. Oblique factor analysis is more flexible in that it not only does not assume that factors are independent, but in fact shows the strength of relationship between factors. Since in the conceptual stage of the research variables were chosen for their theoretical relationship, the oblique method of factor analysis was deemed more appropriate for use in this study. The use of factor analysis resulted in the delineation of three factors for parent's background, eight for social network resources, and four for parent-child interaction.

Discriminant analysis was then utilized with the above fifteen factors, four child-rearing attitude scales, two personality attitude scales, antecedents to early attachment, the ways parents handled irritating child behaviors, and the general and specific physiological measures. Out of this analysis were derived 17 indicators which best discriminated between abusers and neglectors combined and non-abusers. This is still a large number of indicators to use for prediction.

Predictive Validity. When using discriminant analysis to determine sensitivity and specificity of a battery of measures, it is important to look at several problem areas (Morrison, 1969). When the problem and no-problem group N's are skewed, you will get an upward bias in predicting the no-problem group. In this study, the N for abusers and neglectors combined was 67 and for controls was 84. This does not indicate a skewness of concern.

Upward bias can also occur when the subjects on which the discriminant function was fitted are the subjects to be classified. Table 2 shows prediction using this approach with a

sensitivity of 84 percent with 16 percent false negatives and a specificity of 91 percent with 9 percent false positives.

Table 2

Prediction Results*

Actual Group Membership	Predicted Group Membership				Total	
	Abusive		Non-Abusive			
	N	%	N	%	N	%
Abusive	56	84	11	16	67	100
Non-Abusive	8	9	76	91	84	100

Predictive value of a positive 88%
*Same subjects used to derive discriminant function and to classify.

After completing the above procedure, a random sample of the abusers, neglectors and controls was chosen. A discriminant function was derived using this portion of the sample and the rest of the sample was then classified using that discriminant function. Table 3 shows the reduction of sensitivity to 79 percent with 21 percent false negatives and of specificity to 74 percent with 26 parent false positives. This predictive validity is still considered to be high when using 17 variables for prediction. Future plans include looking at the predictive validity of each of the 17 indicators individually.

Table 3

Prediction Results*

Actual Group Membership	Predicted Group Membership				Total	
	Abusive		Non-Abusive			
	N	%	N	%	N	%
Abusive	30	79	8	21	38	100
Non-Abusive	14	26	44	74	58	100

Predictive value of a positive 67%
*Randomly selected subjects classified on discriminant function fitted to remainder of the subjects.

Future Plans. Another factor which inflates sensitivity and specificity of tests is the use of subjects at extreme ends of a continuum (Frankenburg, 1975). In the study being reported, abusive and neglecting parents were matched on 64 cells with non-abusing or control parents. This resulted in two samples, one at each extreme end of the continuum. The present study is being followed by a longitudinal study in which a more representative sample of the population will be selected before childbirth and followed until the child is 2½ years old. Using this more representative sample will permit testing external validity, the ability to use the tests on a sample other than that used for constructing and/or assembling the measures. It will also permit looking at the predictability of each of the measures as well as the battery of measures, and looking at both the predictability by child age group and the problems involved in using the tests with each age group. The larger, more representative sample will permit a better picture of the incidence of serious parenting problems in the population sampled and show the potential of accurate prediction with respect to parents with few or no serious problems.

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Self-Report Schedules for Use in Assessing the Marital Adjustment of Abusive Parents: Some Preliminary Findings

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No single theory of behavior has ever purported to explain parental violence towards children. Abuse and neglect have many related concomitants, and one important concomitant is the marital relationship. Specifically, it has been stated that if the marital relationship is distressed, the child can become injured as a result of displaced marital anger (Paulson et al 1975c; Paulson, Schwerner and Bendel, 1976). Indeed, a recent survey of a military population in San Antonio, Texas, found that family discord accounted for over one-half of the stress factors in the victim's home (Project CARE Report, 1976). The intriguing question is therefore: Do abusive and neglectful parents have marriages that are more distressed than other problem parents?

Seaberg, Gillespie, Long, and Conte (1975) made an exhaustive survey of the measures available for the evaluation of child abuse and neglect demonstration projects. They recommended two measures to assess marital adjustment. One was the Locke-Wallace Marital Adjustment test (Locke and Wallace, 1959); the other was Biennenu's test of marital communication (Biennenu, 1970). The inventory of marital conflicts (IMC) (Olson and Ryder, 1970), found useful by some researchers (see Vincent, Weiss, and Birchler, 1975), was not recommended for use with abusive and neglectful parents.

Although these measures have been recommended for the assessment of the marital adjustment of abusive and neglectful parents, the author is not aware of any published reports, behavioral or otherwise, in this important area. Numerous reports exist, however, on traditional psychometric evaluations of abusive parents (Paulson, Afifi, Thomaston, and Chaleff, 1974; Paulson, Afifi, Chaleff, Thomaston and Liu, 1975 a; Paulson, Afifi, Chaleff, Liu and Thomaston, 1975b; Paulson et al, 1976).

It is the purpose of this report to present and discuss the results of several marital questionnaires administered to abusive parents and to nonabusive parents who attended a clinic social learning group. This report is part of a paper on the behavioral assessment of child abuse (Butler, 1977).

METHOD

Subjects

As part of the Wilford Hall USAF Medical Center's Child Advocacy Program, parents whose children were abused, neglected, or at risk were interviewed to obtain a social history and were given a series of three marital questionnaires as part of a comprehensive assessment package. The assessment package included a social history, home visits, the MMPI for both parents, three marital questionnaires, and, if appropriate, parent-child observation sessions. The groups of abusive and nonabusive parents were comparable on the ages of the parents, the length of the marriage, the age of the problem child, and the total number of children in the family (see Table 1).

Procedure

Locke-Wallace Marital Adjustment Test (L-W). This test has been used by researchers (Vincent et al, 1975; Birchler, Weiss and Vincent, 1975; Birchler and Webb, 1976) to discriminate distressed from nondistressed marital relationships (see Seaburg, 1975; Locke and Wallace, 1959). The item and concurrent validity and reliability of the test have been established (Kimmel and Van Der Veen, 1974). Marriages have been considered distressed if the average couple L-W score is 100 or less and nondistressed if the average couple L-W score is 105 or greater (Vincent et al, 1975; Birchler et al, 1975).

Marital Status Inventory (MSI). The marital status inventory (MSI) is a 14 item, self-administered, true/false Guttman scale which measures the dissolution potential of the marital relationship (Weiss and Cerreto, 1975). The coefficient of reproducibility and scalibility was .90 based on an N of 143 married respondents at the University of Oregon. Weiss and Cerreto also provided the results on the L-W and MSI from a marital counseling sample (N=24) and from a sample of parents seeking assistance for parent-child problems (N=34). A marital relationship could be considered distressed if the average couple score on the MSI was 4 or greater.

Areas of Change Questionnaire (A-C). This questionnaire evaluates the amount of change a couple desires in their relationship (Birchler and Webb, 1976; Weiss and Birchler, 1975). There are 68 specific statements about family life on the questionnaire, 34 under the heading of "I want my partner to...." and the same 34 statements repeated under the heading of "It would please my partner if I...." When the responses from both partners are compared, it is possible to arrive at a change score for each partner and a total change score for the couple. Birchler and Webb also provide normative data on distressed and nondistressed marital relationships. Vincent et al (1975) and Birchler et al (1975) suggest that a total couple change score of 15 or greater would classify the couple as a distressed marital dyad.

All three marital questionnaires have been widely used both in pre-post evaluations of treatment (Margolin, Christensen, Weiss, and Patterson, 1975; Weiss, Hops, and Patterson, 1973) and as a method of including or excluding subjects for research activities (Vincent et al, 1975; Birchler et al, 1975).

RESULTS

Table 1

Group Characteristics

Variable	Parent-Child Group N=15 couples[a]	Abusive Parents Group N=11 couples[b]
Husband's Age		
M	30.4	30.4
SD	7.3	8.7
Range	17.0 yrs.	26.0 yrs.
Wife's Age		
M	28.2	29.8
SD	5.3	7.5
Range	19.0 yrs.	21.0 yrs.
Length of Marriage		
M	7.2	8.8
SD	3.2	7.2
Range	14.0 yrs.	20.4 yrs.
Age of Problem Child		
M	5.03	5.13
SD	2.3	4.2
Range	7.5 yrs.	9.4 yrs.
Number Children in Family		
M	2.3	2.2
SD	1.0	.87
Range	5.0	4.0

[a]Nonabusive parents in a clinical social learning group.

[b]Parents who physically or sexually abused their children.

Table 2

Means and Standard Deviations on the Marital Questionnaires from the Oregon and San Antonio Studies

Questionnaire	Study							
	Weiss & Cerreto 1975 Child Management Sample[a] N = 32		Butler, 1977 Child Management Sample[b] N = 15 couples		Butler, 1977 Abusive Parents Sample[c] N = 11 couples		Weiss & Cerreto 1975 Marital Counseling Sample[d] N = 24	
	Husband	Wife	Husband	Wife	Husband	Wife	Husband	Wife
Locke-Wallace								
M	86.7	85.0	100.6	91.8	101.1	92.6	69.0	68.0
SD	27.9	29.7	29.2	31.1	34.4	32.2	22.8	20.2
Marital Status Inventory								
M	1.8	2.2	2.5	2.7	2.0	2.6	4.4	4.8
SD	2.5	2.6	3.1	3.6	2.8	1.8	2.8	2.1
Areas of Change Total Score								
M			16.6		20.7			
SD			11.8		15.4			

[a]Nonabusive parents who had child management problems.

[b]Nonabusive parents with child management problems attending a social learning group.

[c]Parents who physically or sexually abused their children.

[d]Couples in marital counseling.

An inspection of Table 2 reveals that the means and standard deviations from the San Antonio abusive and nonabusive groups were about the same on all three questionnaires. The parent-child sample of Weiss and Cerreto differs from both our hospital samples on the L-W test; however, all three differ from the marital counseling sample on the MSI. The A-C scores from our hospital parent-child and abusive parent samples were about the same.

To test for the differences between the mean scores of abusive and nonabusive parents, t tests were computed. None were significant (L-W abusive husbands vs. nonabusive husbands, t (24) = .01, ns; abusive L-W wives vs. nonabusive L-W wives, t (24) = .01, ns; abusive MSI husbands vs. nonabusive MSI husbands, t (19) = .05, ns; abusive MSI wives vs. nonabusive MSI wives, t (19) = .64, ns; abusive A-C vs. nonabusive A-C, t (22) = .74, ns).

A complex Chi-Square (X^2) and contingency coefficient (C) (Bruning and Kintz, 1977) were also computed. The results were not significant (X^2 (6) = 2.88, ns; C = .19).

DISCUSSION

This report compared the marital adjustment of abusive and nonabusive parents by means of several marital questionnaires. The central finding is that there was no statistically significant difference in the marital adjustment of abusive parents compared to nonabusive parents who sought assistance because of parent-child problems. However, the small sample size makes any conclusions tentative.

We found the questionnaires easy to administer and to score. Since most of our abusive clients are involuntary, we found it best to administer the questionnaires after several initial contacts with the family. The couple must be socialized to the need for these questionnaires or any psychological test. It takes clinical skill to insure client compliance with tests or questionnaires.

Two additional points about the questionnaires should be mentioned. First, the questionnaires can be easily integrated with more traditional forms of psychometric assessment; second, the questionnaires reveal possible problem areas within the family and marriage which can then be used in planning treatment.

Interestingly, other researchers have stated that abusive parents may not differ significantly from other problem families. For example, Burgess and Conger (1976) found that in their sample of abuse and neglect families, family members tended to act in coercive ways towards one another and direct few positive contacts to one another, and the parents were often deficient in important social skills. In general, Burgess and Conger's families displayed some of the same characteristics noted by Gerald Patterson and his colleagues at the University of Oregon.

In a comment upon the generational hypothesis abuse—that leads to abuse—Jayaratne (1977) stated:

> In the opinion of this author there is little or no empirical evidence to substantiate the idea that abusing parents follow parenting practices that are significantly different from those of nonabusing parents. This statement is made in view of the lack of comparison group studies to test that assumption (p. 6).

If it is true that abusive parents do not differ significantly from nonabusive problem parents in parenting practices or in the area of marital adjustment, then existing behavioral procedures for families could be utilized to assist abusive parents. Behavior therapy has made a great many contributions to the assessment and treatment of parent-child and marital problems. In the past, however, child abuse and neglect has been largely ignored by behavioral practitioners. One hopes this trend will be reversed in the future.

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A Preliminary Report on a Clinical Screening Instrument for Assessing an Individual's Potential for Child Abuse

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A survey of the literature reveals that a wide array of putative traits are presented as descriptors of individuals who abuse and neglect their children. At present, however, we lack reliable and valid measurement techniques for assessing these traits.

The few approaches that have been employed to assess an individual's potential for child abuse have been for the most part relatively subjective and are often used post hoc. For example, one approach involved the formation of a committee, the Vulnerable Child Committee (VCC), at the community level for the purpose of identifying children vulnerable to abuse and neglect (Lovens and Rako, 1975). This committee, on the basis of criteria selected by the committee itself, reviews cases cross-indexed by various community agencies. Although the VCC was established for early identification of children vulnerable to abuse and neglect, the criteria for indexing require for the most part that actual abuse and neglect must have taken place on several occasions in order for the child to appear on the list.

Another more objective approach to the diagnosis and prediction of child neglect involves the use of the Childhood Level of Living Scale (CLL) (Polansky, Borgman, and DeSaix, 1972). This scale was developed to provide data on the conditions of care under which children are raised. In order to determine the probability of neglect in a home, a professional worker is required to fill out the scale by directly observing the home environment, by interviewing the mother of the child involved, and/or by obtaining information from other sources. Norms are provided for comparing an obtained score on the CLL to the study group. The CLL norms are divided into quintiles with a "first quintile" score equivalent indicating a "probably neglectful" mother, while a "fifth quintile" score equivalent indicates that the mother is "definitely not neglectful." Limitations in the CLL are that it concentrates on the mother-child relationship and does not include fathers, it requires extensive time and effort to complete, and its reliability is contingent upon the thorough training of the rater. It should be noted that the final form of the CLL was standardized on a rather limited population. Scoring norms were based upon data obtained from "a combined sample of 91 AFDC families, and 65 low-income mother-child pairs living in a rural county in western North Carolina."

Since debate continues as to which personality characteristics are the best predictors of a person's potential for abuse, the present research employed an "empirical approach" rather than a "rational approach" in an attempt to determine which traits are most representative of the abusing parent. Given the need for a reliable measurement technique, the goal of this research was to construct and validate a test instrument which could be employed as a quick, self-administered screening device for assessing an individual's potential for child abuse.

BACKGROUND OF THE INVENTORY ITEMS

The initial phase of the project involved a comprehensive review of the literature on child abuse and neglect. The primary purpose of the review was to delineate the personality traits which research and theory suggest are characteristic of abusing and neglecting parents. After the various traits were noted, they were grouped into different general areas or clusters. Some of the most frequently mentioned trait areas were: unrealistic child-rearing attitudes and expectations; anxiety over a child's behavior; problems in interpersonal relationships; feelings of inadequacy; feelings of isolation and loneliness; depression; vulnerability; insecurity; inability to handle stress; rigid attitudes; impulsivity; dependency; immaturity; negative childhood experiences including abuse and neglect; and problems in parental relationships. This list of general trait areas is not assumed to be exhaustive nor are the groups considered free from overlap. Indeed, inspection of the trait areas suggests that various degrees of overlap might be expected. The number of these areas identifiable on the final inventory will be determined through factor analysis. Also reported in the literature were a number of less frequently occurring and sometimes surprising personality characteristics which were cited as important in describing abusing and neglecting parents. These traits included a wide range of variables, from poverty, lack of education, and psychosis to having unlisted telephone numbers and closed house curtains.

It is interesting to note that the literature generally does not attempt to separate traits which are characteristic of abusing parents from those which are correlated with neglecting parents. In fact, the definition of "child abuse" often includes neglect. For example, one frequently employed definition formally defines "child abuse" as a situation "in which a child is suffering from serious physical injury inflicted upon him by other than accidental means; is suffering harm by reason of neglect, malnutrition, or sexual abuse; is going without necessary and basic physical care; or is growing up under conditions which threaten his physical and emotional survival" (Light, 1973).

This suggests the possibility that the etiologies of abuse and neglect are often, if not usually, similar. Still the etiologies may differ in the degree to which certain traits are present and to the number and combination of traits which exist in abusing and neglecting parents.

In summary, the literature review indicated that it is presently difficult to delineate which traits are significant predictors of abusing and neglecting parents. It indicated that there has been even less success in the separation of the traits predictive of abuse versus neglect. Consequently, no attempt was made in the preliminary phase of the present study to make such distinctions. The test items were developed from traits found in the literature on both child abuse and neglect. This procedure is consistent with the "empirical approach" to test construction. That is, since there is apparent difficulty in rationally selecting which personality characteristics to include, a large number of items based on as many traits as possible were developed. The only change from a pure "empirical approach" was a slight emphasis on the development of test items from areas which were mentioned most frequently in the research literature. Overall, this results in a "shot gun" type of inventory item development with many items tested on a criterion group.

Four of the major trait areas with a brief sample of items developed to assess each are presented in Table 1.

Table 1

Examples of Preliminary Inventory Items from Four Trait Areas

Trait Area: Inadequate Child-rearing Attitudes and Expectations

Item #32, Most children are alike.
Item #67, Some children will always be bad.
Item #243, Babies should love their parents.
Item #311, Spanking that only bruises a child is good.

Trait Area: Feelings of Isolation and Loneliness

Item #24, I cannot ask others for help.
Item #83, I have several close friends in my neighborhood.
Item #123, I do not like to be touched by others.
Item #237, I often do not understand how others feel.

Trait Area: Negative Childhood Experiences

Item #12, As a child I was often afraid.
Item #43, I would like to be a child again.
Item #66, I did not have many friends in school.
Item #244, I was "different" as a child.

Trait Area: Problems in Parental Relationships

Item #6, My parents were always fighting.
Item #39, I could usually talk to my mother.
Item #113, As a child, I often worried that my parents would leave me.
Item #221, My parents were overprotective.

For the preliminary inventory, an average of fifteen to twenty items were written to sample each domain. Since the specific syntax employed in writing a question might determine if it does or does not discriminate, a given question was occasionally written twice with only a slight difference between the two. For example, a direct question concerning loneliness was written the following two ways: "I sometimes feel all alone" and "I often feel lonely inside".

DEVELOPMENT OF THE PRELIMINARY INVENTORY

Based on the aforementioned personality trait areas which were found in the literature, a preliminary Child Abuse Potential (CAP) Inventory was constructed. This preliminary CAP-Inventory was modified several times. Changes consisted mostly of the addition of new items and the simplification of syntax. The final form of the preliminary CAP-Inventory consisted of 334 items. The items were statements with which a subject was asked to agree or to disagree. A two answer (i.e. agree-disagree) "forced choice" situation was selected for several reasons. First, if a broader array of response categories are provided, such as strongly agree, agree, slightly agree, slightly disagree, disagree, strongly disagree, there is a greater potential for individual interpretations. For example, one person may employ "agree" in the same manner as someone else uses "slightly agree." In addition, it has been reported that slightly higher reliability and validity measures are obtained from forced-choice items than from multiple response items. In order to reduce response bias, items were presented in a random order.

The preliminary CAP-Inventory was administered to nineteen abusing and nineteen matched nonabusing parents. For this pretesting phase of the research, departments of social service located in western North Carolina cooperated to provide subjects for the abusing parent group. An attempt was made to match subjects on gender, age, ethnic background, education, occupation, marital status, number of children, age of children, and sex of children.

The matching of subjects is necessary because a person's child rearing attitudes and expectations vary as a consequence of factors such as age, education, and socio-economic class. If one is to state that observed differences on Inventory item responses are due to membership in the abusing or nonabusing group, one must control other variables which might produce such differences.

EVALUATION OF THE PRELIMINARY INVENTORY

Following administration of the preliminary CAP-Inventory to abusing and nonabusing parents, an item-analysis was conducted. A computer program was written to provide a print-out of each of the 334 inventory items with an associated computation of the percentage of agree and disagree responses for each group. Several statistical procedures including a t-test for proportions were employed to test for a significant difference between the groups in their responses.

This pretesting phase was important for several reasons. It provided a means for uncovering gross defects in the test construction. The inventory was examined for weaknesses in areas such as instructions, format, time requirements, etc. It also provided data for a preliminary item analysis and consequent information on the adequacy of the various items as discriminators of abusing parents. Since the preliminary CAP-Inventory started with a surplus of items (334), only the ones that appeared best in terms of the item analysis statistics were retained for use in the construction of the revised inventory.

A survey of the statistical data indicated that approximately 38 percent of the Inventory items significantly ($p < .05$) discriminated between the abusing and the nonabusing groups. Inspection of these data suggests that items from some trait areas discriminated more than those from other areas. For example, it appeared that trait areas with a relatively higher percentage of discriminating items include: unrealistic child-rearing attitudes and expectations; problems in interpersonal relationships; feelings of isolation and loneliness; inability to handle stress; depression; and insecurity. Items from trait areas which might be labeled vulnerability and social isolation appeared to discriminate less often. It should be pointed out that these conclusions are based only upon inspection rather than factor analysis which will be employed later. In addition, the specific content and the syntax of the items constructed to represent a trait area will to some extent determine the effectiveness of the items as discriminators independent of the predictor value of the trait area.

THE CAP-INVENTORY REVISED

Based on an analysis of the data obtained in the pretesting phase of the project, 160 items were chosen for inclusion in the revised form. The CAP-Inventory (revised) was then professionally prepared and a specially designed computer-compatible answer sheet was developed.

The CAP-Inventory (revised) is currently being administered to a large group (i.e., several hundred) of abusing parents and to a matched group of nonabusing parents. The matching variables are identical to those outlined for the pretesting phase. The abusing parent population is being obtained primarily from selected departments of social service from across the state of North Carolina. In addition, efforts are being made to obtain a representative stratified random sample of abusing parents.

The data obtained from the administration of the CAP-Inventory (revised) will be employed to further validate the remaining items. An elaborate item-analysis will be conducted, including a factor-analysis, to factor out cluster areas which exist in the Inventory. Based on this statistical analysis, a scoring system will be developed. Further considerations at present include the possible construction of two special scales, a Lie scale and a Psychotic scale, that would be part of the final Inventory.

Although the final form of the CAP-Inventory scoring system has not been developed, its form may be hypothesized. The following scoring approach is one similar to that employed by the Minnesota Multiphasic Personality Inventory and has been suggested by others as a type of profile for identifying a potential abuser (Schneider, Helfer, and Pollock, 1974). The hypothetical scoring profile is presented in Figure 1. Based on the factor analysis, it is expected that certain trait clusters will be revealed. If there are, for example, six cluster areas factored out, the final profile might have six traits listed on the abscissa as presented in Figure 1. Also, shown in the figure are a Lie scale and a Psychotic scale.

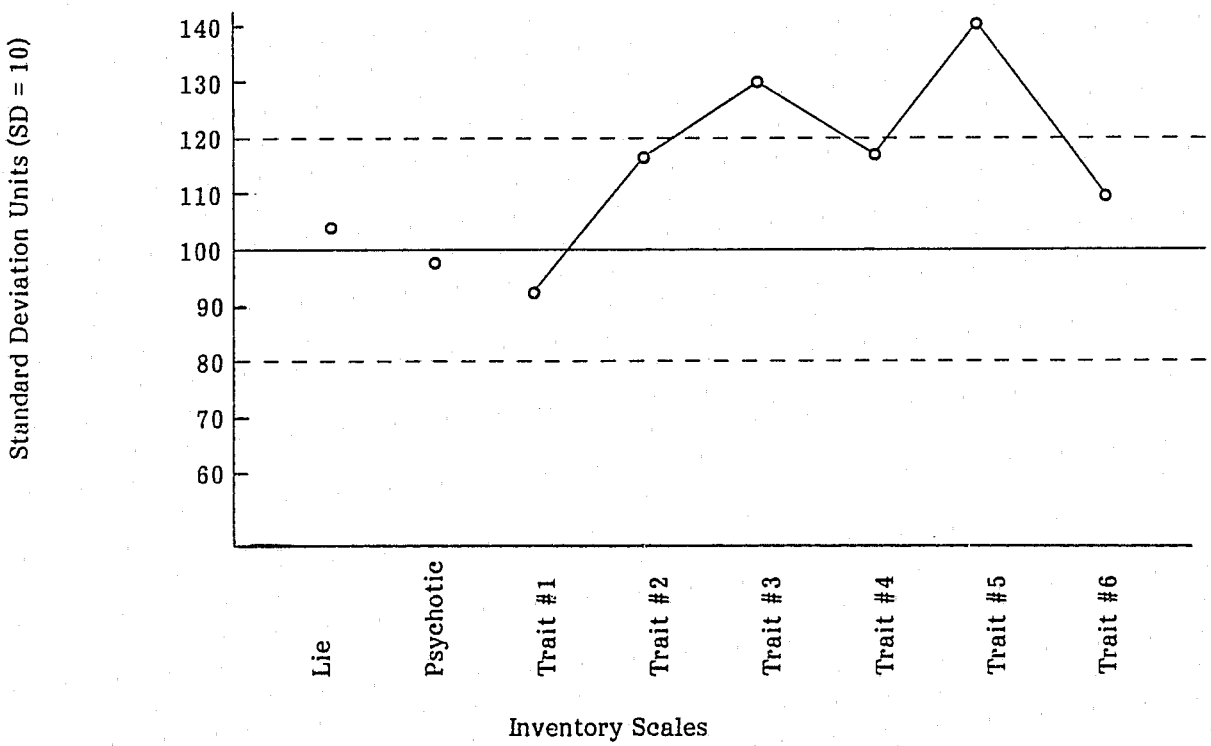

Figure 1. A hypothetical scoring profile with hypothetical data showing variation of scale scores from norm.

On this profile, 100 on the ordinate would represent the middle and mean of the nonabusing population. One standard deviation would be equal to ten units on the ordinate. Therefore, two standard deviations on each side of the mean would represent approximately 95 percent of the population of nonabusing parents. A given individual could score beyond the "normal range" on one or all of the abscissa categories. A hypothetical case is graphed in Figure 1. On this profile, the greater the number of significantly deviant trait scores (those scores in the outer 5% of the population), the greater the likelihood the person will abuse. Further analysis may also indicate which traits or which specific trait configurations are most predictive of abuse. This rather ideal scoring profile, however, remains to be empirically developed.

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Assessment of Impulse Control

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CARE, VIGILANCE, AND PRECAUTION FOR SAFETY

The Encyclopedia of American Jurisprudence (1975) states, "With regard to the degree of standard of care required of a common carrier of passengers, such carriers are required to exercise the highest degree of care, vigilance, and precaution for the safety of those they undertake to transport, and are liable for injuries to passengers resulting from the slightest negligence."

In outlining the minimal medical standards required of pilots, the Federal Aviation Agency Regulations state an airman will be denied medical certification if a disorder of thinking, feeling, or behavior is present, or a history of such a disorder is elicited.

For several years, two computer programs have been in use to identify pilot applicants who are likely to demonstrate disorders of thinking, feeling, or behavior which would disqualify them for medical certification. These computer softwares are: PRIME, which analyzes the interaction of certain cognitive and personality factors to provide a decision point in recommending psychiatric consultation; and PDX, which predicts certain diagnostic classifications in accord with the nomenclature of the Diagnostic and Statistical Manual of Mental Disorders (1968).

Presently, there is no comparable system to evaluate the likelihood a parent will, "exercise the highest degree of care, vigilance, and precaution for the safety" of children in his care. If there were such a system, it could raise as many questions as it would provide predictions. Yet, it is generally agreed society must provide a greater measure of physical and mental health protection for children than is now provided.

This paper considers the feasibility of the development of a system which would evaluate the likelihood a parent would exercise care, vigilance, and precaution for the safety of his children. The working title of that system is ICP.

INCIDENCE AND PSYCHOPATHOLOGY OF CHILD ABUSE

The general public largely is unaware of the incidence and severity of child abuse. Kempe (1971) believes a quarter of all fractures in children under the age of two, and one-eighth of all trauma under the age of three, are manifestations of the battered child syndrome. Clinicians seem to agree the battering parent of today was himself a battered child yesterday. Freeman (1975) suggests it is possible to utilize the dyad "battering parent and battering child" as an hypothesis which may explain the early processes of internalization, and the establishment of object relations.

Freeman feels abusing parents expect and demand a great deal from their infants and children. Not only is their demand for performance great, it is premature in the sense of being clearly beyond the ability of the child to comprehend what is wanted of him, and for him to respond appropriately. Morris and Gould (1963) hold that axiomatic to the child beater is the principle that infants and children exist primarily to satisfy parental needs; that children's and infant's needs are unimportant; and that children who do not fulfill these requirements deserve punishment.

Steele and Pollock (1968) report inability to find a single conventional psychiatric diagnosis which would characterize battering parents. While there may not be any one profile of the abusing parent, Freeman feels they are action-oriented rather than given to dependence on thought and the delay of impulse gratification. According to Freeman, 80 percent of a group of abusing parents had unresolved identity conflicts which played a major role in determining their behavior, and almost the same number showed significant depressive trends and feelings of unworthiness. Although feelings of suspiciousness and distrust, and of being victimized, were extremely common, only one individual in the group could be classified as paranoid. Freeman felt a failure to establish a successful synthesis of identity fragments was typical of these parents.

FACTORS PREDICTED TO INCREASE INCIDENCE OF CHILD ABUSE

Steele and Pollock characterize the abusing parents as not having an identity in Erickson's meaning of the term: "The sense of being a unique, separate individual with consistency of personal character and ability to maintain solidarity with society (Erickson, 1950).

Is it possible then, that as activist and special interest groups and attitudes proliferate, individuals may have increased difficulty maintaining solidarity with a society which itself is "splintered?" Will unisex, affirmative action, and racial exclusiveness, for example, increase the incidence of child abuse?

Restriction of personal space has been associated with aggressive behavior. Is it possible restriction of mobility resulting from energy conservation will increase the output of impulse behavior? Could energy conservation so increase adult frustration that child waste results?

With increasd governmental emphasis on paternalism, will the citizen's conscious or unconscious realization that his economic position and ability to make independent judgments and decisions have been lessened serve to increase his level of affective arousal? Will children bear the brunt of this realization?

TECHNIQUES USED TO ASSESS PSYCHOPATHOLOGY

Eysenck (1967) holds that impulse behavior is associated with social underconditioning. PDX uses a social value scale to assess identification with, or alienation from, commonly accepted values.

An individual's level of aspiration appears to be associated with his need for self-esteem. Success has been shown to increase effort to attain a goal. Failure to attain a goal tends to produce feelings of inadequacy which, in turn, may elevate levels of affective arousal. Certain classes of patients attempt to reduce levels of affective arousal by impulse behavior. Gross overestimation of expected performance has been observed to be associated with lack of judgment and/or an inability to reach conclusions which are reality bound. PDX quantifies the several levels of aspiration.

Eysenck reports individuals who demonstrate markedly elevated levels of affective arousal and extraversion often develop impulse behavior patterns. PDX uses a modification of Eysenck's personality scale to compare levels of extraversion and affective arousal.

During simple conditioning procedures, Walter (1964) recorded a surface negative DC shift from the posterior frontal areas of the brain. This shift appears to depend upon a stimulus-induced state of expectancy. Termed the E-wave, this shift is reported to be absent in adults who have been convicted of repeated offenses of impulse behavior. In light of this finding, a neural mechanism for the control of impulse behavior has been postulated. PRIME and PDX appear to assess cognitive function (cortical control) as influenced by thalamic or hypothalamic centers. Working with Walter (Vinson and Walter, 1977), a technique is being developed which requires the individual to maintain a relatively constant level of affective arousal while carrying out simultaneous information exchanges within the nervous system. Findings to date support the theoretical basis, and may prove to be invaluable in evaluating impulse behavior and lack of cortical control.

DATA BASE OF IMPULSE BEHAVIOR

Since 1973, more than 1,000 PRIME/PDX evaluations have been made to rule out disorders of thinking, feeling, or behavior. These evaluations have been validated against supervisory ratings of on-the-job performance and against other external criteria.

One hundred Sheppard and Enoch Pratt Hospital patients, referred to psychiatry for diagnosis and treatment of disorders of thinking, feeling, or behavior have been evaluated on PDX. The patients were distributed as to percentages of incidence of disorders as they occur in the practice of psychiatry. Based on regression analysis of the performance data of this group, an estimating equation predicted the criterion (DSM-II classification) beyond the .1 percent level.

From 1968 to 1976, predictions of levels of aggression were compared with observed levels of aggression using the performance data of 500 professional football players and the external criterion of professional football coaches. Agreement between predicted and observed aggression was beyond the five percent level.

Fifty-two patients at the Devereux School (Victoria) were assessed by PDX; a number of these patients were assumed to be battered children. PDX and staff observations were in agreement for 43 of these patients. Of the total group, 75 percent demonstrated below average impulse control. It is hypothesized there is agreement between having been subjected to physical abuse as an infant or child, and impulse behavior in later years of youth. The hypothesis has not yet been tested formally.

When mathematically modeling human behavior, to evaluate only the unusual or pathologic population would be insufficient. Within the data base used in the development of PRIME, PDX, and perhaps ICP are the performance data of approximately 35,000 high performing normals.

"ICP," A PROPOSED COMPUTER SOFTWARE

Since 1968, Assessment Systems, Inc., (ASI) has developed cost-effective health care delivery systems which assess cognitive and personality functions under conditions of physical and/or non-physical stress. The state of the art would permit the development of a computer software system which, within probability theory, would identify persons who under conditions of physical and/or non-physical stress would be likely to demonstrate overt acts of child abuse.

With ICP, as in all ASI health care delivery systems, performance data would be acquired by paraprofessional personnel trained by ASI. Data acquisition for processing such a report is estimated to be less than one hour per subject.

A user would have the option of transmitting the acquired data by telecommunication to ASI for computer processing of the data. Or, the data would be suitable for processing at the user's facility by stand-alone unit. The information exchange between a user and ASI is shown in Figure 1. Information processing by a user at a stand-alone unit is shown in Figure 2.

It should be emphasized ICP would be designed only to provide a decision point in exploring certain relationships between parent and child.

A prototype report of ICP is shown in Figure 3. It is anticipated a processing charge would be approximately $35 per subject, excluding telecommunication charges.

CURRENT SYSTEM IMPLEMENTATION FOR MENTAL STATUS ASSESSMENT

VIA TELECOMMUNICATIONS

- o 30 Minute Turnaround From Output of Scores to Receipt of Preliminary Report
- o User Subscribes to "Service Bureau" Function of Assessments Systems Inc.
- o Assessment Systems Inc., Subscribes to Tymeshare Inc., for Computer Services

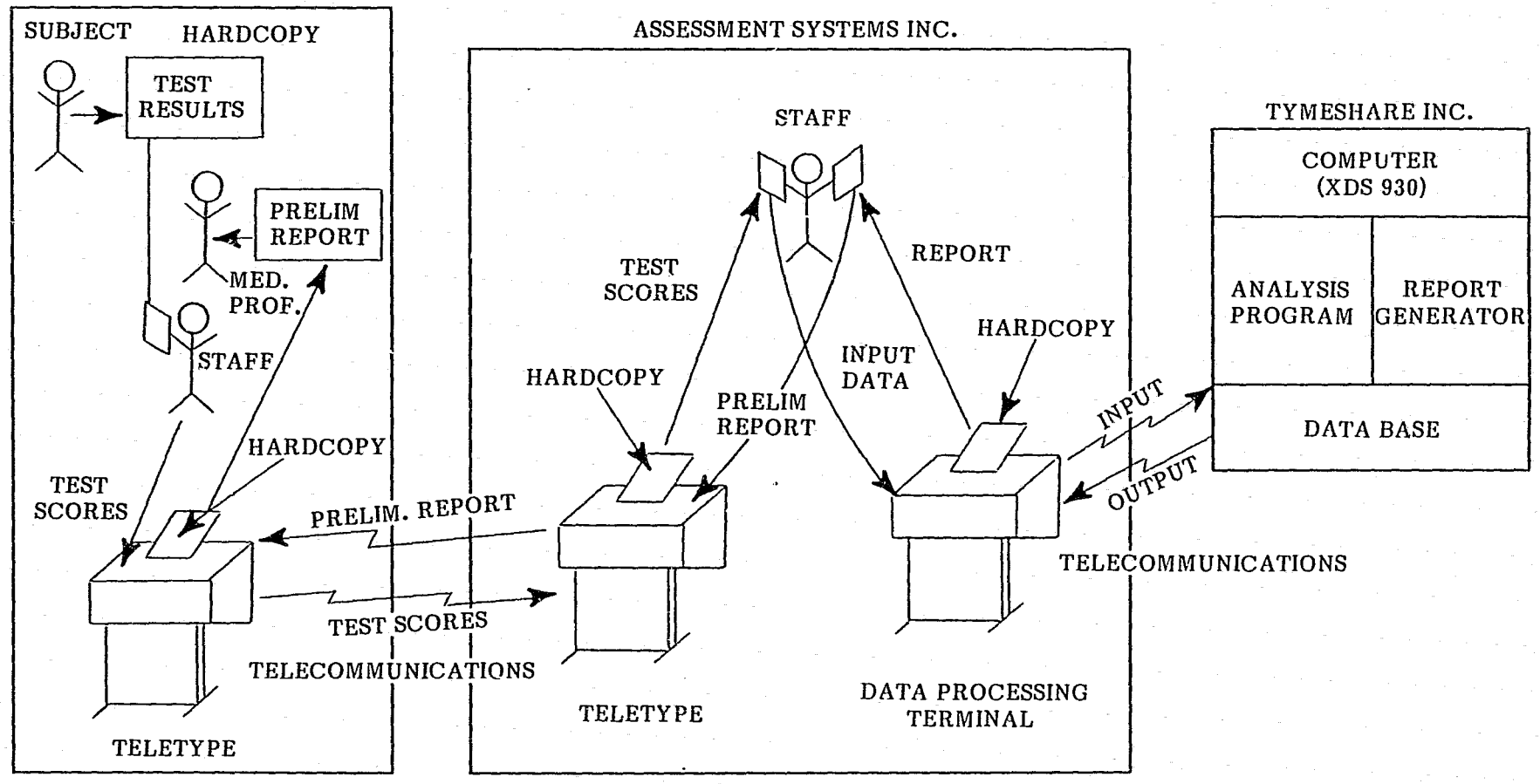

FIGURE 1

A STAND-ALONE SYSTEM AT USER'S OFFICE

10-MINUTE TURNAROUND

USER'S FACILITY

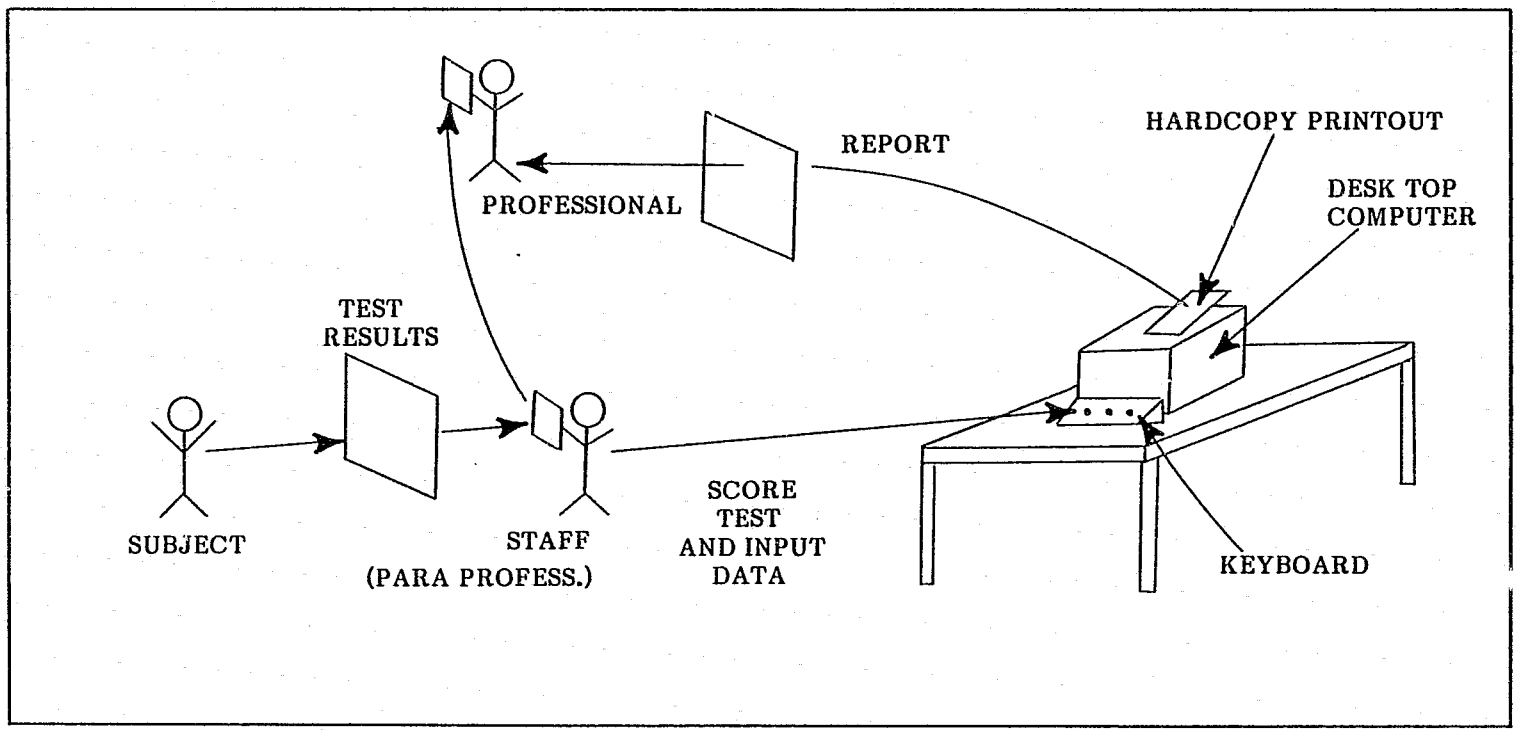

FIGURE 2

FIGURE 3

ASSESSMENT SYSTEMS, INCORPORATED
"ICP PROTOTYPE
MARCH 4, 1977

DBV-0000943

The patient reports certain attitudes and behaviors which are compatible with social underconditioning. This finding would be compatible with externalized aggression and/or impulse behavior.

When the patient's expected and observed performances on certain tasks of information processing are compared, gross overestimation of expected performance is demonstrated. This finding would be compatible with difficulty reconciling reality with expectation.

The nonphysical stress load associated with the parent-child interaction, which is reported by the parent, is above average.

The level of affective arousal reported by the parent is compatible with a conscious and/or unconscious attempt to present an idealized image of self.

The ability of the patient to carry out simultaneous selective attention and information storage/retrieval operations is within normal limits.

IMPRESSION:

> Based on the patient's performance on certain techniques which assess information processing, and personality function, it appears likely psychiatric consultation would support below average impulse control.

This report relfects physical and emotional status of the patient at the time of the examination and should not be used as a sole basis for action or decision.

The report will be signed only when the data acquisition, scoring, and calculations on which the report is based have been verified.

_____PhD

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Signals of Family Stress in High-Risk Families

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Discussing relative differences between children and adults, family psychiatrist Nathan Ackerman observed,

> "In the adult there is a more fixed organization of basic drives and adaptive reactions, more intactness of personality, more individuality, and more internalization of conflict" (Ackerman, 1958).

This description implies that the adult is responsible for his behavior and able to constrain his impulses, and avoids acting out in an unreasonable fashion. That is, the adult is assumed to have some insight into the social and emotional sequela of his/her behavior.

The child, on the other hand, is physically, sexually, emotionally, socially, and intellectually immature, forcing him to be massively dependent upon his/her relationship with that individual who is defined as "adult".

As the child travels the path toward independence the relationship that develops between the immature child and adult is never without conflict, but the juxtaposition of positive and negative experiences is generally sufficient for the development of an adequately functioning "adult" at journey's end.

The authors of a popular book dealing with the juvenile court's role in the life of children (Goldstein et al, 1973) provide an apt description of the need for regularity within this child-adult relationship,

> "Continuity of relationship, surroundings, and environmental influences is essential for a child's normal development. The instability of all mental processes during the period of development needs to be offset by stability and uninterrupted support from external sources" (Goldstein et al, p. 31).

Providing that this aforementioned "relationship" develops in a sound manner, the child will move from what child psychoanalyst M. S. Mahler (1963) has termed "normal autism" in the first few weeks of life to unique independent patterns of behavior that may be categorized as "adult".

Unfortunately, however, this natural and essential process can easily become disrupted. In many cases the symbiotic aspect of the parent-child relationship may become too strong and their need for each other may extend into aberrant styles of role adaptation, e.g., child maltreatment. In this event the developmental mastery of the child may never be complete.

The potential for disruption of a child-adult relationship within the framework of the family is the subject of this paper, which will examine specific signals and patterns of family stress bearing upon the interactions of dysfunctional families at risk of child maltreatment. The basic concepts presented herein will be recognizable to anyone familiar with the child maltreatment literature as elements discussed in R. E. Helfer's "World of Abnormal Rearing Cycle" (Helfer, 1975). The author is indebted to Dr. Helfer for the provision of that sound theoretical framework.

THE SEQUELAE OF DYSFUNCTIONAL REARING PATTERNS

Although the concept that "abusing parents were abused children" (Fontana, 1973, p. 109) has come under fire of late, the health care provider cannot ignore this concept in any effort to arrive at some understanding of risk factors inherent within a given family. If for no other reason, it seems clear that some element of the transmission of abusive behavior from adult to child lies within the fact that children accept parental patterns as "right", and model them (Bandura, 1969). This modeling factor is encountered not only in child abuse but in related patterns of violence such as juvenile delinquency (Bolton et al, 1977) and the battered parent (Kelley, 1972). Even at the most general level it would seem safe to conclude that the battered child may grow up to become an adult with violence "playing a prominent role in his behavior repertoire" (Kempe and Helfer, 1972, p. 104).

Psychodynamically, the child who is confronted with a maltreatment situation in his/her developmental sequence is faced with an overwhelming burden of rejection. The maltreatment situation confr nts the child in two distinct ways:

a. The anxiety produced by viewing the parent as irrational as opposed to reliable and dependable is too great for the child to bear. Rather than accepting the irrationality of the parent, the child accepts the "blame" for the act and begins a destructive pattern of convincing himself/herself that he/she is a "bad person". This "bad person" view is often translated into a critically low level of self-esteem.
b. Having discovered that the parent is not consistently emotionally available to him/her, the child develops an inability to trust. This element becomes the basis for a continued inability to trust any person.

The child is isolated through an absence of the internal sense of "object permanency" (Piaget, 1954) or "object constancy" (Hartman, 1964) with reference to his/her parents. Placed in a position of essential powerlessness, the child, because of his/her inability to alter his/her environment, must continually alter himself/herself as perceptions of the unique environmental demands upon him/her dictate. The insecurity in a growth pattern such as this is obvious; however, the results may be potentially more destructive than simple insecurity.

As the child plays developmental roles dictated for him by his environment, little or no room remains for tenderness, love, and affection. At best, the child may avoid situations requiring love and affection, an avoidance due to his deep need for them and fear that they will not be available. At worst, he will undergo a "malevolent transformation" (Sullivan, 1953) at any sign of tenderness and become destructive. In either case the possibility of affection is rapidly obliterated.

As time progresses, given the picture of a physically maturing person who has been powerless during most of his/her life, has a very low level of self-esteem, finds trusting another to be a near-impossible task, and hungers deeply for love and affection, the choice for improving life is often having a baby.

Despite the fact that the child-adult relationship is one of the most difficult human undertakings, our commonly pronatalist society promotes the positive aspects of the relationship and maintains an understanding that "all children love their parents".

As the maltreated young adult seeks a positive life experience, he/she views the essentially biological functions of child producing as failsafe, ignoring the psychosocial functions of the parents' role. The felt love-hunger drives the young person toward the myth, and the child becomes a reality.

In the immediate postnatal period the parent quickly finds himself/herself unprepared to cope with the relationship and finds the child unprepared to cope with his/her affective and behavioral demands. The cycle may once again have been created.

The entry of this highly desired infant into the previously maltreated person's world is a crisis point. Lacking the warm sensitive interaction necessary for his/her own growth and development, this person will not be capable of the empathetic care necessary for the development of his/her own child (Steele, 1975). Telltale patterns of behavior that may identify potential risk factors in such a situation would be obvious elements of immaturity, inadequate coping skills, or extreme dependency and rigid reliance upon commercially available parenting suggestions for the new parents.

Clearly, when the described elements of history and personality interact in this fashion, the outcomes for the child and family may be highly dysfunctional. It is important, at this point, for the health care provider to be reminded that these factors within familial interaction patterns are indicators of high risk rather than causal variables in the child maltreatment situation.

Moving from this high risk indicator to the next, Steele and Pollock (1972) have noted that many maltreating parents learn early not to rely upon others. This failure in reliance may result in limited and unrewarding interactions with others, a factor which leads to social isolation.

SOCIAL ISOLATION

Mental health is often viewed as a continuing struggle for personal adaptation. It cannot be maintained in isolation. The readily understandable fact is that we, as human beings, often require others to lean on and reflect ourselves to and through (Guntrip, 1969). At no time is this sharing phenomenon as important as when a parent is attempting to cope with the stresses of child rearing.

In corollary fashion we must sometimes escape those who "need" us, to "recharge" and provide ourselves with a reidentification of our thoughts and a personal space which we all require.

It is the rare parent who will not admit the need to be away from his/her children at times. If erroneous parenting messages have reached these parents which indicate that "a good parent never leaves his child" the family is at risk and in need of parenting education. The clear fact is that the effort to contain the frustration and conflict brought on by children until an internalized solution becomes available may result in a tendency to discharge the tension through the vehicle of irrational actions.

The pure knowledge of stresses inherent in the family system should not be construed as the capacity to respond to the stresses, however. An emotional balance can only be maintained with the help of emotional support from others. In short, there must be an extended emotional support system upon which to base a viable dynamic familial process.

The existence of this emotional support system must be real enough to demonstrate the possibility of actual contact between members. Knowing that your mother loves you is helpful; being able to drop your children off at her house when they are driving you crazy is heaven—and effective.

Unfortunately, the rapid pace of today's world with its resultant emotional and physical transience often leaves the family system with a continuing series of emotional vacuums. Social activity may be minimal, friendships shallow, and contact with the outside world maintained chiefly through artifical stimulators such as radio and television.

In this high risk situation, meaningful human interaction is at a dangerously low level. If and when the desire for contact is felt, the people involved are faced with the fact that the type of communication they most need is unavailable to them.

COMMUNICATION PATTERNS

In viewing the problems of run-away youths, many researchers have focused upon the child. One writer in the field recently offered a message that all may learn from, "Everyone knows that parents don't run away—physically" (Riley, 1972, p. 6). Parents do run away. They run away into themselves where they are able to hide and avoid true communication.

The communication offered to a child from parents serves as a transmitter of cultural value systems and, in reality, is the child's contact with the adult world (Glasser and Navarre, 1973). The child's early experiences are limited to those which the adults provide.

If this communication is to be sound there must be a relatively clear awareness of strivings and values, and an attitudinal structure toward communication based upon mutual understanding and an empathic tolerance of differences (Ackerman, 1954, p. 155).

In an effort to identify more "operational" definitions, the National Association for Mental Health has outlined an ideal communication system in the emotionally healthy family as "love, acceptance, security, protection, independence, faith, guidance, and control" (Sewell, 1973, p. 2). It is doubtful that all of these elements will be readily apparent in the assessment of the family, but they may provide some benchmark against which to assess the communication levels within the family. The communications utilized in the disciplinary system are a good vantage point from which to view this exchange.

Dealing with the concept of discipline is somewhat difficult for all concerned. The line between discipline and punishment may be quite thin. Most of us have been involved in punishment and bring our own definitions to the act (Bakan, 1971, p. 18). Therefore, the term discipline may have a variety of definitions, meanings, or connotations. In a general sense, discipline is that type of training which leads to the gradual and consistent development of self-control, character, orderliness, and efficiency (Sewell, 1973, p. 4).

In an effort to examine the communication system within the disciplinary structure we must ask: Who controls the discipline? Is control shared? Why does discipline take place? When does discipline take place?

The high risk family will demonstrate an inability to control discipline through the fact that what begins as discipline toward the child culminates in emotional release for the parent. The discipline is out of control and serves the needs of the parents, not those of the child.

If discipline is inconsistent or not adequately shared, the results will be highly detrimental. Inconsistent discipline on the part of one parent or inadequate sharing of disciplinary activity between parents may leave the child without the predictability necessary for adequate and secure growth. Consistency provides the child with an "anchor" from which he may venture, returning as his needs dictate. In the non-shared disciplinary system the child will quickly learn to play both sides against each other, a process which negates the potential good in the disciplinary system itself.

The "whys" of disciplinary communication must be examined not only in parental actions but as a function of the roles of the child as well. If the child forces discipline upon himself/herself as a measure of attention, there is a clear message that other means of attention-getting have been choked off.

Discipline must take place at the time of the offensive act. The child functions much more in the here and now than does the adult; this is a function of the discrepancy in the volume of memory available to each. If discipline takes place after the fact the disciplinary communication is minimized. The communication "wait till your father gets home" is an error.

It is the communication to the child which often builds or destroys his self-image. While most parents err by not considering the child as important as an adult from time to time, the dysfunctional family will work actively in the direction of negative communication.

Families at risk are those which heap large measures of negative communication upon a child or in which the child is placed in a position of never being able to satisfy or "do right".

The communication in the high risk family may be more than absent or inadequate, it may be an active insidious attack upon people within the family and in the world immediately beyond.

The structure of the high risk family is so fragile and its own sickness so frightening to its members that all symptoms may be transferred to one identifiable member or to the world at large which is perceived as being essentially "against" the family.

The health care professional must be acutely aware of the communication doors that the high risk family utilizes in its escape from the dysfunctional reality that is its perception of its world. While these doors are being discovered we must assess the perceptions of family members that are created as a result of the dysfunctional communication system and the effect of these perceptions on the family.

EXPECTATIONS OF CHILDREN

"Each child's development unfolds in response to the environmental influences to which he is exposed" is the statement offered regarding child development by the authors of *Beyond the Best Interests of the Child* (Goldstein et al). It is often surprising how few persons with children understand the unique, variable nature of a child's development. Armed with manuals and schedules, they confront the health care provider with concerns and questions as to "what's wrong" with their child. The majority of these questions are answerable; the danger comes when the parents are not aware enough to ask the question.

Three factors appear consistent in the family who may exist at high risk for child maltreatment:

a. The level of knowledge available to them regarding child development is consistently overestimated by professionals.
b. They often expect the family to develop emotionally as a result of the child rather than the reverse.
c. They consistently have unreasonably high expectations for their children.

The child born into the high risk family has a prewritten job description revolving around service to the family. This service is demonstrated through tasks undertaken for the parents, an excessive volume of chores, and acceptance of blame for family problems. When the child fails to perform he pays a price. His failure may be nothing more than the crime of being only a normally developing child. When development is not normal, the price may be even higher.

THE PRESENCE OF A "SPECIAL" CHILD

The child who fits into this category may be somehow different and special or he/she may be somehow the same and also special.

If it is the differentness of the child that causes concern to the family it is likely to be a difference that causes frustration to other family members or one that causes the child to somehow look or act differently from other family members. This problem may be as complex as being emotionally handicapped, mentally retarded, or hyperactive, or it may be as simple as being prettier, more intelligent, or more sensitive than other family members. The difference sets the child at high risk and provides a ready target for the emotional and physical blows that arise in the dysfunctional family setting.

If sameness of the child is the problem, it is most likely to be a resemblance to a disliked relative, activating excess baggage still carried from the past, or a sameness representative of acts of a present or previous spouse.

The child in this setting is caught helplessly between an existence of being different and wishing he weren't or being alike and, perhaps, unaware as to why that is a problem. In a family that exists at high risk it takes but a small event to alter potential into reality.

CRISIS

Crisis may be the single most important element in this formulation, for a family that presented no great risk prior to onset of a crisis may become a family at extreme risk with the introduction of a crisis into its world.

Crisis has a peculiar nature since it cannot be defined by anyone save that one person who is caught in its midst.

Crisis may occur in an emotional form, e.g., loss of a loved one, or in a logistical form, e.g., lack of adequate food. Its intensity is a personal experience that can be shared and empathized with, but never fully understood.

This element, of all six, has the greatest potential to destroy the family unit completely. In the face of the potential destructive power of the crisis, we must remember that the crisis situation also offers the greatest opportunity for adjustment and change.

If the professional dealing with the potentially abusive family can accept the family's report that it is in crisis, regardless of the surrounding causal factors, and avoid the trap of placing his/her own values upon the response to the crisis, the opportunity for positive change may be at hand.

CONCLUSION

None of the signs presented in this paper are absolute indicators of an abuse situation. They are only guidelines and representations of elements that will alert the observer's clinical judgment that there may be potential for maltreatment in a given family system.

Many helping professionals feel this to be the most frustrating family style to deal with and, indeed, in many ways it is. However, success with this family style brings many rewards to the helper and success can be ours with patience and persistence.

Moving away from the scientific and reaching once again to the human, it is wise to remember the words of R. D. Laing in *The Politics of Experience* (1970) as he states, "We know less than we feel. We feel less than we love. And to that precise extent we are less than we are".

The potentially maltreating family will ask the helper to be more than he feels, more than he is, but, with an ample dosage of caring, he will be all he needs to be.

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Burns as Abuse

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INTRODUCTION

Inflicted injuries to children passed as accidental until Caffey (1946) pointed out the relationship of long bone fractures and subdural hematomas. Later, Henry Kempe (1962) coined the term, "the battered child syndrome", describing a number of inflicted injuries to children. Through the last 20 years a pattern of child abuse has emerged that involves not only fractures but abdominal injuries, subdural hematomas, contusions, and malnutrition. Little emphasis has been placed on the burned abused child; few articles in the literature specifically deal with this problem. Keen (1975) describes fractures and burns as concomitant injuries, suggesting skeletal x-rays in instances of non-accidental burns. Stone et al (1970) specifically address child abuse by burning and list twelve criteria to be applied to burns which are suspected to be non-accidental. (Appendix A)

Since January, 1974, Stone's criteria have been used to investigate burns admitted to Hillcrest Medical Center, the Burn Center for Northeast Oklahoma. The establishment of a multidisciplinary team to manage and coordinate such cases facilitated identification and assessment of children with inflicted burns. Although Stone and his associates described effective means to recognize non-accidental burns, little is written on the social characteristics which may aid in identification and disposition of such children. The following is a report of our 24-month experience.

THE BURNED ABUSED CHILD

Twenty-seven children with burns received SCAN consultations. All of these children were evaluated because of scalds, unusually acquired burns with unusual distribution, delays in therapy, or burns found incidentally when the child was brought to the hospital for another reason. Of the 27 burns investigated, fifteen were found to be accidental, seven were accidental with extreme degrees of neglect, and five appeared to be inflicted.

The fifteen cases of accidental burns consisted of eight scald burns, two hot grease burns, one case of touching a hot stove or floor furnace, and three flame burns from clothes catching fire. One case turned out to be an infected felon with skin sloughing rather than a burn. In all instances, the home environment of the accidentally burned child was found to be relatively stable with few chronic social or emotional problems. Children demonstrated little or no developmental delays, nor did they display characteristics of withdrawal. There was in every case of accidental burn a crisis within the home which occurred immediately prior to the child's injury. Moderate neglect was noted in two of these cases which seemed directly related to this acute crisis.

ACCIDENTAL BURNS ASSOCIATED WITH EXTREME NEGLECT

Case #1: A twelve-month-old Negro female sustained 75 percent second and third degree burns in a gas heater explosion. A sibling was killed outright. The children had been left alone for an extended period of time while their mother went to do the laundry. Admission hemoglobin was 6 gm percent. After a stormy 25-day hospital course the child died of sepsis. Autopsy revealed only burns and sepsis. The family history included poor home care with a dirty, ill-kept home, little food, and a history of previous neglect. The mother was unmarried.

Case #2: A three-year-old white male was brought to the emergency department presenting a skull fracture from a fall from a dresser. In addition, a two week old 10-15 percent burn of the legs was found, attributed to spilled hot coffee. Social history included a stormy marriage, with frequent beatings of the mother by the father, who was currently in prison. Mother appeared to be manipulative and her responses to the child appeared superficial. The conclusion was that this child sustained an accidental fracture and accidental burns in two separate instances due to lack of supervision and poor social and emotional relationships within the home. The child was sent home under protective services supervision.

Case #3: A four-month-old white male was burned on the legs by hot coffee when a thermos accidentally spilled while he was sitting on the front seat of a car. A five percent burn

of the posterior calf and thigh was noted. This family was previously known to protective services because the father was an alcoholic and had attempted suicide on several occasions. The parents had a history of difficulties coping with the child and were frequently overwhelmed by routine infant care. Both parents were intellectually limited. The child was sent home with protective services supervision.

Case #4: A ten-month-old Negro male was seen in the emergency room with a one week illness with severe pneumonia and iron deficiency anemia (hemoglobin was 6.8 gm percent). Several one inch long burns on the forehead were noted. The child had allegedly "crawled into a heater" Skeletal x-ray survey was negative. The mother was unmarried, and was described as uncooperative and uncommunicative by the nursing staff. The home situation was striking because of filth and lack of food and clothing. The child was discharged to foster care.

Case #5: A fourteen-month-old white female sustained a 13 percent second degree burn when a six-year-old sibling in charge of the care of the other four children placed the patient in a tub of hot water. The mother was twice divorced. Her current male companion was an ex-convict known for a violent temper, who had attempted to rape his own daughter by a previous marriage several months prior to this incident. The living conditions were described as "filthy" and the children were inappropriately clothed for weather conditions. The family had previously been investigated by protective services for neglect. The conclusion was an accidental burn occurring in the presence of a severely neglectful situation. The child was returned home, but because of continued neglect and lack of cooperation on the part of the mother, all children were removed and placed in foster care within six months.

Case #6: A five-year-old Negro female sustained 13 percent second degree burns of the back, buttocks, and left arm when her dress caught fire while she stood in front of an open heater. This was the only source of heat in the home. No effort had been made to protect the child from the heater which was fully exposed at the time of the incident. A children's protective unit caseworker had been involved with this family because of previous neglect, poor physical care, and the family's difficulty in coping with a deaf child. Mother was intellectually limited and had difficulty dealing with basic child care. All her children had been in foster care for six months prior to the incident due to mother's inability to cope. This child was again placed in foster care following discharge from the hospital.

Case #7: A twelve-month-old Indian male sustained a three percent second degree burn to the soles of the feet after climbing out on a hot roof. His mother was a 17-year-old single woman allegedly involved in prostitution. She also was a chronic drug user. The protective unit had received previous complaints from a neighbor concerned about numerous individuals involved in the child's care. The home was described as "dirty", and the child had extremely poor hygiene. The conclusion was accidental burn resulting from neglect, and the child was returned home under the supervision of the Welfare Department.

ABUSE AND NONACCIDENTAL BURNS

Case #1: A six-month-old Negro female sustained a six percent second degree burn of the back when her mother tripped over her and spilled a pan of hot water. Numerous scars and bruises of the face and lower trunk were noted, allegedly caused by an older sibling. The hemoglobin was 8.9 gm percent. X-rays revealed "stress growth rings in the epyphysial area and periosteal new bone formation of the left humerus and both radii and ulnae." A rib fracture which had been missed on the first admission was found. The child was sent home with protective unit supervision, but due to mother's mobility was never seen by a welfare worker. The child returned to the hospital three weeks later with bilateral parietal skull fractures, thirteen rib fractures, and a severe hemothorax requiring chest drainage and transfusion. Mother was recently separated from her husband and presented a very passive response to inquiries by hospital personnel. The child was dismissed to foster care.

Case #2: A seven-month-old white male was found by firemen in a burning home. He showed 15 percent second degree burns to the legs and buttocks from an old scald burn and sustained flame burns of the hands and face from the house fire. On the second day of hospitalization, seizures and coma occurred. A linear skull fracture of the right parietal area was found. A stormy course ensued, and he died on the eighth hospital day. Autopsy showed sepsis, a perforating ulcer, and skull fracture. The history later revealed that the house was set afire by the child's father following a violent argument with the mother over a planned move out of state. The conclusion was abuse with old scald burns, skull fracture, and recent flame burns due to the father's intentionally setting the house afire.

Case #3: A ten-month-old Negro female was presented with blisters of the face, ears, eyes, and right leg—a total of 10 percent second degree surface burn. The mother did not know the cause of the burns. She had placed Tri-Optic drops in the child's ears before putting the child to bed the evening prior to admission. The child was irritable throughout the night and awoke with the blisters present. The child also had scleral and subconjunctival hemorrhages and a contusion in the right frontal area of the skull which the mother reported was due to a fall from the couch two days prior to admission. Hemoglobin was 10.8, skeletal x-ray survey was negative. We felt the child had burns of an unknown cause and eye hemorrhage probably due to trauma. The child was placed in foster care but because of strong pressures from the parents was returned home one week later. Seven days after returning home the child was presented dead on arrival at another hospital. The cause of death was listed as acute and chronic bronchiolitis.

Case #4: An eighteen-month-old female sustained a five percent second degree burn of both hands when she placed her hands in a bathtub of hot water where her mother had been washing dishes. Bruises of the back and strap marks on the thighs were present. The mother was described as uncooperative and very anxious, and had much difficulty agreeing to treatment for the child. She had left another hospital emergency room to come to Hillcrest, initially refusing to cooperate when admission was suggested. The child was finally admitted by court order. The family was known to protective services because this mother had removed, against medical advice, a younger sibling with environmental failure to thrive. The child's hemoglobin was 10.6. X-rays of the chest and long bones were normal. The child was discharged to foster care.

Case #5: A twenty-month-old Negro male sustained a 33 percent second and third degree burn of the buttocks and legs having been placed in a tub of hot water. He had human bite marks on his arm, black eyes, hematomas of the scalp, cigarette burns in the abdominal and pubic areas, and numerous scars on his neck which appeared to be rope burns. He also demonstrated no reaction to pain, and maintained a fetal position responding only with darting eyes or characteristic fearful attentiveness when approached. The child initially had hemoglobin 14.9, probably due to hemoconcentration as his serum iron was 32 mg percent. Later the hemoglobin dropped to 10 gm percent. He had been extensively evaluated in a hospital in another city for failure to thrive the summer prior to his admission in late fall. The conclusion was the child had non-accidental burns, abuse, failure to thrive due to environmental deprivation, and severe developmental delays. He was placed in foster care. Later, parental rights were terminated and he was placed for adoption.

DISCUSSION

Review of these cases emphasizes significant physical evidence which appears to differentiate not only burns due to abuse or neglect from true accidental burns but also to differentiate children with the accidental/neglect burns from those suffering from inflicted burns. The combination of physical findings and psychosocial assessment can provide diagnostic criteria which may enable the multidisciplinary team to assess not only the nature of the injuries, but to aid in determination of a disposition and follow-up expectations.

PHYSICAL EVIDENCE

1. Characteristics of Burns.

The cause of the burns in the accidental/neglect and abuse groups were significantly different. In the accidental/neglect group, two children suffered from flame burns, two from scald burns, and two from burns with a hot object. In the group with the inflicted injuries all received scald burns. One of the abused children had a combination of flame and scald burns.

All but one burn in each group were under 15 percent of total body surface. The distributions of the burns were significant, but only in that they did not appear to correlate adequately with the medical history given. The specific descriptions of burns as those described by Stone and Keen, such as stocking-like distribution of burns on the extremities and burns on the buttocks from radial electric rings or other electrical equipment, were not found. The scald versus flame burn may be a valuable criteria in further differentiating accidental from non-accidental burns.

2. Other Injuries.

Every child in the abuse group demonstrated significant old injuries. The burn was not the first inflicted injury. It is possible that the use of hot water may be the culmination of the abusive pattern. Keen notes that burns and scalds seem to be more calculated and premeditated than injuries produced by sudden outbursts of violence. Scalds coexisting with other types of injuries to soft tissues or with fractures also present an impressive parallel with Caffey's original

example of child abuse. Only one victim was suffering from severe nutritional and emotional deprivation.

In contrast, the accidental/neglect group demonstrated no other physical injuries secondary to the burn. One child had a documented history of accidental skull fracture, and this was the primary injury for which he was admitted. It is significant that all of the children in the accidental/neglect category demonstrated significant poor physical hygiene. Three children were malnourished and two had failure to thrive.

3. Age

The accidental/neglect group in general appeared to be older. The total ranges of ages went from four months to six years, most being over one year of age. In contrast, children with inflicted burns were all under twenty months of age, the majority being under one year of age. It is interesting to note that the oldest child in the inflicted burn group was suffering from the most severe old injuries. He also had profound deprivation and growth delay.

4. Sex.

Both the accidental/neglect and abuse groups were equally distributed in terms of sex. The sex of the child seemed to determine the role that child played in the family. In case #2, the three-year-old male was held in a special position in the family because he was the only boy. The mother had extremely ambivalent feelings about her husband, who was currently in prison and had repeatedly battered her. Consequently, she had mixed feelings about this child, and she gave the child mixed messages about his own self-esteem.

5. Delay in Treatment.

In the abusive group, there was little delay in getting treatment. Because the injuries were cumulative and severe, the parents seemed to panic. Of the children with inflicted burns, two had significant past histories in which documented abuse had occurred; one child had documented failure to thrive.

In two accidental/neglect cases, delay in treatment was noted. Although these children had very extensive burns, the delays were explained in both cases, with "I didn't know the burn was that bad." No children in the accidental/neglect group had a history of previous injury which could have been considered abuse, but five of the seven children had histories of chronic neglect.

6. Concomitant Illness.

Illness, commonly presenting as an acute upper respiratory infection, was a secondary diagnosis in both the abused and neglected children. It appeared that the respiratory ailment did not precipitate the crisis in the neglectful families; these mothers seemed almost unaware that their children were ill until it was pointed out to them during hospitalization.

In the abused children, the illness appeared to precipitate abuse on two occasions. Children were described as irritable, cranky, and unwilling to mind or to be comforted and consequently punishment was exacted accordingly.

7. Severity of Injury.

The most severe, permanent, physical damage was present in the abused children. The multiple nature of their injuries, some of which were more severe than the burns themselves, played a significant role in their long term physical problems. Of the abused children, two died and two suffered serious, permanent physical impairment, while only one child in the accidental/neglect group died and none of the children in the neglected group were permanently physically impaired.

8. Developmental Characteristics.

Three of the children in the abuse categories demonstrated moderate to severe withdrawal and developmental delays documented prior to injury.

In the accidental/neglect group, four children demonstrated developmental delays and behavior which included crying, clinging, and some extreme passivity. It was difficult to say from observing the behavior at the time of hospitalization whether or not this behavior was permanent or transient.

PSYCHOSOCIAL EVIDENCE

1. Precipitating Factors.

In all five cases of physical abuse, the male adult's leaving or returning to the home may have precipitated the abuse. It is interesting to note that although the family dynamics of the crisis which led to abuse appear fairly clear, the identity of the abusive parent could not be specifically determined. In all of the cases of physical abuse there were two adults present, involved in a relationship struggle within the home.

In the accidental/neglect cases, mothers had significant problems with adult relationships, and seemed to have difficulty in maintaining appropriate long term relationships with individuals of the opposite sex. There was no instance in which the adult male in the home identified as paramour or spouse appeared directly involved in the child's injury, although he may have indirectly influenced it by directing the mother's attention away from the child. Chronic patterns of neglect related more directly to the children's mother's lifestyle rather than to the entrance or disappearance of a male figure in the home. The mothers of the neglected burned children tended to live alone.

2. Violence.

In three of the five cases of abuse there was repeated violence in the home, including wife battery. In one case, the mother denied the source of her beatings, although it seemed probable that the adult male in the home was abusing her. One mother denied violence in the home but admitted to heated verbal arguments with her spouse. In the abusive families the violence seems to remain within the home.

In the accidental/neglect group, violence was documented in all seven cases. Some of the violence remained within the home, but a significant portion appeared as outside violent activities, which in two cases resulted in jail sentences for fathers. In one family, the father attempted to injure himself on multiple occasions, and his suicidal gestures seem significantly tied to feelings of being overwhelmed and guilty about his child. This particular father was also alcoholic.

3. Employment History.

No father or male in the home in any of the twelve cases surveyed was employed at the time the injuries took place; only one mother was employed. In all of the families where accidental/neglect burns took place, chronic unemployment problems were present.

In the cases of physical abuse, one-half of the families documented chronic unemployment and the other half documented recent unemployment problems.

4. Mobility.

Only one family of twelve had lived in the same home for more than five months. Interestingly, this particular mother planned to move soon because she and her husband had had multiple marital difficulties and she was again separated from him. Mobility appeared closely coupled with suspiciousness and financial difficulties. In a number of cases, families indicated that they moved because they were unable to pay next week's rent.

The correlation of suspiciousness with mobility was more pronounced in the families who had children with inflicted burns. One example of this was a mother who repeatedly gave false addresses in an effort to discourage any home visitation or evaluation. Three of the five families of children with inflicted burns moved an average of once a month. It is our guess that increased mobility and poor housing may be closely correlated. Most families stated that they paid their rent on a weekly basis. They moved into homes that were poorly kept, but left them in worse condition when they moved out. Their general physical hygiene seemed somewhat better in the abuse group, although one very poorly kept home was described. This parent came from a background which was severely culturally deprived and reported that he lived this way as a child.

Substandard housing was present in all cases involving accidental/neglect. In one case the home was described as being extremely dirty--the floor covered with human and animal feces, numerous dishes filling the sink, overflowing stopped-up toilet facilities, unwashed dirty diapers, great piles of newspapers on the floor, and vermin present in the home.

5. Maternal Behavior Characteristics.

Severe emotional illness was not obviously prevalent. In evaluating the attitudes of the mothers of the abused children, some severe difficulties with parenting and general difficulties in forming adult relationships were seen, but symptomatology did not require immediate psychiatric hospitalization. Keen stated that because injuries such as burns appear to be "more calculated and premeditated than injuries produced by sudden outbursts of violence, a higher proportion of psychopathic parents might be expected in this group."

Mothers of the children with accidental/neglect burns were presented as: depressed-overwhelmed (28%), fearful-defensive (43%), or manipulative-sociopathic (28 percent). The mothers that appeared to have the most empathic responses to their children were those in the depressed-overwhelmed group. These mothers seemed to be reacting to their own low self-esteem and tremendous feelings of lack of control.

Mothers in the fearful-defensive group seemed less responsive to their childrens' needs and more concerned with their feelings of loss of control. They appeared to handle feelings of helplessness with anger. They seemed to have a great need to "appear" to be adequate and were

very defensive when it was suggested that they might have played a significant role in their child's injury. This need to maintain appearances was often egocentrically based and at times was an obstacle to these mothers' ability to pick up cues from their children.

The manipulative-sociopathic group appeared generally superficial, both in their responses to their children and to hospital personnel. Mothers attempted to say and do the socially acceptable things, but appeared to have no depth of commitment to carrying out their own responsibilities in regard to their children. We felt the most uneasy about this group because of the lack of maternal responsiveness to the child's needs. It is interesting that one child in this group who was returned home with supervision never returned for a follow-up medical appointment although her mother repeatedly assured the staff she would return. She also moved within three weeks of the child's discharge and since that time has not been located. A second mother was unable to change her patterns of chronic neglect and eventually all of her children were permanently removed.

Abusive parents have been described as isolated, suspicious, rigid, dependent, and immature (Helfer and Kempe). The lack of what Steele (1968) calls "empathic mothering" is an important indicator in assessment of these children. The severity of non-relationship was significant in all of the abusive mothers. Maternal characteristics in the inflicted burn group seemed directly related to difficulties with the bonding process. In every case, the parents appeared to be responding to their own needs, either through passive withdrawal or through hostility.

Mothers in the passive-withdrawn category were described as non-verbal, extremely passive, and strikingly lacking in affectual responses, not only to children, but to others around them. They reacted with avoidance rather than dealing directly with their child's needs.

The hostile mothers presented anger in a very defensive way. These mothers tended to be rigid and saw a question of etiology of their child's injury as an assault on their individual rights and identities as parents. One mother in this category stated, "You have no right to take my child; think of how it will make me look". In general, abusive mothers appeared much more difficult to reach emotionally than their neglectful counterparts.

6. Maternal Backgrounds.

In both abuse and neglect cases, mothers described their childhoods as chaotic. In the accidental/neglect group, two mothers came from culturally deprived environments, and five came from emotionally disturbed homes fraught with divorce, alcoholism, and emotional, if not physical, abuse. In the abusive group three mothers came from emotionally disturbed homes, and two from culturally deprived environments.

DISPOSITION

After evaluating both physical and psychosocial characteristics of these children and their families, the question must be now can this information be used in an effort to identify future cases and to determine the best course of action for the child and, secondarily, for the family? The 40 percent mortality of the abusive group and the severity of the other children's injuries suggest that the abusive pattern may have been well ingrained at the time of the burn. Inflicted burns appear to require some premeditation. This fact in itself places a poor prognosis when these children are returned to their homes. Both children who were initially removed from their homes and then returned appeared again at the hospital, one dead and one severely battered. These families have been some of the most difficult and uncooperative of all the cases of abuse. We cannot overstress the need for intensive intervention with these volatile families.

Disposition in the accidental/neglect cases holds a still grim but somewhat more hopeful outlook. In this group one child died as a consequence of his burns. Two of the children were initially placed in foster care; one of them has returned to his home, and physical conditions within the home have improved. One child remains in foster care and is presently being considered for alternative long-term placement. Four children went home with supervision. Of these four, two had mothers who were categorized as manipulative-sociopathic. Mothers with these personality types had much difficulty changing their patterns of behavior.

PREDICTION

In cases of burns due to abuse, 60 percent were known to the children's protective unit prior to the burn incident. On two occasions previous abuse had taken place in the home. In one case, the child was known to be suffering from severe failure to thrive.

In the accidental/neglect burns, five out of the seven families were known to the protective unit and had been investigated because of neglectful conditions. Intensive treatment

might have prevented future abuse and neglect. When protective unit facilities function on a crisis basis and lack the man power to be able to provide intensive services for these types of families, prevention is not possible. Children in these families need long-term follow-up by both medical and social agencies to insure their safety and adequate growth. Dealing with these families in a time of crisis is not sufficient. Active investigation, coordination, and responsible dispositions are necessary.

CONCLUSIONS

Our experiences show that inflicted burns are among the most serious crimes against children. There appear to be significant physical characteristics, including type of burns, burns with other injuries, and distribution of the burns, which may aid the diagnostic team. Social characteristics such as high mobility, history of unemployment, and unsanitary home conditions may further serve as assessment indicators.

The final question is, "What are the effects of such trauma on these children?" In a series of French follow-up studies on abused children, which included children in foster care and in their natural homes, 20 percent carry physical marks of inflicted injuries, 43 percent have moderate emotional difficulties, and 10 percent have grave emotional problems (Straus and Girodet, 1976). Only time will tell whether or not these abused and neglected children will become the abusive and neglectful parents of tomorrow. Burns in children can no longer be considered a purely surgical problem. Evaluation of such children opens a panorama of medical, social, and emotional factors in assessing burns as abuse.

APPENDIX A

Criteria for Suspected Burn Abuse (Stone, 1970)

1. Multiple hematomas or scars in various stages of healing.
2. Concurrent injuries or evidence of neglect such as malnutrition.
3. History of prior hospitalization for "accidental" trauma.
4. An inexplicable delay between the time of injury and first attempt to obtain medical attention.
5. Burns appearing older than the alleged day of the accident.
6. An account of the incident not compatible with the age and ability of the patient.
7. Responsible adults alleging that there were no witnesses to the "accident" and the child was merely discovered to be burned.
8. Relatives of the parents bringing the injured child to the hospital.
9. The burn is attributed to action of a sibling or other child (this does in fact occur).
10. The injured child is excessively withdrawn, submissive or overly polite, or does not cry during painful procedures.
11. Scalded hands or feet, often symmetrical, appearing to be full thickness and depth, suggesting extremities were forcibly immersed and held in hot liquid.
12. Isolated burns of the buttocks which in children could hardly be produced by accidental means.

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Alcoholism, Drug Abuse, and Pregnancy: Causative Factors in Child Abuse and Neglect?

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The role of alcohol, drug abuse, and pregnancy in the causation of child abuse and neglect is only beginning to be explored by authors in the field (Mondanaro, 1976; Klaus and Kennell, 1976; Kempe and Helfer, 1976). The effect of alcohol use on the fetus in a pregnant woman has recently come to light (Chafetz et al, 1971; Hindman, 1975; Jones and Smith, 1973). The use of heroin and other opiate-like drugs has been more energetically explored (Carr, 1975; Mofenson, 1974). Attitudes toward child-rearing held by women who are pregnant and concurrently are drug users have been documented by a handful of researchers.

All communities, large and small, have a select population of pregnant women who ingest drugs—prescription, over-the-counter or street—at least once during their pregnancy, other than at, or about, the time of delivery (Arms, 1975).

Growing research regarding drug-related effects on the fetus is coming to light (Shre, 1970; Wilson, 1972). The teratogenic effects of thalidomide are well known. Warnings in medical journals regarding the use of particular medications during pregnancy state "Weigh potential benefits against possible fetal hazards" or "Safety for use in pregnancy has not been established."

Accumulating research in the field of child abuse is beginning to relate the problems of children in families to substance overuse or abuse. In reviewing some of the dynamics existing in families where there is abuse and/or neglect, it follows to discuss how drug use affects parental behavior.

The general characteristics of a high risk abuse situation are generally agreed upon. There is a parent with the potential to abuse, a child that is seen as "special" or "different", a "crisis", and a spouse who is unsupportive or absent.

Many abusive parents were abused or neglected themselves as children. Most have low self-esteem. Most are socially isolated, mistrustful, and have no "life-lines" or resources during times of crisis. A large percentage of parents have unrealistic expectations for their children. There is often poor communication within the relationship with the spouse/partner. Some are punitive disciplinarians, some have poor impulse control. Controlling anger is particularly difficult.

The addicted woman, whether or not she is pregnant, is often a product of battering. Within her family setting, both as a child and as an adult, household violence is common. This results in poor self-worth and a deep sense of personal inadequacy. She is frequently exploited by her addicted partner. He pushes her into prostitution, or demands she traffic the drugs, for her involvement in his habit and its support reduces her criticism of him and decreases the guilt caused by objectional behavior. The work of several authors reveals that these young women who turn to drug use are neither cognitively (knowledge regarding family communication and child-rearing tasks) nor affectively (emotional inner resources and sense of adequate self) prepared to parent without overwhelming difficulties. Added to this situation is the resultant drug-addicted baby whose medical problems necessitate the infant's separation from mother and placement in a neo-natal intensive care unit. The sick infant does not meet parental expectations as the "cute, cuddly, responsive" child they anticipated. Augmenting this problem, the infant addicted to opiates and opiate-like drugs is an irritable baby, more comfortable at rest than being handled. This baby cannot respond positively to the common parental attempts to love, caress, and feed the infant. The attempt at bonding (Klaus) has been disrupted and low self-esteem, personal inadequacy, and rejection have been reinforced in the new parent/addict. Emotional distance as a response to the infant's "rejection" can easily result in social distance, and future attempts to "re-attach" may be undermined.

Drug abuse in families is gradual. It is often unrecognized as a problem until it is unmanageable for both parents. Then not only the marital relationship is involved but the children and their safety as well. The use of depressants and/or sedative-hypnotics (alcohol, Valium, barbiturates) decreases impulse control and increases aggressivity. Initially it can exaggerate self-esteem and then rapidly lower it (depressant effect). It will exaggerate sociability and then rapidly create feelings of social isolation. Judgment and decision-making capacity are impaired. Chronic use of alcohol can lead to a psychotic state (Korsakoff's psychosis) with its amnesia and subsequent confabulation (making up facts to fit into the bits of memory retained) in order to fill-in the memory gaps. Over time these people become so socially isolated that old friends observing their alcohol problems are no longer around to be "life-lines".

The use of heroin and other opiates or opiate-like drugs is more complex, for overlaid on the drug problem is the illegality. In addition to problems already mentioned in the addicted pregnant woman, heroin use in a family is a fully encompassing pastime. It is well confirmed in the drug field that the drug addict is "never bored", but always involved with the cycle of "fix", "hustle", "jive", "hit", "meeting the man", and "nodding out". The mood swings, as they actually affect children, appear to be those of lassitude and "don't bother me" and "paranoia"—both seeking an impossible goal (delusion) and being sought. The potential for neglect seems to be more the risk here than in the family with an alcohol problem, wherein abuse, neglect, and incest have been frequently described.

Concise as this over-view has been, it proposes some original thought and leaves many questions unanswered. It will be of crucial importance to continue multidisciplinary efforts in the areas of training both drug workers and protective service workers alike and in research in order to obtain skills and share information that will aid in the care of the family—both parent and child—all victims of abuse and neglect.

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Treatment

Is Child Abuse Treatable?

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THE MODES OF TREATMENT

I know of no shortcuts in the "treatment" of families with abuse problems. In fact, it can be dangerous and a waste of energy to make blanket statements concerning the best kind of "treatment" for certain persons.

The word "treatment" is in quotes because I am uncomfortable with what it implies. Treatment implies that by curing a specific ailment there is a beginning and end to certain symptoms. Child abuse is a symptom of a malfunctioning parent-child relationship caused by a complex network of factors. I am not sure we can assign a beginning or end to symptoms. To clearly define an abusing family's unique network of factors, we must transpose them onto a background which will magnify and more precisely delineate the factors. A backdrop must be provided against which this intricate network can be studied, and which can help alleviate present problems and eventually prevent further malfunctioning. What is this background or backdrop?

Let me return to the family structure of past generations. The community and older generation formerly assumed responsibility for helping young persons raise their children. This extended family had drawbacks, but it provided some basic and necessary resources and a support system for the "new" family. Becoming a new parent signals the transition from the fantasies of childhood to the realities of parenthood. Parenting is a growth process. The family is a dynamic, changing set of circumstances and relationships. It is never static. The extended family provided long-term, transitional support for the new parents and children. By providing a sense of roots, the extended family helped stabilize the young family, offered vital "on-site" information about children, and provided some parameters and expectations for parental behavior.

In today's society parents are isolated from the older generation, and the communities of the past no longer exist. Today's parents are alone and without resources in raising their children. At best, our young families live on a street in suburbia where all parents are the same age, as are their children! This helps create an atmosphere of destructive competition between parents (Whose child walked first? Whose child shares best?) and increases their insecurities and anxieties regarding their parenting skills. Can this not precipitate abuse?

I feel the vast majority of parents who abuse their children do not need a cure. They need a system which provides long-term transitional support during their growth as parents. This system must be available to all parents, not solely to those with "diagnosed" problems of child abuse. This system becomes the background upon which parenting can be viewed. Only then can the contributing factors of child abuse be seen more clearly. We may then be able to define more specific modes of treatment.

Yes, there are families who, at present, are untreatable. I have not found the diagnostic tools with which to quickly and clearly identify them, and time is important when dealing with these families. These diagnostic tools can and will be developed when the family has this system of support.

FOCUS OF TREATMENT

In my experience I have found this transitional support has three important aspects:

(1) Parents must have an opportunity to resolve or at least cope with the conflicts, feelings, fantasies, and stresses which interfere with their ability to assume parental responsibilities;
(2) Parenting is a growth process, and parents must have quality nurturing to grow; and
(3) Parents must have an opportunity to learn about children.

These three components cannot be offered in a fractured, uncoordinated, band-aid fashion. The components must function continuously and be well-integrated. Unless they are well-nurtured and their conflicts and stresses alleviated, parents cannot learn about children's behavior. Then, over time, family members can begin making changes to enhance parent-child relationships. This will, in turn, help make family members more productive and their lives less stressful.

We have made commendable efforts in understanding and treating child abuse. There are programs and agencies that can help many families. Unfortunately we do not have enough programs, and too many families are not reached. These programs seem destined to remain inadequate simply because funds are limited. The coordination of services among these agencies and programs is, at best, incomplete. At this time, service coordination may be an impossible task. Staff "burnout" is high, and funds are depleted.

Where do we go from here? What can be done to continue treatment and prevention of child abuse on a larger, community-based scale? Where can we find the backdrop on which to view parenting and more clearly define the factors of abuse?

We must look closely at existing schools and child-care programs. We must look at all the alternatives, including supplementary and educational care for children (hospital prenatal classes, infant day care, elementary schools, high school counseling, etc.). Is there an existing system which can help families? School and child-care program staffs are already providing counseling and support. What could be done if these staffs are given additional training and support! These staffs have daily, ongoing, long-term contact with families, and these programs are a daily part of our "healthy" community. Most existing child abuse treatment programs are now designed exclusively for "problem people." These schools and child-care programs are an accessible system for easy referral and coordination of services.

During the 15-20 years I have been involved with schools and child-care programs, I have seen the potential effectiveness of this approach. It can alleviate the symptoms of child abuse and provide necessary transitional support. I think it deserves serious consideration as an approach to the treatment and prevention of child abuse.

Some Treatment Issues in Child Abuse

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The major objectives of a child abuse treatment program are to create a safe environment for the child and to modify the potentiating factors underlying maltreatment. Therefore, an effective treatment program must deal specifically with the personality traits of the parents that contribute to "abuse proneness," the environmental stresses which increase the burden of child care and trigger the abusive interaction, and the characteristics of the child which make him vulnerable to abuse and scapegoating.

An ideal program should provide parents and children a broad, comprehensive, and relevant spectrum of services in order to strengthen and maintain the family constellation. This requires a multidisciplinary team approach, geared to provide the maltreating families with a wide variety of home-based comprehensive services. The Comprehensive Treatment Program for Abused Children and Their Families at the Downstate Medical Center includes staff from the Departments of Pediatrics, Psychiatry, Social Services and Nursing. The program is coordinated by a child psychiatrist and psychiatric social worker. The following is a description of the program.

A. Intervention with parents designed to modify their impulsivity and abuse proneness.

1. Individual therapy and/or counseling

The crucial ingredient in this process is the involvement of the parent in a corrective emotional experience with an accepting, gratifying, and uncritical worker. The helping person need not be a psychiatrist or physician. Social workers, nurses, parent-aides or volunteers who have mothered successfully may be trained to help these parents. This process consists of:

a. Helping the parent establish a trusting, supportive and gratifying relationship with the therapist and other adults;
b. Helping the parent improve his chronically devalued self-image;
c. Enabling the parent to receive satisfaction from his own accomplishments and from contacts with others so that he will no longer depend on his children to bolster his self-esteem;
d. Providing the parent with a positive child-rearing model for identification;
e. Enabling the parent to derive pleasure from the child, and increasing the parent's capacity to "give" (love, warmth, attention, etc.) to the child so that the role reversal will be eliminated;
f. Providing the parent with basic information about child-rearing and child development. Special counseling will be made available to parents of vulnerable children with physical, emotional, and intellectual impairment; and
g. Helping the parent understand the relationship between the painful experiences of his own childhood and his current misperception of the child.

2. Group Therapy

Group therapy is available to some mothers receiving individual psychotherapy as an additional therapeutic modality, or it may be offered as the major form of treatment to some of the mothers not involved in a one-to-one therapeutic relationship. Mothers' groups may operate in both the day-care facility and in the outpatient treatment facility. Group therapy for both parents, or for fathers exclusively, might be appropriate for certain families.

Groups are led by treatment staff members who are experienced in group psychodynamics and treatment. If possible, two leaders, a male and female, are assigned to each group in order to duplicate a family constellation with two parents. Group therapy can be useful to abusing parents in the following ways: It may act as a bridge to therapeutic involvement in extremely defensive and mistrustful parents who are threatened by a one-to-one relationship. The realization that their problems are shared by

others tends to diminish their guilt and low self-esteem. The permissive atmosphere of frank and open discussion facilitates the expression of long suppressed personal feelings, and reduces vulnerability to criticism; and the establishment of personal ties with other group members fosters social contact with others. Group therapy is often the treatment of choice for abusing fathers, who are notoriously reluctant to seek help because of their difficulty in acknowledging passive-dependent wishes.

Self-help groups, such as Parents Anonymous, have benefited individuals who are more comfortable in a peer-group milieu divorced from an organized treatment center. This group might also serve as an after-care facility in the community for those parents who successfully terminate their outpatient treatment.

B. Alleviation of Environmental Stress

This can be accomplished by eliminating the discrepancy between the limited child-rearing capacity of the family and the increased child-rearing pressures by providing help with direct child care. Child-rearing advice, based on an understanding of the child's physical and psychological development, will counter inappropriate parental expectations for precocious or unrealistic performance. Homemakers may be assigned to the families when appropriate, as well as routine visits by nurses. The availability of day-care facilities for infants and preschool children will relieve child care burdens and facilitate identification of pathological deviant traits which would increase a child's likelihood of being abused. Availability of the treatment staff for emergencies on a 24-hour basis, and use of a hotline will help defuse crisis situations and strengthen the therapeutic alliance. Routine home visits by nurses and other staff members permit a better understanding of the family environment, psychodynamics, and the special needs of each family member. This outreach component of the program insures ongoing therapeutic contact with families who have difficulty in participating voluntarily in an outpatient setting.

Since the child-abusing population in the inner cities is characterized by poverty, low socioeconomic status, and family disorganization, a vigorous social service input is necessary to secure adequate food, clothing, housing, and other essential services.

C. Treatment of Abused Children

Despite the documentation of severe developmental and psychological sequelae of abused children, the subject of psychiatric treatment for these children has been virtually absent from child abuse literature. Outpatient psychiatric intervention with abused children is an important component of Downstate's treatment program. These children are characterized by typical symptoms, personality traits, and defects, which include a basic mistrust and suspicion of others, low frustration tolerance with impulsivity, a need for immediate gratification, intellectual and cognitive impairment, and developmental lags, often in speech and language. They frequently demonstrate violent and aggressive behavior, and are preoccupied with fantasies depicting scenes of physical attack, spankings, and retaliation. They also exhibit depressive affect with a poor self-concept, and a proneness towards self-destructive fantasies and behavior. When abused children reach school age, they invariably demonstrate major academic and behavioral difficulties.

D. Treatment Objectives for Abused Children

The initial goal of intervention with abused children is to prevent further maltreatment and scapegoating, which may be accomplished by strengthening parental functioning where possible, or by temporary removal from the home if the abusive environment proves refractory to change. The delivery of crisis-oriented comprehensive psychiatric, social, and medical services to abusing families in order to maintain the integrity of the family unit and secure the safety of the children must precede or accompany any direct psychotherapeutic involvement with the abused child.

Once these children are safe, every effort should be made to reverse the serious emotional and cognitive impairment associated with their traumatic life experiences. A wide range of psychotherapeutic and educational techniques have proven successful in reducing the deficiencies and symptoms of abused children. Psychoanalytically oriented play therapy and psychotherapy have been used effectively in Downstate's treatment program for abused children. Certain modifications of therapeutic technique are required to deal with the high incidence of developmental deviation and psychopathology present in abused children. Their ego deficits and cognitive impairment require an emphasis on ego integration, reality testing, containment of

drives and impulses, and strengthening of higher level defenses using techniques similar to those applied to borderline and psychotic children.

Without therapeutic intervention, the abused child will perpetuate the traumatic condition by projecting his struggle with internalized bad parents onto new objects in his environment. Therefore, once the abused child's personality is formed, modification of the traumatic home conditions may not be sufficient to reverse his maladaptive behavior. This is illustrated by the large number of abused children whose aggressive and provocative behavior contributed to their expulsion from foster homes which provided them with adequate parental figures and material supports.

E. Effectiveness of Treatment

There has been considerable controversy about the efficiency of rehabilitating abusive parents. Although Helfer (1975) and Pollock and Steele (1972) report a success rate of 70-80 percent of abusing families, others like Young (1977) are pessimistic about the ability of these parents to change. The latter group would rely on placement of the children as the major therapeutic modality. In Downstate's treatment program, criteria for a successful therapeutic result with the abusive parents include cessation of physical abuse and neglect, increased capacity to provide nurturance and protection to the children, and an ability to derive gratification from child-rearing activities. While the first goal was often attainable within several weeks or months after entering the program, basic improvement in parental functioning occurred in three-fourths of our patients, and took one to two years to achieve.

The following characteristics of abusive parents may interfere with a successful treatment outcome:

1. Their suspiciousness and mistrust resulting from their life-long experience of humiliation and criticism at the hands of their own parents and authority figures;
2. Their narcissism and fragile self-esteem which causes them to regard therapeutic exploration and counseling as critical and accusatory;
3. Their masochism and provocativeness reflect an unconscious need to turn the therapeutic relationship into a repetition of their victimization by parents and spouses;
4. Their resistance to therapeutic intervention with their abused children is based upon the threat of change in their special relationship with these children; and
5. The impact of ongoing investigative and punitive procedures inhibits the establishment of a confidential and supportive relationship with the therapist. The problem of confidentiality may be handled by divorcing the child-protective services and court-related activities from the therapeutic process. Psychiatric evaluations required by the agencies or the court should be performed independently by their own personnel if possible. Experience has indicated that reporting, investigation, and supervision of abusing families by agencies and the courts are incompatible with the establishment of a therapeutic relationship. Therefore, child protective agencies and family court personnel should not be expected to provide rehabilitative services to their clients.

Additional obstacles to treatment are determined by personal attitudes and feelings elicited in therapists by abusive parents and the act of child abuse itself.

1. The tendency of the therapist is to condemn a parent who would intentionally injure an innocent infant or child. The primary therapist, as well as the entire treatment staff, must learn to control feelings of anger and self-righteous indignation;
2. The therapist tends to overidentify with a "good" parent, in order to rescue the child from a threatening situation. These rescue fantasies are often accompanied by an attempt to "reform" the abusive parent. Such attitudes are incompatible with the establishment of a therapeutic alliance; and
3. The infantile, demanding qualities of the abusive parent often disturb the therapist, especially when the parent displays hostility and lack of commitment to the treatment process. These parents fail to keep appointments and seem unappreciative of the time and energy invested in their rehabilitation. Their behavior poses a threat to the narcissistic gratification of the therapist.

These obstacles to treatment posed by the nature of child abuse, and the characteristics of abusing parents and their adverse impact on the treatment staff often combine to insure therapeutic failure. A small percentage of abusing parents refuse treatment or will only participate in a program if mandated by the court. Nevertheless, the majority of abusing parents can be treated. The alternatives of termination of parental rights with placement of the children in foster homes and institutions is usually more costly from both an economic and psychological point of view. Abused children usually manifest serious psychiatric impairment and may adjust poorly to placement. In addition, the quality of institutional and foster care leaves much to be desired, and in many cases may damage the child more than the original home environment. Foster parents vary immensely in their child-rearing capabilities, and it is not uncommon for abused children to receive additional maltreatment in foster homes. A high "turnover rate" of abused children in placement has also been reported. When placement is effected, the therapeutic focus shifts from the natural parents onto the child and his new milieu.

The following sequelae have been frequently observed after removal of one or more children from abusing parents, due to changes in the psychodynamic equilibrium of the family:

1. Depressive reaction: the separation from children, regarded as need-fulfilling objects, constitutes a significant object loss for the parent;
2. Search for a new "scapegoat:" any child remaining in the home may be used as a replacement for the previous "scapegoat." The parent's unacceptable wishes and attributes are very threatening, so they must be projected onto another child or spouse;
3. Increased conflict with spouse: the spouse of the abuser often assumes the role of "scapegoat" formerly held by the abused child. The nonabusing spouse blames the abusing partner for the loss of the children. The increased friction between parents often leads to separation; and
4. Pregnancy: the typical mother of an abused child becomes pregnant within a year after placement of her child(ren). This urgent need to have a baby is a means of coping with the depression resulting from the loss of her children.

CONCLUSION

The placement of dependent children in institutions and foster homes and subsequent changes of caretakers poses major problems of adjustment for the children, parents, and fostering individuals. Therefore, the use of placement as a major therapeutic intervention in maltreating families is recommended only as a last resort. The vigorous deployment of crisis-oriented social and psychiatric services to these families should be the main therapeutic modality, with emphasis on home involvement. Maintaining the stability and integrity of abusing and neglecting families where possible should be the primary focus of treatment. This type of service delivery can also save considerable sums of money by sharply reducing the number of children requiring placement and by reducing the length of hospitalization for maltreated children ("boarder babies"). Such hospital-based treatment programs, like Downstate's comprehensive treatment program, are inexpensive to maintain because they largely rely on existing personnel from the Departments of Psychiatry, Social Service, Pediatrics, and Nursing. These centers could be self-supporting if third party payments could be recovered and diverted back into the program.

If placement of maltreated children should prove necessary, more vigorous social service and therapeutic involvement with natural parents and children is warranted. Better training and education of foster parents is also required. In our experience, the prospective foster parents have little or no knowledge about the special problems and difficulties maltreated children will pose for them. In some cases, foster care agencies deliberately conceal major cognitive and emotional difficulties of the children so as not to jeopardize their chance of placement.

Since placement of abused children not only fails to solve the original parental problems, but contributes to additional sequelae, providing parents with ongoing social and therapeutic services is essential for strengthening their child-rearing capacity. This is likely to be tested by new offspring or by the eventual return of their maltreated children from temporary placement.

Finally, therapeutic intervention with the abused children is often indicated whether they remain at home or in foster care. The younger children may benefit from such services as special nursery or day-care programs, while many school age children can utilize psychotherapy to good advantage. Psychological assistance might be indispensable in helping these children adjust to the stress of separation, placement, and readjustment to unfamiliar family environments.

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The Medical Role in the Management of Child Abuse and Neglect: Realities and Dilemmas

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The abuse and neglect of children is complex and disturbing. Many physicians and nurses experience difficulty approaching this problem with the same logic and order with which they approach other complex child development and family problems. The distress associated with thinking about child abuse can be expressed in denial; we may fail to consider the possibility of maltreatment and limit our activities to treating the child's injuries. And when we suspect child abuse or neglect, our uncertainty and worry about how to deal with the family may lead us to ignore our legal responsibility to report the case findings to the mandated protective agency. If we report, we may assume we have passed the buck and are no longer obligated to the child and his family.

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

WHAT IS CHILD ABUSE?

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

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

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

Maltreatment need not be willful, but this does not mean that a parent's anger, expressed actively or passively toward a child, is not primary in many child abuse and neglect cases. Abusive and neglectful parents may have excessive and premature expectations of their children, and believe in the value of physical punishment to correct undesirable behavior. Often the angry feelings, of which the child's condition is a symptomatic expression, are derived from the violent circumstances or deprivation of the parent's own upbringing, and may reflect a deep disappointment that the child has not met the parent's own dependency needs.

PHASES IN MANAGEMENT OF CHILD ABUSE AND NEGLECT

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

The phases in the management of child abuse and neglect are summarized in Table 1.

Table 1

PHASES IN MANAGEMENT OF CHILD ABUSE AND NEGLECT

Phases in Management	Primary Considerations	Interventions to Protect the Child and Help His Family
A. Diagnostic Assessment 1. Medical History 2. Physical Examination 3. Skeletal Survey 4. Laboratory Tests 5. Photographs 6. Consultations for evaluation of family dynamics and child development	Are the physical findings at variance with the history? Is child abuse or neglect suspected? What is the legal responsibility regarding suspected child abuse? Is the home safe for the child? Is the child "at risk"? What is needed to make the home safe for the child's return?	Provide more comprehensive medical workup. Inform the parents of the suspicions and the physician's responsibility to protect the child. Make a report to the mandated agency. Continue the evaluation on an out-patient basis. Hospitalize the child for protection and further evaluation. Arrange for multidisciplinary conferencing for disposition planning.
B. Rehabilitation Program 1. Health Needs 2. Physical, Social, and Environmental Needs	What resources will meet the needs of the child and his family?	Arrange for primary health care and appropriate treatment for the child and family. Mobilize community resources (e.g., child care, homemaker services, foster home placement, etc.).
C. Follow-up Planning 1. Medical Care 2. Social Work Services 3. Nursing Services 4. Other Services	Who will monitor the health and community services to the child and his family?	Provide coordination and integration of helping resources.

In child abuse and neglect, the diagnostic assessment involves compiling an adequate medical-social history and completing a physical examination, including an assessment of the child's development. If the physical findings are at variance with the history, a more comprehensive medical workup, including a skeletal survey and laboratory tests, may be needed. If child abuse is suspected, photographs often are taken of the child's injuries. Photographs are not always necessary, however, and may be contraindicated if the family views them as part of an interrogatory and alienating approach to their problems with their children.

The physician is dually responsible for offering necessary emergency treatment and protection to the child, and to address the parent's distress. The physician must emphasize to the parent the child's need for treatment and protection, which may include admission to a hospital, and demonstrate concern and ability to help the parent through the crisis. No attempt should be made to elicit a confession from the parent. Such maneuvers hamper gathering of vital information and fostering of a helpful professional relationship. Interviewing the parent can be difficult and vexing for medical staff, who may feel anger toward abusing and neglectful parents. One must remember these parents may have been abused or neglected when young, and may follow the same pattern in raising their own children.

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

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

In explaining his legal obligation to report suspected child abuse under state law, the physician's compassion and honesty will help allay parental anxiety. The parent must know what actions will result from the physician's report to the child protective agency.

IMPLICATIONS OF CHILD ABUSE REPORTING STATUTES FOR CLINICAL PRACTICE

An accepted tenet of child abuse management tells professionals to be compassionate, and to convey to parents their interest in helping maintain family integrity. However, child abuse reporting laws may force us to make onerous and heavily value-laden judgments about families. Additionally, the perceived effect of reporting is to begin operation of a quasi-legal mechanism which, while nonpunitive in theory, may be opposite in practice. In some states, reported parents may be jailed.

Professionals may thus be torn between their legal responsibility to report and their clinical judgment which suggests that reporting may jeopardize the opportunity to develop a satisfactory family treatment program. This conflict often is reticently expressed upon informing families they are being reported, or by reluctant or even frank refusal to report cases of abuse and neglect.

While no clear-cut rules exist which definitively resolve this conflict, two simple guidelines make it easier for the mandated professional to rectify his legal responsibility and clinical judgment:

1. The professional must tell the family a report is being filed. Much of the apprehension which surrounds this notification can be alleviated by explaining the reporting process to the family. It does not necessarily mean the child will be taken away or that a court hearing will be held. The reporting process can be best explained as a referral of the family for services, and an explicit acknowledgement that they have a serious problem in protecting their child, which others, including the reporting practitioner, can help solve; and
2. The mandated professional can explain that the practitioner is bound by law to report suspected child abuse and neglect.

Often, rather than reacting hostilely, families greet the news with relief. The reporting process may procure help they have long sought. Reporting may relieve parents because concerns about their parenting abilities are finally out in the open where they can be dealt with straightforwardly.

While such an approach to child abuse reporting may palliate the anxiety of the professional and the family, it does not remove the real, inherent labeling and stigma of the reporting process as it exists today in most of the states. Unfortunately, this is a problem which cannot be alleviated simply by revising the process. Rather, it is an aspect of our society's perception of child abuse and the abusing parent. So long as society views child abuse as a form of radically deviant behavior and a symptom of pathology and sickness, the stigmatizing process will continue. All who are concerned with prevention and treatment of child abuse must, therefore, destroy the myths surrounding it, and recognize that we all have the potential to act "deviantly." Until attitudes and policies change toward troubled families, whose children may bear physical signs of their distress, we shall have to work within the prevailing legal framework and ensure, to the extent possible, that children and families are helped—not harmed—by it.

All state statutes abrogate privileged communication when it involves a case of known or suspected child abuse. In reporting to mandated state agencies, the reporter should identify only the facts. Hearsay and secondary source information should be labeled as such. Most states have statutes that provide for central registers, which may store both founded and unfounded information, depending on the expungement provisions of the statutes. The state determines who has access to this information, and one must remember that information submitted in such reports may be used later in considering the competency of a family or risk to a child.

The principle on which most prevailing statutes are built is that services should be available to families in which child abuse has been reported. The professional who reports a suspected case must remain involved in order to ensure appropriate help is given, and that the family does not "fall into the cracks" of the service structure.

CASE MANAGEMENT

A report of suspected child abuse or neglect is assigned to a protective agency worker for investigation of the allegations, determination of the family's needs, and provision of appropriate services. The first issue considered must be whether or not the child can remain safely in the parental home. The decision-making process must answer the following questions: Do child and family need protective services? Is immediate action needed? Should the child enter protective custody? Should the child leave the parental home? Is court involvement necessary?

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

In the past, the protective agency's activities often involved removing the child from the hazardous home. The book, *Beyond The Best Interests of the Child,* emphasizes the need for choosing the "least detrimental alternative" when deciding on appropriate child protection. This concept suggests that professionals must consider the impact on the child's development in any decision affecting his family. Studies show that foster home and institutional placements often result in long-term damaging effects on children and their families. Therefore, a child should be separated from his family only after evaluation reveals he could likely be reinjured, and time is needed to activate the necessary supportive services for the troubled family.

Divergent opinions exist regarding hospitalization of children whose conditions do not medically indicate admission. The American Academy of Pediatrics Committee on the Infant and Preschool Child advocates hospitalization as a means for providing the necessary time and resources for complete diagnostic evaluation. Additionally, until a more thorough evaluation is made, the hospitalized child is protected. Every hospital should formulate a policy concerning admission of suspected abused or neglected children. Whatever policy is adopted, it should be coordinated with the local child protective agency. Some state statutes allow physicians or hospital administrators to admit a child to a hospital without parental consent. This requires a court order which may be obtained by telephone and justified the next court day. However, if parents are treated with sensitivity and honesty, most physicians should not have difficulty convincing them of the need to hospitalize the child.

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

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

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

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

In handling abuse/neglect, intervention is more effective if the dynamics of the abusive pattern are understood. It has been found that many abusive parents, as children, experienced very traumatic experiences frequently involving abuse or neglect. In essence, they may raise their own children similarly. Abusive parents not only often demand excessive performance from their children, but also ignore the children's own needs, limited abilities, and helplessness. Children often are perceived as being different from siblings and other children, may fail to respond to the expected manner, or possibly they are different (e.g., retarded or hyperactive). Crises stemming from personal, social, economic, and environmental stresses play a crucial role in family life, and often precipitate abuse.

Perhaps no universal pattern underlies neglectful actions involving children. However, neglect appears to be a parental response to internal and external stresses; parents themselves are often victims of misfortune.

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

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

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

Providing and coordinating the services each family needs is beyond the capability of any one professional, discipline, or agency. However, the interdisciplinary nature of case management frequently proves problematic because of ineffective communication among professionals. One must remember Abraham Maslow's warning that if the only tool you have is a hammer, you treat every problem as if it were a nail.

INTERDISCIPLINARY AND INTERINSTITUTIONAL ISSUES

Primary professionals involved in management of child abuse and neglect are physicians, nurses, social workers, lawyers, and judges. Table Two presents a conceptual model of three levels of action for each discipline, and the interdisciplinary relationship at each level.

Table 2

INTERDISCIPLINARY AND INTERINSTITUTIONAL ISSUES

Level of Action	Disciplines		
	Medical	Social Work	Legal/Judicial
Social Policy	Statutory Mandate: Reporting of Suspected Child Abuse to Protective Services.	Protective Services: Appropriations for Services and Staff; Community Resources.	Child Abuse Legislation; Mandate for Reporting by Child-caring Professionals; Helping Resources for Families.
Institutional Practice	Education/Practice: Prevention and Treatment of Child Abuse and Neglect; Hospital Policies and Procedures.	Agency Orientation: Investigations, Service Programs, Multidisciplinary Case Management.	Judicial Response: Differing Courts' Policies on Professional Testimony; Policies of Legal Representation for Victim, Parents, & Agency; Disposition Planning.
Individual Case Management	Identification, Diagnosis and Reporting of Suspected Child Abuse; Multidisciplinary Management.	Family Evaluation; Family Rehabilitation; Multidisciplinary Management.	Possible Court Action: Multidisciplinary Disposition Planning.

SOCIAL POLICY

Every state has passed legislation requiring reporting of suspected child abuse to public authorities. In earlier statutes, physicians were primarily responsible for reporting suspected physical abuse to the protective service agency. The focus now includes other child-caring professionals, but physicians in hospitals and private practice still play the central role in identifying, diagnosing, and reporting child abuse.

Early state child abuse legislation was viewed as a case-finding tool to identify abuse at the earliest possible time, and as a means of strengthening child protective services. But if laws requiring protective services are to be effective, appropriations to support expansion of these services are essential. Many services to children and families depend upon a combination of federal, state, and local appropriations. These appropriations currently lag far behind the level needed to create good service programs and to staff them with the number and quality of workers required to make them effective. If protective service agencies and workers cannot respond adequately to reports of suspected abuse or neglect, they lose the confidence of physicians, other reporting professionals, and the troubled families. Families stop asking for help and professionals stop filing reports except in the most blatant abuse cases. Early identification and intervention are lost.

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

INSTITUTIONAL PRACTICE

Frequently physicians have no training and clinical experience in prevention and treatment of child abuse and neglect, in evaluating nonmedical family problems, or in planning appropriate long-range family rehabilitation with multidisciplinary professionals. Not understanding the orientation and practice of social workers, lawyers, judges, and members of other nonmedical

professions, physicians may feel uncomfortable working in interdisciplinary management of abuse cases.

Child abuse imposes many stresses and strains upon medical personnel. Decision-making is enhanced in hospital settings by written policy and procedures in handling suspected child abuse and neglect cases and by available consultants. Physicians in private practice may be disadvantaged in working with troubled families if they do not have easy access to consultants and colleagues for emotional support. Physicians are reluctant to report abuse based on suspicions, and may delay reporting until more substantial evidence is available. When reporting leads to court involvement, physicians often lack the skill and experience to present testimony in the best interests of child and family.

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

By tradition, training, and experience, child protection has been the responsibility of social workers. This specialized child welfare service is delegated by law to offer help to any neglected, abused, or exploited child. The protective agency is obligated to explore, study, and evaluate the facts of suspected abuse and neglect cases, and to provide appropriate services until the family situation has stabilized, and the potential hazard to the physical or emotional well-being of the child is lessened or eliminated. Too often the agency is prevented from fulfilling its role by ineffective programs, inadequately trained and limited staff, insufficient funding, and insufficient essential community resources. It is a startling fact that no state has developed community child protective programs adequate to meet the service needs of all reported cases of abuse and neglect.

To cope with the acute and complex problems found in child abuse and neglect cases, an effective child protective program needs comprehensive staff development and sufficient staff to allow each worker a manageable caseload of about 20-25 active cases. Although an important aspect of protective services involves application of basic social work knowledge and skills, an interdisciplinary approach to case management is imperative. Cooperation and coordination between social work, medical, and legal/judicial resources is vital.

Judicial proceedings may be necessary to provide care and protection for the child, and to modify parental behavior or circumstances affecting the child's welfare. Too few provisions protect the legal and constitutional rights of child and parents. Parents have the right to counsel in a suspected abuse or neglect proceeding. Of special concern is counsel for the child. Recently, provisions for the appointment of a "guardian ad litem" to protect the child's interests have been made statutorily possible in some jurisdictions.

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

CASE MANAGEMENT

Identification, diagnosis, and reporting of child abuse are critically important, but cannot by themselves assure children protection. These initial activities must be correlated with effective services to abused children and their families. Physicians should realize that the major function of the protective service system is the coordination of acute care services. When the roles of the professionals from the several disciplines involved are defined, a serious gap in services may exist: no professional or agency has assumed responsibility for provision and coordination of long-term therapeutic intervention. Health workers can become child advocates and prime movers for the development of multidisciplinary child abuse and neglect programs within their communities.

REALITIES AND DILEMMAS FOR HEALTH PROFESSIONALS

While much recent literature on child abuse and neglect focuses on clinical aspects of diagnosis, intervention, and treatment, little attention is given to the impact on clinical practice of the orientation of institutions and the professionals who staff them. The actual incidence of child abuse and neglect is continually debated, with annual estimates ranging from 200,000 to 4.5 million cases. Many case reports originate from hospitals. However, pediatricians and other

child health providers are aware of many cases of suspected abuse and neglect which are not reported to the child protective agency.

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

Although it is unlikely that the conceptual and philosophical orientation of medical practice will change dramatically overnight, there are, nonetheless, several important and abiding realities of child abuse and neglect cases that are particularly noteworthy for health care professionals to consider during the diagnostic and treatment process:

1. Child abuse is a symptom of family dysfunction resulting from complex causal processes. Frequently, physicians view child abuse and neglect cases in terms of its physical symptoms (e.g., fractures, bruises, burns, and failure to thrive), and give little attention to the underlying causes of family dysfunction. Traditionally, the training of physicians and other health personnel has focused narrowly on the biological aspects of the etiology of disease, and has only recently acknowledged the importance of environmental and social determinants of illness. The complexities of managing child abuse and neglect cases overwhelm many physicians. Access to a competent multidisciplinary team can expedite help for the victims and their families and provide valuable support and consultation to physicians;
2. Child abuse and neglect occur in all cultural, social and economic levels of society. When the professional staff is socially, culturally, and economically discrepant from patients, behavior may be interpreted in a culturally biased fashion; family strengths may be seen as weaknesses; or a child's illness may be characterized by a more value-laden diagnostic label than would occur in a similar situation involving a child from the same social background as the professional staff (e.g., "child abuse" vs. "accident" or "neglect" vs. "failure to thrive");
3. Child abuse cases arouse overwhelming emotional reactions which may interfere with the objectivity and sound judgment of involved professionals. Professionals often are not consciously aware of these aroused feelings. The accessibility for consultation with others not directly involved in the management of a particular case, but who are sensitive and competent to deal with the technical and human aspects of case management, provides professionals with a mechanism for dealing with these feelings, and not permitting them to jeopardize the management of the case;
4. The initial assessment in child abuse and neglect cases frequently is oriented towards diagnosis of adult psychopathology. The physician's orientation to abuse and neglect is to search for psychopathology in suspected perpetrators. Several studies demonstrate that a small percentage of abusive adults have serious mental illness. A more productive approach would be to concentrate on the family's potential to respond to helpful services. Successful intervention builds on the family's strengths, and uses community resources to enhance the family's functioning;
5. Child abuse and neglect are not monolithic entities. Child abuse and neglect are complex problems with medical, social, psychological, and legal components. After completing the diagnostic assessment there are no simple solutions or cures. Therefore, the outcome in case management cannot be predicted with certainty. However, it is recognized that many abusive and neglectful parents genuinely want professional help to become more nurturing, protecting parents, and to stabilize their family situations. A compassionate and understanding response is essential if parents are to come to terms with their problems and responsibilities in protecting their offspring;
6. In child abuse and neglect situations, family rehabilitation usually requires prolonged involvement. These situations can be especially distressing for professionals who are accustomed to an efficient diagnostic and treatment process: defining the etiology of the illness, operating on its causes, either with drug therapy or surgical intervention, and waiting a short time for the therapeutic outcome. Child abuse and neglect cases almost never follow this pattern, although the rewards of successful treatment can be no less gratifying;

7. Many people perceive the door to the physician's office, or the entrance to the hospital emergency room, as the only portal into the human service system. At a time when availability of services and resources to assist families with life crises is diminishing, and as social and economic stresses increasingly threaten family integrity, it is little wonder medical personnel hear cries for help from patients and their parents. Isolated families may have nowhere else to turn. If we are not sufficiently cognizant of this new role thrust upon us, we may force parents to package their problems in ways they know will demand attention. All too frequently, we look retrospectively in the medical chart of a neglected or abused child to find that his parents frequently brought him to a physician or hospital complaining of vague or undetectable symptoms. One can only speculate about the number of such cases that might have been prevented had time been taken to discover why the family sought help at that time;
8. The severity of a child's physical symptoms may bear no relationship to the prospect for the successful management of his family's problems. The child's symptoms do not always accurately reflect the nature and extent of family dysfunction. In fact, chronicity may be more important in estimating prognosis. Long-term behavior patterns may have lasting and profound implications for both child and family. Here again, the importance of early recognition of family distress is underscored;
9. Child abuse and neglect cases necessarily bring health professionals in contact with other disciplines whose professional orientation, training and skills, and methods of practice may be unfamiliar. Medical personnel must respect and acknowledge the opinions and orientations of workers in other professions whose actions and recommendations are formed by different underlying principles and assumptions. Coordinated interdisciplinary management is essential to successful intervention in child abuse.

PRIMARY AND SECONDARY PREVENTION

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

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

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

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

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

Poverty is an aggravating influence to families with the potential to maltreat their children. Environmental and social stresses are more serious, and the opportunities for occasional relief from child-caring responsibilities are fewer. It is possible for a concerned professional community to make delivery of services to the victims of poverty less chaotic, more

reliable, more supportive to personal dignity and self-esteem, and thus more protective to children. We can work, furthermore, for the development of social policies which provide more equitable access to society's goods and resources.

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

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

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A Family Systems Approach to Treatment of Child Abuse

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A family systems model has refocused the thinking about psychopathology and treatment for several diagnostic groups (Berger, 1974; Minuchin et al, 1967; Rothman, 1976). One group to which it has not been applied previously is the abusing family. The abuser is still usually regarded as sick, and treatment is focused on the individual (Gelles, 1975). This continues in spite of the growing belief that all family members may contribute to the abusive behavior and should be involved in treatment if change is to occur (Gelles, 1975; Justice and Justice, 1976).

This paper will consider the application of a family systems model to child abuse. The emphasis will be on patterns of abuse and on the external and internal forces acting on the family and contributing to its behavior. This approach offers a new point of entry for the clinician. The traditional approach entails examination of the personalities of the major participants—mother, father, and child. It considers the historical and situational factors which may contribute to the behavior of each and from these assessments extrapolates treatment objectives and strategies. The approach proposed here looks directly at family patterns and considers abuse to be just one of the possible destructive patterns that might result from the particular family organization. How to change those patterns becomes the focus of treatment.

THE SETTING

This approach evolves from treatment of abusive families at the Philadelphia Child Guidance Clinic. The clinic is housed in west Philadelphia, adjacent to the Children's Hospital of Philadelphia and close to the University of Pennsylvania campus. It is near but separated by the university complex from the low-income families it principally serves. Every family treated is assigned a therapist from one of the mental health disciplines. This therapist sees the family in formal sessions and includes siblings, extended family, community members, and friends when appropriate. There are several programs offered as an adjunct to treatment. The therapist remains in charge of treatment whether or not the family participates in one of the programs. Among the programs is a school which accomodates 98 children and a residential setting for 24 children. Both the school and hospitalization program are short-term. A child can attend the school for a maximum of six months and residential program for two months.

In addition, there are two apartment units where families may reside for up to two months. Other programs include an after-school program for adolescents, a preschool program, and an outreach program which employs paraprofessionals who assist in managing the practical problems a family encounters. The persons may see the family during hospitalization or in the home.

THE APPROACH

The approach used for assessment and treatment is based on a model of family systems intervention developed at the Philadelphia clinic. The basic tenet is that families evolve patterns of interaction. The patterns develop because of certain basic ways the family is organized. Families in which role definitions and lines of power or authority are clear, in which there is allowance for disagreement and an orderly process for solving problems, are considered functional. In such families, members can develop without compromising the organization of the family. In contrast, dysfunctional families are ones in which rules are too loose or too rigid, not permitting members to feel they have a voice and a place in the family organization.

The objective in any family interview is to determine areas in which family members do or do not work well together. The clinician examines the underlying organization to determine whether it is too rigid or vague to meet the needs of all members. The clinician's task is to assess the degree to which dysfunctional patterns of behavior can be changed by encouraging members to shift roles, use power differently, or perhaps ally differently with other members. The clinician must carefully assess how invested members are with present patterns, and which incentives can be used to motivate them to change their roles in a particular sequence. The basic technique is to change family organization by modifying behavior patterns. It may be necessary to alter the patterns of several different activities before any perceptible changes occur in family organization.

PATTERNS LEADING TO ABUSE

Abusive families are so heterogeneous in composition, interactional patterns, background, and current external stresses that no single typology adequately accounts for individual behavior or family patterns. It is erroneous to label patterns observed in families as those always associated with abuse. However, as underlying family organizations are subjected to careful analysis through observation of behavioral patterns, it may be possible to identify those organizations, backgrounds, and current stresses which, when combined, lead to abuse. An attack on a child may reflect an underlying family organization which prevents frustration, anger, or anxiety from being expressed in other ways.

In the discussion which follows, abuse will be considered a violent act which injures the child to the extent physical evidence is present, including x-ray evidence. Not included in this definition are acts of omission such as neglect and mental abuse.

At this time, we can report some patterns observed in abusing families. We realize these same patterns may be seen in any disorganized family, and that abuse is only one possible result of a particular family organization. Other manifestations of dysfunction include spouse abuse, neglect, self-imposed injury, or disruptive behavior in one of the children. With this in mind, a description of some family organizations and related behavioral patterns is presented.

Spouse Conflict

Marital conflict may present various patterns. In one pattern, each partner perceives the other as more powerful and effective than himself in areas in which he wants more control. Each solicits support from others, including his own parents, the children, and friends, in trying to rebalance the organization in his favor. A child may be encouraged to side with one parent. The other parent reacts by hurting the child, who is now perceived as disloyal.

In another pattern both parents jointly attack the child, thereby not confronting their own marital problems. Avoiding problems in one relationship by focusing on another is a pattern often seen in dysfunctional families.

Lack of Role Resolution Between Generations

Members of abusing families often have not resolved how they will interact with extended family members, especially members a generation removed. Parents either may have no relationship with their own parents or a relationship so conflicted that any display of grandparental attention toward the children triggers an attack on those who accept the grandparents' overtures.

Low Frustration Tolerance In One or Both Spouses

One or both spouses may be unable to tolerate stress. This may be congenital, learned, or a combination of both. In families where both spouses manifest low frustration levels, all the children may be at risk, although the child who is least able to meet parental expectation is most vulnerable. In families where one parent has low frustration tolerance and the other a higher tolerance level, problems may arise when the more tolerant spouse withholds support at a critical time. The parent who cannot handle stress abuses the child when he reaches his tolerance limit. Or, the attack may come from both parents. The low-tolerance parent attacks the child but at the same time pleads for the other parent to assume control. The more tolerant parent, faced with chaos, eventually loses control and turns on the child who is perceived as the cause of the stress.

Family Disorganization as a Function of Developmental Stage

There are critical times or stages in the development of all families. Particularly stressful is the birth of a baby, death of a family member, and departure of grown children. Families vary in their ability to cope with each event. One couple, for example, may easily tolerate their first child because the event binds them together. The birth allows each to focus on something other than marital conflicts. For the same couple, the child's desire to develop relationships outside the home may prove extremely stressful. The child may become the target of abuse when indicating his needs for autonomy. For another couple, the birth of an infant may be devastating. The parents, now forced to provide for an infant, may find each has less time for the other. This loss of emotional support is attributed to the child, now perceived as an intruder. He then becomes the focus of the couple's frustrations.

Family Disorganization as a Function of Environmentally Produced Stress

Just as families vary in their capacity to cope with stresses associated with various predictable events in their lives, they will also vary in their management of externally imposed stresses. These stresses include loss of income, relocation to another community, and increased financial obligations. A family's organization must adapt to changes in resources and relationships outside the home. A family which has been close to extended family, or which resided in a community where members had friends or other sources of support, may become disorganized when isolated in another community. Conflict is no longer diluted by frequent contact with understanding extended family or friends, and discord among members escalates. If the family's characteristic pattern is to turn to others rather than handle an issue directly, a child may become the target of family frustration.

Role of the Special Child

The special child is one who for congenital or situational reasons is perceived as different from other siblings. He often cannot adapt to the family's expectations, is perceived as disruptive and difficult, and may become associated with any of the disorganized patterns considered here. He perpetuates his part in the abuse sequence because he derives some attention.

The One-parent Family

The one-parent family does not have a unique family organization. While there may appear to be only one person in the parental role, there may be others in the background who assist or actually control. A friend or grandparent may substitute for an absent parent, or an oldest child also may carry out this function. Once the "other" parent is identified, it may be possible to discern patterns similar to those discussed under other headings.

CHANGING THE FAMILY ORGANIZATION

Changing the underlying organization is difficult even when working with a highly motivated family. While a pattern may change, if the underlying structure remains untouched, the pattern will recur. In abusive families, the patterns and organization may be particularly resistant to change. The act of abuse itself suggests that more radical solutions have replaced other, more moderate alternatives.

The task of the clinician working with an abusing family is the same as when working with any family. He must find incentives for members to give up their part in dysfunctional family patterns, and work with the family to find new, attractive roles for all family members, roles consistent with an organization which is more adaptable and functional.

If the clinician fails to account for each person's need for a new role, the member(s) who was not considered will attempt unconsciously to reestablish the old organization. Suppose, for example, an abused child often runs to the grandparents for protection, describes to them how his parents mistreat him, and then the grandparents intervene in his behalf. The therapist may be able to stop both parents from attacking the child, even when the child is particularly provocative. The child's disruptive behavior may diminish. However, without consideration of the whole family, before long several events may occur. The grandparents, deprived of their former role, may seek their special grandchild. The child, anxious to regain their attentions, may renew his provocative behavior. The siblings, sensing parental favoring of a formerly scapegoated brother, may begin to misbehave. The siblings expect the parents to respond with benevolence. Since the behavior of all the children worsens, the parents complain that intervention is unsuccessful.

A successful therapeutic intervention requires a new role for grandparents. Similarly, the therapist must encourage the parents to allow the difficult youngster to become more positively connected with his siblings. The parents may need to encourage one of the influential siblings to ease the difficult child into their group.

Parents must realize that a change in their relationship with the child will leave them more free time for each other. It is important to insist that parents care for and support each other during this difficult period. Perhaps 10 minutes an evening can be set aside for parents to discuss changes they have carried out. An additional five minutes might be designated to discuss issues unrelated to the child, thus encouraging the couple to develop other interests.

USE OF MULTIPLE TREATMENT MODALITIES

The basic unit treated is the entire family, although others outside the family may be included. Formal treatment sessions at which all family members are present, including siblings and

extended family when appropriate, occur at the outset. After initial assessment the therapist may choose to see only certain family members at a specific session. Then, intermittently, the entire group is reconvened to determine whether the family's maladaptive patterns are changing. All sessions, regardless of the number of family members present, are geared to assessment and intervention. The family is encouraged to enact its problematic behavior in the sessions with the understanding that family and clinician will collaborate to change or eliminate the pattern.

While the family is seen in formal sessions, other approaches may be used. For the parents who are isolated from other adults in their community and limited in their exposure to sources of support and recreation, the clinician encourages participation in self-help groups or membership in a community club. If the child is "special," a thorough evaluation is required and the appropriate services arranged. For parents who do not know how to organize their home, it is essential a worker help them acquire practical skills. When family disorganization is extreme and motivation for change either unknown or insufficient to promote change, hospitalization of the entire family may be necessary. In such a setting, family and staff can work together 24 hours a day in sorting out and changing problematic patterns.

THE ROLE OF THE FAMILY IN THE THERAPEUTIC PROCESS

The therapist, from the beginning of treatment, should encourage a collaborative relationship with the family, rather than projecting himself as someone on whom it can lean. Respect for the parents as the source of family control, and respect for the family as a viable system is important. The goal is to work with the family in areas the members perceive as problematic, while at the same time pointing out their collective and individual strengths. Parents must help define treatment goals which may or may not include counseling for abuse. Also, it is essential the family be encouraged to collaborate with all persons involved in its care.

EXAMPLE OF FAMILIES TREATED

The following examples are provided to illustrate some differences among families, differences in treatment objectives, and the diversity of treatment modalities employed to carry out the objectives.

Family One

This example illustrates treatment of a three-generational family, with a special child, who had failed to improve despite years of outpatient work in various settings. The family organization can be described as intractable. Treatment took place in our inpatient setting.

Bobby, a 6 year old white male, was hospitalized at the clinic with his mother and maternal grandmother. This treatment followed four years of various kinds of outpatient therapy for Bobby and his mother which failed to change their interaction. Bobby, cerebral palsied, slightly retarded, and very large for his age, had a history of attacking his mother, his grandmother, adults in charge of him, and other children. His behavior was so unmanageable that long-term institutionalization was considered the only suitable option at the time the family moved into our apartments. Bobby's mother was considered responsible for his many bruises and welts.

In an initial session with the family, the clinician encouraged the family to be as natural as possible, allowing some of the disruptive behavior to occur. The clinician then offered some alternatives to determine the degree of flexibility in the family and the ease with which Bobby would respond. It was evident that the mother often disrupted Bobby when he was absorbed in an activity. Bobby also became disruptive when his mother or grandmother criticized him, or talked about him without including him in their discussion. A third pattern occurred when the mother insisted he complete a frustrating task. He would respond by protesting and when this failed, by attacking her.

It was clear in the initial interviews that the mother and grandmother could not talk together apart from Bobby. Discussions between them always were initiated by Bobby's disruptive behavior. Focus remained on his behavior, with the grandmother providing comfort to her daughter only after she had been attacked. It then was hypothesized that Bobby served as a go-between for his caretakers; they remained conflict-free as long as Bobby's behavior was disruptive.

Early in treatment, it was apparent Bobby would continue to react violently until one caretaker was clearly in charge. He received conflicting messages from his mother and grandmother. Discussion revealed that the grandmother was willing to relinquish many of her child-care responsibilities. The mother agreed to take charge if the grandmother would

occasionally assist and verbally support her. Bobby's mother took primary charge of him, with the grandmother assigned the role of helper. The grandmother observed her daughter and Bobby behind a one-way mirror, and offered guidance when the mother requested help. She also cared for Bobby when the mother asked for time away from him.

A number of techniques were used to help the mother control Bobby's behavior, including staff modeling, educating her about the sequence of their pattern, and coaching her during therapy sessions in management of her child. Multiple-family-therapy, in which this family was brought together with another which also had a young abused boy, was used to help both families develop skills through observation of each other. A support system also developed which we hoped would be generalized outside the hospital setting.

Inclusion of "rehearsal sessions" was also important. The mother would describe an intolerable situation which occurred routinely at home. The clinician and mother would then decide which part of the sequence needed to be disrupted if Bobby's behavior was to change. Staff assisted the mother by rehearsing with her what interventions and danger signs she need to look for to prevent Bobby's outburst. The mother was able to provide a few gentle reminders before changing from a pleasant to less pleasant activity; this stood in contrast to her past behavior when she would abruptly inform Bobby it was time to stop an enjoyable pastime. She also began to enforce rules consistently but with flexibility.

Important throughout the six-week hospitalization was a constant reappraisal of what behaviors and roles needed to change to avoid reversals of significant shifts in the family organization. It was considered important that each family member be allowed more autonomy in some areas as well as more emotional support for carrying out his responsibilities. More clearly defined roles also were considered essential.

The mother's behavior changed when the grandmother became less active in caring for Bobby. As the mother's control over Bobby's destructive behavior increased, her appearance improved. She began wearing makeup and dressing in a more feminine, attractive way. She also began participating in activities apart from Bobby, articulating to the staff and her mother the pleasure she felt as she developed interests outside her role as mother of a difficult child.

Bobby changed as he experienced rewards for good behavior and more realistic expectations from his mother. He began requesting time away from his family, and could tolerate entire days away from his mother in our school program.

Gradually, the grandmother began to see herself as an entity apart from her daughter, and to derive satisfaction from renewing old friendships and pastimes. These changes occurred as her daughter was observed by the staff to speak more kindly and directly to her mother about her expectations of the grandmother. The grandmother told the staff she felt freer to engage in her own activities as she observed her daughter's willingness to care for Bobby.

Six weeks was a short time, and many issues went unresolved. However, the family was able to return to its rural community where a relationship had been arranged with a family therapist in an outpatient clinic. Bobby remains in a day program, although the family has moved to another part of the state. The mother currently is involved in a satisfactory relationship with a male friend, and the grandmother, who now has many other interests, is no longer central in the care of Bobby.

Family Two

This example illustrates treatment of a large, intact family with marital conflicts, and in which a special child, the youngest of five, was the focus of abuse. Treatment combined outpatient care, day treatment in our school, and eventual placement of the child in a day school for learning-disabled youngsters.

Alex, an 11 year old white boy, was referred to the clinic by the local school system because he disrupted class, attacked children and adults, and would run away from school when under pressure. He also was disruptive at home, often defying his mother.

Child abuse became apparent after a few clinic sessions. The father admitted he most often disciplined the child. He felt the mother actually protected Alex from him, and that she would admit to Alex's problematic behavior only when she felt unable to handle him. Father felt that at these times she expected him to chastise the child severely. The mother, however, expressed concern for Alex's safety when the father disciplined him.

Assessment of this family suggested highly interlocking relationships among Alex and the parents. Alex and his mother were particularly close. The father often felt left out. Alex's disruptive behavior would bring the parents emotionally closer to each other. When Alex was not

disruptive, the father remained aloof. The other children seemed closer to the mother than to the father, but unlike Alex, were sufficiently compliant to avoid attack.

The objective in this family was to strengthen the parental relationship. The parents were encouraged to discuss how they would handle issues together, and present a united front. The mother was encouraged to seek out the father in the evening to discuss management problems before feeling completely at a loss and in need of a "rescuer." The parents were encouraged to cooperate with each other in dealing with Alex's school. The father's relationship with Alex and the other children also was strengthened by having the father help with homework, and relieve his wife of other child-related tasks.

A well-defined perceptual problem was found to be the cause of Alex's inability to read. He spent approximately four months in our day school and then transferred to a school for learning-disabled youngsters. After one year of treatment, Alex attends the same school. He no longer runs away from school. He reads, although his reading skills are far below age level, and the family reports the home is peaceful.

Family Three

This family illustrates two generations of abuse. The child is the focus of conflict between grandmother and mother. The mother is domineering and the stepfather allies himself with the mother against his stepdaughter. Outpatient care combined with our preschool program were the treatment modalities used.

Dawn, a 5 year old girl, was referred by the local protective services following numerous unexplained injuries. Dawn named her mother as her assailant but her mother denied the allegations. The family also included a stepfather and two younger halfbrothers. The youngest, an infant, was the result of the union between mother and stepfather.

Dawn and her middle halfbrother came to live with the mother and stepfather following her mother's marriage two years prior to treatment. The halfbrother was not abused. Prior to this, Dawn, her mother, and halfbrother lived with the maternal grandparents, who showed great affection for Dawn, but treated her mother poorly. The mother reported she treated Dawn in the same way she herself was treated as a child.

Apparent from the first session was the severe conflict between parents about how to handle the children. The mother decided when disciplining was necessary and invited the stepfather to help only when she described herself as exhausted. Dawn appeared adept at playing one parent against the other. When alone with one parent, Dawn would report that the other parent had engaged in some unacceptable behavior. Also, she would tell her grandmother how she had been beaten by her mother. The grandmother, in turn, would chastise the mother. The mother would then enlist the support of the father, and Dawn would be hurt.

This family is still in treatment. Objectives include helping the parents rely on each other in a way that neither feels compromised or alienated. Once the parents can agree on methods of handling the children, they then can face Dawn's grandmother. The stepfather now helps the mother limit her telephone conversations with the grandmother, and supports her when the grandmother attempts to interfere. The grandparents have been asked to visit only at specific times. In order that the grandmother not feel unwanted, the mother asks her for help in areas other than child management. Since both parents felt they devoted too much time to child-rearing and household chores, another treatment objective was to find more time for each to devote to the other. The father, who was unemployed, was encouraged to find work and reduce his amount of housework. The mother, who had no job skills, was encouraged to acquire clerical skills to bolster her self-esteem and to facilitate part-time work.

The child participates in our preschool day program. The parents are encouraged to collaborate with the staff on management issues. Therapy sessions often include the clinic staff and all three children. Dawn frequently tells stories about her parents to the staff, and stories about the staff to her parents. Sessions at which all parties are present discourage this behavior. The parents are beginning to express relief that the staff listens to them and takes their suggestions seriously. At this point in treatment, staff and parents actively advise each other.

CONCLUDING REMARKS

In conclusion, it is not possible to talk about what kind of family or what particular pattern causes abuse. Rather, it appears practical to concentrate on those family patterns which can be changed. In order to effect change, the therapist must understand what each member might lose or gain when the behavior patterns change. For intervention to succeed, the total gains must be

maximized for all family members. Any number of treatment modalities will work as long as the basic family organization is considered.

We are using a family systems approach to change patterns which lead to abuse. The substitution of more adaptive family patterns causes changes in the basic family structure. These structural changes, in turn, sustain the new behavioral pattern.

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A Family Systems Approach to Treatment of Child Abuse: Etiology and Intervention

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This paper will briefly review the traditional theories of both the etiology of, and intervention with, child abuse situations. A different orientation and perspective of child abuse will then be elaborated, both theoretically and as practiced at a therapeutic pre-school, infant, and family center in the southwest. This perspective is a family systems one where relationships, transactions, and reciprocal social exchanges have an effect on how child abuse may start, continue, and be stopped.

TRADITIONAL THEORIES OF CHILD ABUSE--ETIOLOGY

The two major traditional theories of the etiology of child abuse are: (a) the psychopathological model in which child abusers are seen as sick and abuse is a result of the parent's pathology and (b) a sociological-environmental model in which child abuse is seen as the result of multiple socioeconomic and cultural environmental factors.

The psychopathological model states that child abusers have certain characteristics and childhood experiences which cause them to abuse their children. Note that while many proponents of this theory acknowledge there must be a child (seen as different, etc.) and a form of crisis (Kempe and Helfer, 1972), the child's difference is usually explained as a projection or an unrealistic expectation, and the crisis as a precipitator, not a cause of the abuse.

Child abusers have been described as having a general defect in character that allows for aggressive impulses to be expressed too freely (Spinetta and Rigler, 1972), having a defect of the character structure (Kempe et al, 1962), sadomasochistic (Bennie and Sclare, 1969) and having many other emotional problems such as isolation, inadequate self esteem, and dependence (Kempe and Helfer, 1972). Some explain the entire process of abuse on the basis of the parent's psychopathology. Goldstein (1971) believes "The parent who batters his child hates some part of himself which he projects onto the child. He beats the child to exorcize that attribute while still retaining that part of the child he loves. The parent who neglects his child hates some part of himself which he denies. To avoid his self-hatred he must avoid the child in whom he fears to see himself" (p. 584). The developmental cause of these types of character descriptions and abusive behavior is frequently stated as the abusing parent having been abused, and/or emotionally abandoned when he or she was a child. Goldstein (1975) and Gelles (1973) believe that research on the psychopathological attributes of child abusers as a determinant of abuse has been inconsistent and weak. Some of the problems have been the representativeness of samples, the general lack of control groups, the low agreement of authors on personality traits, and the anecdotal and ex post facto design and after-the-fact explanations generally used.

The sociological-environmental model states that external stresses are the main determinants of child abuse. Light (1973) mentions size of family and unemployment as contributors to abuse. Gil (1970) cites studies which show child abuse to be higher in the lower socioeconomic classes. Gelles (1973) believes that childhood socialization, economic strain and frustration, values and norms of the subculture of violence, authoritarianism, large families, and unwanted children are all possible stresses which may lead to child abuse. Gelles states that an unwanted child is beaten not because of a projection or "transference psychosis" but because the child is concretely a source of stress and trouble. The proponents of this model also believe that psychopathology of the parent is a possible but not necessary or frequent cause of abuse. While some, such as Gil (1970) and Alvy (1975), see child abuse as a multidimensional problem with changing causation and influence in different situations, many in the field are still predominantly oriented to one viewpoint.

TRADITIONAL THEORIES OF CHILD ABUSE--INTERVENTION

Models of intervention generally follow both the psychopathological and social environmental models of causation.

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Direct services to parents consist of indivdual, group, and lay therapy; self-help groups such as Parents Anonymous; and volunteer companions. These services deal with the psychopathology of the parents and give them the parenting they "never had". Proponents of direct services believe that these services are always necessary and frequently sufficient to stop abuse. Until the personal problems of the parents are dealt with, child abuse is very difficult to stop. Direct services based on the sociological-environmental model focus on political, social, and environmental issues and problems.

Direct services to children consist of medical care, permanent or temporary institution or foster home placement, and play therapy, prescriptive classes, or diagnostic testing for the disturbances and developmental delays which may result from the abuse. While abused children have many problems, not only are direct services to them infrequently given, but haphazard placement and hospitalization without supportive services further exacerbate the situation.

As some theoreticians have accepted both models of causation, many agencies make more than one type of service available to the abusing parent or to the abused child.

FAMILY SYSTEMS APPROACH TO CHILD ABUSE--ETIOLOGY

A family systems approach states that abuse is part of a pattern of relationships and reciprocal transactions between parent and child (and other family members) in which all parties play a part.

General systems theory states that "organized systems are the product of the dynamic interaction among their parts". The whole or the characteristics of a system cannot be explained by the nature of the parts themselves but only by the continuous "interchange of matter, energy, and information among these parts," (Durkin, 1972, p. 11).

A family systems perspective of child abuse is intended to be a useful (and sometimes possibly the most useful) orientation to the understanding and intervention of child abuse. It is not intended to explain all causes of child abuse nor does it deny the influence of either psychopathology or social environmental stress.

Kempe and Helfer, Gelles, and others mention the role of the child in child abuse. As stated previously, they see the child's input as his status (unwanted) or the parent's distorted expectation or projection. The input of the child really being different (handicapped, hyperactive) is mentioned infrequently and not followed up. In almost all cases the child is not considered an important causal element. Some exceptions are Jacobnizer (1964) who felt that more knowledge is needed about the type of children who "invite" abuse and Milow and Lourie (1964), who found that some abused children are not only difficult to manage but also unappealing.

While a family systems orientation has been developed mainly through the experiences at and the philosophy of the center, other theoretical influences have been family therapy, the effect of the child or infant on its caregiver, and research into the interaction between a child's temperament and parental functioning.

Most models of family therapy see the family as a system and are concerned with family norms, homeostasis, and communication rather than individual symptoms and psychopathology (Boszormenge-Nagy and Framo, 1965; Haley, 1970; Ackerman, 1966).

The family itself is seen as the patient and the member who is initially referred, blamed, or pointed out is purposely called the identified or supposed patient, the person in pain, or the person expressing the symptom (Framo 1972). Framo states that "whenever a group of people are closely related to each other, as in a family, they reciprocally carry part of each other's psychology and form a feedback system which in turn regulates and patterns their individual behaviors" (p. 271).

The major reasons that a family therapy orientation is not used in child abuse is the age of many of the children in question and the likelihood that many workers in the field do not use a family orientation. Family therapy is generally used with families with adolescents and latency aged children; infants and children under the age of 6-7 are usually excluded. The most frequent and most damaging abuse, however, occurs in families with infants and pre-school age children.

The effect of the child or infant on its caregiver refers to the great influence children (however young) have on their parents. Increased sophistication in communication theory as well as the realization of the great quantity and individuality of neonatal behavior has made this concept more evident. An example is the current perception of the coldness of some parents of autistic children as the result, not the cause, of the child's autistic behavior (Kozloff, 1973). Kozloff has slightly altered traditional operant conditioning to take into account a family's "system of structured exchanges" which are recurrent and greatly influence each other.

The publisher's statement concerning the book *The Effect of the Infant on Its Caregiver* (Lewis and Rosenblum, 1974) succinctly describes the effect "even" an infant can have. Fifteen contributors discuss the significance of the interaction between mother and infant and the subtle contributions that each makes to the other in shaping their ongoing dyadic behavior. Emphasis is placed on the impact that the infant has as a source of information, regulation and even the malevolent distortions of the caregiver's behavior. The resultant picture of the infant is one who, even at birth, is no mere passive recipient of stimulation from this environment.

Another indication of the influence children have (alone and in concert with the parent) are the findings of Chess and Thomas as reported by Chess (1971). In discussing the genesis of behavior disorders, Chess reports significant problems with theories based on inborn differences or pathogenic influences. The longitudinal data on temperamental individuality and clusters show no strong relationship between a child's temperament and the presence or absence of a behavior problem. What was found to be the crucial etiological factor in each case of behavior disorder was the interplay among the child's temperament and characteristics, parental functioning and other environmental circumstances, and environmental demands which are stressful for the child's behavior style.

While many of the children with behavior disorders were classified as being temperamentally difficult, it was the parent-child interaction which was crucial. Most parents were generally similar in parental functioning. Many parents with children with behavior disorders would have had children without behavior disorders if their child had a different temperament and vice versa.

It seems reasonable, therefore, that the child himself, and certainly the interaction of child and parent, is a stronger influence on child abuse than has generally been acknowledged. These influences are especially strong in the continuation and escalation of child abuse. In these cases children with, e.g., "difficult temperaments" may encourage poor parenting, which results in poorly behaved or undisciplined children, which causes a parent to have to tolerate frustration longer and more often, which makes it less likely to be able to control impulses or temper, which results in abuse and a reciprocal pattern of child behavior and parental abuse. The observation that many abused children are difficult to handle, hard to take, obnoxious, etc. lends credence to children as possible inviters of abuse, if not initiators.

This certainly does not (especially by itself) account for all abuse nor does it take away the great responsibility of parents for their abusing behavior, nor does it preclude the influence of psychopathology and/or environmental stress. Though this discussion has stressed the relationship between parent and child, the theory may also be applicable to the relationship of the total nuclear and extended family, as well as the neighborhood and cultural environment, to child abuse.

FAMILY SYSTEMS APPROACH TO CHILD ABUSE—INTERVENTION

A family systems approach focuses upon the entire family or parent-child interaction as a system. An intervention using the family systems approach may deal with the relationship and interactions between family members in one of two major ways. The intervention may focus upon more than one member at the same time, as in family therapy and interactive play; or focus on both parent and child separately while dealing with the reciprocity or effect of a particular behavior of one on the other.

A personal survey of major child abuse demonstration projects revealed no program whose focus was the treatment of parent and child as a unit. Parents have traditionally been excluded from the direct services to their children because of a general tradition of separation of child and parent services, an attempt to isolate and protect children from abusive parents, and the previously mentioned belief that it is both sufficient and necessary to "cure" the parent of his or her psychopathology before any real change can be made.

Most family therapists exclude young children and infants from family therapy because of their short attention span and lack of verbal facility; and almost all would exclude a family with only young children. Most therapists who work with the parent and most of the smaller number of therapists or teachers who work with the child do not work with the other members of the family. There are some parent training groups but again in isolation, without children present.

In order to work with parent and child together, a therapeutic school, infant center, day care, residential treatment center, etc. is logistically and therapeutically helpful. These programs provide a wealth of possible activities to help understand and improve the relationship of abuser and abused. It is possible to have family activity therapy where parents/family members play with their child under therapeutic supervision, monitoring, and intervention. These

types of activities are important due to the age of the infant or young child and the absence of the actual abuse or the precipitating stimuli in normal interview situations (even when older children are involved).

The child and parent may at times be seen separately if they are worked with sequentially or concurrently and intervention focuses on their relationship. At times a child is inherently difficult or behaves badly due to abuse and poor parenting. At times a parent has poor frustration tolerance and impulse control due to some measure of psychopathology and/or environmental stress. Most often, both processes occur together. Whichever situation is in effect, improved behavior of the child and improved parenting ability of the parent may have a reciprocal cumulative effect on each other, with a resulting decrease of child abuse. If a parent has poor tolerance for frustration, the better behaved the child, the less chance for frustration to reach the point of abuse and the greater chance of the parent having positive feelings for his or her child. If the parents improve their parenting techniques, they have alternatives to abuse and there is a much greater chance of improved behavior on the part of the child. If only the child's or parent's behavior is worked with, change is not only less likely, but is frequently exhibited only in specific situations (e.g., school) and not generalized to parent-child interactions.

THE FAMILY SYSTEMS APPROACH TO CHILD ABUSE AS USED AT THE THERAPEUTIC CENTER

The therapeutic center was established in December, 1972, in Albuquerque. It is located in what is essentially a low socioeconomic area with a predominantly Chicano population.

The program is for families with pre-school children and infants who are commonly labeled abused, neglected, emotionally disturbed, developmentally delayed, and autistic. The parents may be under severe stress, deficient in parenting techniques, or have substantial serious emotional difficulties of their own. The families may be intact, broken, or disorganized. A wide variety of events, experiences, and attitudes may result in problems and high risk situations occuring within a family. The single most common referral, however, is for abuse and neglect.

The total program now consists of a therapeutic pre-school and outreach program for approximately sixty children and infants. Extensive supportive and adjunct services are given, and training and consultation are very strongly stressed. Most important is a comprehensive program of parental training, counseling, and involvement, with emphasis on parent self-concept and parenting skills.

The initial step of the program for child abuse families is an intake procedure, although crisis, individualization, and flexibility often result in this procedure being altered or ignored. Parent and child are seen together. While the parent (and sometimes child) and staff member are conversing and the child is receiving a developmental screening, parent-child interaction and parental expectations are carefully observed. The child is escorted into a classroom where he or she interacts with staff and materials while being observed by the teacher. At the same time the intake continues with the parents in the conference room, where topics which may be harmful for the child to hear are discussed. The philosophy of the school in terms of parent involvement and family orientation is discussed and an agreement of participation is asked for. Empathy is offered for the difficulties a parent has with parenting and environmental stress, but abusive behavior is never overtly or covertly accepted. Listening to parental goals, expectations, and problems is stressed. Afterwards the staff observes the parent's and child's reactions to each other in the classroom and/or conference room. Family configuration and strengths, motivation, possible pathology, types and degrees of stress, understanding of child development, influence of extended family and neighbors, any important cultural characteristics, and degree of danger present for the child are assessed. A study of possible clashes between parenting functions, including discipline, expectations, and acceptance/rejection and the child's temperament and behavior, which may be difficult, obnoxious, teasing, etc., are studied and discussed. All these topics, of course, remain important after the intake.

Staff and parents then make a number of decisions. These include a selection of a half-day class for the child, the number of days per week a parent must be in the classroom, whether the parent will be encouraged to have individual therapy and/or group counseling, and initial goals (including implementation) for parent and child. Child abuse parents differ greatly in many respects and therefore treatment plans differ. They may be in the classroom from one to five days a week. Some learn primarily by modeling and some by structured instruction. Some always work with their own child. Some may begin by fixing snacks and cleaning the room and some may only work directly with children. Some may read and discuss theory and some may be retarded and/or not able to understand abstractions. Some may be cooperative and friendly and some

hostile and resistant. Some may healthily focus on parenting skills and some may be extremely disturbed, e.g., suicidal or schizophrenic, and focus on personal functioning. The variability in the quantity and quality and type of participation is due to the interaction of many family and program factors and changes over time.

In general, parents interact with (and watch the interactions between the teachers and) their child. Direct training, modeling, feedback experimentation, and constant support are used to change the parent-child interactions. Techniques and philosophies ranging from behavior modification to Parent Effectiveness Training are used when relevant and productive. Parents have a chance to learn to deal with their behavior and feelings in critical abuse-precipitating situations which previously have resulted in an abusive response.

An important aspect of the parent program which cannot be overemphasized is a mood of friendliness, respect, informality, comfort, and support which, with quality services, has enabled the program to work with many parents who were extremely hostile and negative towards all agencies and helping services. The content of many good parent programs is excellent. Rarely, however, are the programs' delivery systems and environments sufficiently individualized and sensitive to work effectively with the so-called "difficult non-motivated" parent. Because a poor self-concept and deficient parenting ability may have a vicious reciprocal effect on each other, the acquisition of parenting skills and group warmth may do more for the abuser's self-concept than direct individual therapeutic intervention.

The child is, of course, also worked with intensively and the change in the child's behavior frequently changes the parents' pride and enjoyment in, and patience with, their child. Home visits may be made and a home program planned. The parent is encouraged to use the resource room and library and check out books and toys. The program frequently and readily deals with personal and environmental concerns ranging from a death in the family to problems with food stamps to scheduling a pediatric neurological examination.

SUMMARY

In summary, an approach to understanding and stopping child abuse which may be used alone or with other more traditional approaches has been discussed. Any time the parent-child relationship can be examined and intervened with as a unit, a unique opportunity exists to help remedy the family crisis of child abuse.

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Working with Parents of Abused and Neglected Children: A Counseling Approach for Professionals and Lay People

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INTRODUCTION

In the area of child welfare, professionals, paraprofessionals and other individuals are becoming increasingly aware of the need to develop their intervention skills for working successfully with parents and families of "high risk" children. This is especially true for those who work with parents in areas where the physical well-being of children is at stake. However, only in the area of child abuse and neglect are the feelings and emotions of those seeking to give help, human services workers, so strongly intertwined with those they seek to help: parents and other caretakers. Some of the strongest human emotions—anger, love, denial, guilt, sorrow, shame—are invoked from within parents. Moreover, these feelings often precipitate acts of violence that sometimes result in the death of the child. On the other hand, involved workers react with feelings along a continuum that ranges from disgust and anger to identification. Many human services workers have registered feelings that translate out as "I could never hurt a helpless child" or "Thank God it was her and not me because I've felt the same way so often." Regardless of the origin of the perception, the problem of child abuse and neglect means getting involved in parents' rights, children's rights, human rights, parenting practices, and civil rights. These complex issues, viewed from either end of the spectrum, constitute a serious strain on the ability of either of the affected parties to communicate with one another.

This is so mainly because it is hard to maintain an accepting point of view when consumed by such strong feelings. However, working with abusive parents requires a non-punitive point of view. Human services workers should keep in mind that working with parents is one way of insuring that the problem of child abuse is recognized by the family and, most importantly, that the child is protected. In this parent-centered treatment process, the family is perceived as a unit by human services workers who recognize that family members do not operate in isolation from one another, nor from society.

It should be emphasized that working with parents adds another preventive dimension to the child abuse rehabilitation process. If parents are seen as allies and not adversaries, the child is the ultimate benefactor. Recognition of the fact that the pendulum is swinging away from permanent removal of the child from the family home advances the concept of parent counseling as a preferred mode of treatment. Therefore, greater effort on the part of human services workers to insure good relationships between themselves and the parent can bring increased dividends. This will come about as more and successful shared intervention opportunities increase the chances for improvement in parenting practices.

Another factor that enters into a cooperative parent-human services worker relationship is the theory of punishment versus help. Abusive parents whose children are temporarily removed and then returned to them are more inclined to be accepting of the human services worker who has been a friend and not an antagonist throughout the trials and tribulations of temporary foster placement outside the home. It is not hard to relate in a positive fashion to a person who has refrained from a "punish the guilty offender" attitude. This parent-worker relationship tends to foster an atmosphere of safety for the child. Thus, working with parents takes on added significance as a way of protecting children.

However, by its very nature, working with parents produces an interesting paradox. Many of the human services workers on the front line of child abuse treatment are still not being trained to view the parent positively. Similarly, in many instances the parent has been influenced to regard human services workers negatively and with distrust. This culturally oriented bias is at the root of many of the dilemmas which are experienced by human services workers in child abuse and counseling situations. Resolution of this paradox is fundamental in working with abusive parents.

THE CHILD ABUSIVE PARENTS OR FAMILY

A parent is first, a parent. Only in the laboratory of child rearing does the parent assume the role of child abuser. This is the outgrowth of parenting practices that he learned from his parents. Some characteristics of abusive parents are:

1. Immaturity and dependency
2. Low self-esteem and sense of incompetence
3. Difficulty in seeking pleasure and finding satisfaction in the adult world
4. Social isolation and reluctance to seek help
5. Role reversal
6. Fear of spoiling the child and strong belief in value of punishment
7. Lack of ability to be empathetic and respond to the child.

In addition to the above characteristics, abusive parents cling tenaciously to the adage "My home is my castle". Therefore, the term child abuse can rightfully be viewed as family abuse since it exists "in house". Moreover, because it is a "family matter", abusive parenting practices tend to be passed on from generation to generation and to occur in the home.

Examination of research on the incidence of child abuse shows that abused and neglected children range in age from infants to adolescents. Also, fifty percent of this group are six years of age or younger and the most seriously injured are infants. Hartly (1969) and Sussman (1968) agreed in separate studies that abused children were generally below the age of three years. Furthermore, the number of reported cases of battered children—15,000 to 25,000—represents only a fraction of the total, and the incidence of abuse is higher among handicapped, premature, multiple-birth, adopted, foster, and step children.

A MISPLACED CULTURAL MYTH

From previous data and from a historical point of view, one might tend to believe that lower income families are overrepresented among abusive parents. This statement gives rise to the supposition that child abuse and neglect is a phenomenon of racial minorities and poor parents and families. While early statistics reflected this fact, they were not true indicators of the nature of child abuse and neglect. There were several reasons for this misrepresentation of facts. One, minorities and poor families had to use public facilities, welfare agencies and public hospitals, and were therefore more vulnerable to reporting. Two, private physicians of more financially able parents were reluctant to report child abuse cases for fear of endangering their rapport with the families. Three, some family practitioners failed to recognize cases of child abuse when they saw it (Neff, 1975).

These factors contributed greatly to the misconceptions surrounding child abuse, minorities, and the poor. In reality, child abuse cuts across all economic levels and racial groups. Steele emphasized this fact when he said:

> "Unfortunately, because so many of the early reports and descriptions of child abuse came through welfare agencies and municipal hospitals, it became a common belief that abuse and neglect of infants were associated with racial minorities and poverty-stricken groups of people. Such ideas still persist in many quarters, despite the increasing knowledge that child abuse and neglect occur among families from all socioeconomic levels, religious groups, races and nationalities" (Steele, 1975).

However, the evidence of social and economic deprivation, substandard housing, unemployment, and racial prejudice should not be discounted as stressful factors in the life styles of parents who abuse and neglect their offspring. These stress factors affect the quality of life and are often precipitators of abuse and neglect. They should always be considered in any program that seeks to treat and remediate abuse-prone families.

OTHER VARIABLES IN CHILD ABUSE

Although no major comprehensive research has examined the presence of a handicap as a causative factor of abuse and neglect, several researchers have reported findings which reveal a strong relationship. Other studies have indicated that abused children are seen as different or difficult to raise by their parents (Soeffing, 1975). Although it may be difficult to assess whether the handicap or the abuse came first, the child who is handicapped, different or viewed as deviant is a high risk case and likely to be abused by an abuse-prone parent.

In addition, a more comprehensive analysis of abuse and neglect could be expanded to include the area of sexual molestation. It is probably a truism that this area can be certified as

the last frontier in child abuse and neglect. Child sexual molestation as a form of abuse is far less popular to treat than physical abuse and is least likely to be faced head-on. Therefore, reluctance to report is high and the pressure to ignore the problem sometimes borders on harassment (Sgroi, 1975; Kempe and Helper, 1972). Nevertheless, these cases should be considered abusive acts, and sexual molestation is contained in the child abuse reporting statutes of many states.

When examining child abuse and neglect, there appear to be three major contributing variables. Helfer identified these variables thus:

Parent + Child + Situation = Abuse

Furthermore, he identified these same variables in neglect. Therefore, those who want to work with parents of abused and neglected children must focus on all three variables. Only by approaching the problem in this fashion can effective treatment be rendered by the human services worker.

SKILLS FOR THE FAMILY ENCOUNTER

Having discussed the variables that are present in any abusive or neglectful family situation, attention can now be focused on specific skills needed by human services workers to be effective in a parent counseling program.

No matter where the initial meeting with parents takes place, intervention will have a more useful beginning if human services workers have the skills to work with adults who don't want their help or don't think they need it. Therefore, the first most valuable skill to be utilized is attentive listening. Abuse-prone parents need a sympathetic, responsive and nonjudgmental ear. People who have never been listened to without fear of reprisal or threat will have a difficult time feeling at ease. Thus, if the human services workers can wait, and can provide an opportunity for parents to talk by open, attentive listening, they will increase the opportunity for parents to relate to them. In this manner, parents will feel less threatened and distrustful and the worker can show by his ability to listen that he has honest respect for their feelings.

Attentive listening can fulfill another important function. Abusive parents were characterized above as immature and dependent, lacking in self-esteem, and typed by role reversal. Awareness of these factors in the makeup of abusive parents allows the human services intervenor to listen for role discrepancies. Ross, in *The Exceptional Child in the Family,* describes three kinds of role discrepancies—cognitive, allocative, and goals—that are pertinent to the worker working with abusive parents. Cognitive discrepancy exists when one or more of the family members involved in the family role system does not know or is not sufficiently familiar with the roles required of him by other family members. Allocative discrepancy results when the individual refuses the role allocated to him or when other family members fail to complement his role. Goal discrepancy occurs when the goal of one family member is to obtain some form of gratification from another, but the other fails to meet the demand because his goal is related to withholding or he is unable to satisfy the demand (Ross, 1972).

Those who are interested in working with abusive parents should be knowledgeable about these three forms of discrepancy. Cognitive discrepancy can occur when the universal role ascribed to the child by the parents is not fulfilled. This could happen in situations when the parents expect the child to be still or to be quiet when teething or when ill at an early age. Sometimes the child is not capable of satisfying this demand. The child has not yet learned his ascribed role in the family system. When this happens the parents' demands are not met and abuse may follow. These parents' unreasonable demands were fostered by their previous recollection of parenting practices. The cognitive discrepancy was accelerated by unrealistic parental expectations that served to bring about a disequilibrium of the family system. Abusive parents often assign roles to their children and then are angered, sometimes to the point of violent aggression, when children cannot fill the assigned role.

In allocative discrepancy, role reversal occurs when abusive parents adopt the role of the child, that is, they have needs that were not met as children and they now desire the child to fulfill these needs for them. The result is that the requirement of complimentariness of roles is not met and abuse of the child follows.

An understanding of goal discrepancy is an extremely important ingredient of attentive listening. While listening in an open and respectful manner, the worker is in an excellent position to recognize goal discrepancies that result in family disequilibrium. These discrepancies in goals can be either motivational or biological in origin. Moreover, illness, lack of maturation, or

intellectual deficiency are generally paralleled by a restricted capacity for goal attainment. These biological (and any motivational) limitations may cause disequilibrium. This is especially true when the parent is unable or unwilling to change his level of expectancy concerning goal attainment by the child. Thus, one role partner, the parent, may be disappointed and cannot accommodate the limited biological or intellectual functioning of the child. The child has disappointed the parent by not fulfilling parental expectations. These situations occur frequently in the families of abused children and are commonplace in families where children are thought to be different, deviant or handicapped.

Thus, expressions of tension, anxiety, and hostility may be verbalized in the encounter between parent and worker. Open listening can do much to: (1) create a friendly atmosphere; (2) defuse tension and hostility; and (3) identify what discrepancies exist within family systems.

As parents begin to talk, the worker in the initial stage takes the role of a passive listener. Later as the parents become more comfortable, the human services worker can begin to respond to the central concerns of the parents. Allowing the parents to talk can lead to an opportunity to exercise the second skill, the skill of reflective feedback. This is the skill of responding verbally to parents, usually by paraphrasing, without passing judgment.

Furthermore, the worker can begin to assume a more active role in the counseling process. However, the nature of the worker's response can do much to dictate the course of the encounter. It is critical in this phase of parent relationships that the worker not be influenced by the nature of the abusive act. The worker must continue to be accepting of the abusive parent. Therefore, the worker continues to maintain an attitude of open and attentive receptivity to the parent. The worker should listen and be alert to recognize that the feelings being expressed during the encounter may not be the true feelings of the parent. It may be that the parent needs those feelings that might otherwise consume him. The worker should remember that he is working with a parent who has the following needs:

1. Parents need help in feeling good about themselves, to make up for the devastating belittling they've experienced in their own lives.
2. Parents need to be comforted when they are hurt, supported when they feel weak and liked for their likeable qualities--even when these are hard to find.
3. Parents need someone they can trust and lean on, someone who will put up with their ill temper and someone who will not be tricked into accepting their low sense of self-worth.
4. Parents need someone who will not be exhausted with them when they find no pleasure in life and defeat all attempts to help them seek it.
5. Parents need someone who will be there in times of crises.

If workers respond to the feelings of abusive parents through the medium of reflective feedback they can avoid registering the attitude that their approval or disapproval is being given. It also allows workers to be alert to and to be able to respond to the nature of the feeling (negative, positive, or ambivalent) and the direction of (toward police, counselor, or self) the feeling without being misunderstood. Therefore, the worker can nod his head, ask relevant questions or replay the feeling back to the parent.

Reflection of feeling can also help parents to work through goal discrepancies. Through reflective feedback and paraphrasing (replaying what the parent has said in your own words) the worker can often be effective in holding up reality to a parent without arguing the point. If a parent denies the severity of the abusive behavior, the worker can reflect or replay the denial to him. It is important for the worker to help the parent recognize and clarify his discrepancies by replaying the information back to him. In this manner the parent can begin to discover potential alternatives for dealing with his concerns and needs. The worker should remember that many parents are not aware of the discrepancies in their parenting practices and the concomittant inconsistencies in their communication to him. It is within the parent encounter that the worker has the opportunity to help the following parents:

1. Parents who need someone who understands how hard it is for them to have dependents when they have never been allowed to be dependent themselves.
2. Parents who need someone who will not criticize them...that will not tell them what to do or how to manage their lives.
3. Parents who need someone who will help them understand their children without making them feel imposed upon...or stupid.
4. Parents who need someone who can give to them without making them feel of lesser value because of their needs (Davoren, 1975).

These parental needs vividly make the point for reflective feedback. In reflective feedback, the worker promotes discussion by responding only to what the parent is really saying and by encouraging the expression of feeling. This means that the worker's goal in responding is to understand what the parent is expressing and to communicate "I am with you". Therefore, it would be inappropriate for the worker to pass on his interpretations to the parent. It has already been stated that parents are in need of someone who will help them without making them feel of lesser value, who will not criticize or tell them what to do or how to manage their lives. With reflective feedback, the worker can assist the parent to identify and choose alternative socially acceptable behavior rather than abusive parenting practices.

Finally, the skill of summarization makes it possible for the human services worker to assume his role as advocate or ombudsman. Summarization is the ability of the worker to "put it all together" for the parent. Without this skill, the worker will find himself at a loss in dealing with abusive parents. Therefore, while maintaining an open and accepting attitude, the worker must also look for ways to summarize the feelings that he has heard in the encounter and be able to go beyond reflective feedback to help the parent. The abusive parent should hear the substance of his feelings as a "complete" replay rather than as an "instant" replay. This is the major difference between summarization and reflective feedback. Therefore, summarization might occur at the beginning of the counseling encounter, several times within the encounter or at the conclusion of the session.

The strength of summarization lies in the fact that it allows the worker in the counseling encounter to choose his path of action with the client. If the client is moving toward resolution of his dilemma (e.g., goal discrepancy), the worker can function as an ombudsman and continue to mediate the problem. If it appears that the parent is having difficulty in resolving the goal discrepancy, then the worker may become an advocate for alternatives. These may take the form of: (1) referrals for psychotherapeutic intervention if the denial is too rigid; (2) continuing to work conjointly with the parent in a support role; or (3) regarding the situation as hopeless and unchangeable.

Most human services workers who seek to help abused and neglected children probably never give way to the third alternative. Rather than viewing the child as an unfortunate victim of negative parental influences about which nothing can be done, most continue to exhaust their energies in attempting to work with abusive parents. They develop skills and help parents grow into tolerant human beings.

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The Battered Adolescent: A Developmental Approach to Identification and Intervention

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INTRODUCTION

> The family has been called the "giant shock absorber" of society—the place to which the bruised and battered individual returns after doing battle with the world, the one stable point in an increasingly flux-filled environment. As the super-industrial revolution unfolds, this "shock absorber" will come in for some shocks of its own (Toffler, 1971, p. 238).

One of the shock absorbers to which Toffler refers may be the particular family member(s) who become the bruised and battered individuals referred to in the literature as "abused children". This article will look at one aspect of this problem, namely the adolescent segment of the abused population, with a particular interest in the abused adolescent with developmental disabilities.

EXTENT OF THE PROBLEM

In a review of a national, a state and a local study, an increased incidence of abuse in youths over 12 years of age was indicated, from 16% of all abused children in 1967 to 30% in 1976. In one study, 32,500 adolescents were identified as abused in Florida in a five year period from 1971-1976. No data is available on the numbers of adolescents in this population who are developmentally delayed.

Table 1

Percent of Abused Children Over 12 Years of Age

Source:	White House Conference on Children, 1970	
	Year:	1968
		16.2% of total population of abused children were adolescents
Source:	Florida Five Year Study	
	Year:	1971-1976
		25% of total population of abused children were adolescents
Source:	Local Study—Broward County	
	Year:	1976
		30% of total population of abused children were adolescents

These statistics suggest that there is a large population of youths who have not found effective ways to ward off the attacks of caretakers. This paper will describe one such case. It will also identify inferential etiological factors leading to abusive activity toward adolescents, and then sketch out a plan of intervention.

THE CASE

Jenny, a 15-year-old, mildly retarded child was referred to the Mailman Center for Child Development by her mother due to an inability to control the child's seizures and behavioral problems. Over the Christmas holidays, when the support staff was not in close touch with the family, Jenny received two black eyes from a male companion of her mother (with her mother present) when Jenny became disobedient. Jenny also had been severely beaten by her mother as a small child.

Her developmental history indicated that she was an unplanned pregnancy, and that her mother had made several attempts to abort the fetus. The infant was cyanotic at birth, had seizures at the time of delivery, and had been treated throughout her childhood for a convulsive

disorder. She also underwent seven surgical procedures to correct a club foot. It was determined that she had a bilateral moderate to severe. high frequency sensory neural hearing loss. In addition, she was in need of speech therapy. Jenny is known to be sexually active and was found to have venereal disease. She was sexually provocative with her monther's boyfriends, and possibly had had incestuous relations with her alcoholic father.

Jenny's mother was an illegitimate child in an extremely religious family and was punitively raised by a maternal great-grandmother. She became pregnant out-of-wedlock with Jenny, and the subsequent marriage to Jenny's father lasted 9 years. Her husband was physically abusive to her. She is known to entertain men in her home and has an alcoholism problem.

A male child, born a year later, has no medical abnormalities.

CHILD ABUSE AND DEVELOPMENTAL DISABILITIES

> In the past few years, interest in the area of child abuse has grown to mammoth proportions. Many areas of the problem have been researched; however, the connection between developmental disabilities and child abuse appears to have been left relatively unexamined. ...Recently, researchers are beginning to connect what they already know about child abuse with the special problems of the developmentally disabled. The stress of mothering has been one of the factors pointed to as a potential cause of child abuse. Children with special physical and emotional problems, such as the developmentally disabled, may put a higher stress on the family involved and thus precipitate incidents of child abuse. Unrealistic expectations and parental ignorance are also noted as problems which may lead to abuse... This problem is heightened for some parents of developmentally disabled children, who may see their child's behavior as intentional naughtiness rather than normal for their ability. (Chotiner, 1976, p. 6)

The intent of this paper is to examine the effects of the concurrence of developmental disabilities with the onset of adolescence, thereby placing the youth at risk of abuse.

REVIEW OF THE LITERATURE

In a computer search of 283 citations the author found only one significant article related to the battered adolescent. Dr. Ira S. Lourie, M.D., coordinator of child abuse programs at the Center for Studies of Child and Family Mental Health, NIMH, states that, "We have heard a lot about the battered child, but little about the battered adolescent, even though adolescent abuse sometimes accounts for a third of all juvenile abuse reports" (Lourie, 1977).

In light of the dearth of information regarding the phenomenon of adolescent abuse, a review of the literature on the relationship of developmental disabilities to abuse of the younger child may shed some light on the problem of adolescent abuse.

Elmer (1967), in a study involving 50 children with bone injuries, 22 of whom were known to have been abused, obtained the following data. 30% of the abused children weighed less than 5½ pounds at birth. At the time of the study, one third of the abused children were below the third percentile for height and weight. Slightly over 30% had signs of central nervous system damage. 57% had an I.Q. of 80 or less.

In 1968, Birrell and Birrell found that 25% of a sample of 42 maltreated children had congenital anomalies. In a 1968 study of 101 children with inflicted injuries, the Denver Department of Welfare found that 70% of the children exhibited some physical or mental deviation prior to the reported injury. 19% were delayed in their speech and 17% had manifest mental retardation or learning disabilities.

In 1969, the Los Angeles County Hospital identified 50 abused children of whom 15 had significant growth retardation. Gil (1967-78) reports that 14% of the abused children in his research manifested deviations in physical functioning.

These observations raise the question of whether children who have some physical or developmental deviation are at higher risk for abuse or whether this reported deviation possibly results from unreported abuse or neglect by the parents in the past, as per Martin et al (1974).

Let us look at some larger populations of children who manifest developmental deficits. In a study of 18-year-old youths rejected by the Selective Service in 1965, 15% were rejected because of chronic handicapping conditions. It was estimated that a third of these conditions could have been prevented or corrected if diagnosed before the young men had reached age fifteen, and almost two thirds if found before age nine. These factors strongly reinforce the need for prevention (Travis, 1976, p. 4).

Another study reports an incidence of congenital malformations of 7% in a group of 6,000 children followed until one year of age (Travis, p. 5). Another reports that of the viable infants born, between 4% and 7% have moderately serious birth defects (Travis, p. 5). In addition, educational data estimates that about 12% of school age children are in need of special education because of handicapping conditions (Travis, p. 5).

Zill (1977, p. 1) captures part of the problem when he states that "There is a lack of recognition of the need for large-scale programs of detection, prevention, and assistance for kids in bad economic and social circumstances...and there is an incredible paucity of data regarding their needs." Let us look for a moment at one population with special needs, school underachievers, since these children are frequently seen in protective service agencies.

Hammar (1967) reviewed 73 cases referred for school underachievement over a two year period to an Adolescent Clinic. He found that 56 cases, or 77%, had been identified by teachers before the third grade. Twelve of 25 of the adolescents with suspicious medical histories suggestive of organic brain damage were identified. Thirty-eight of the youths were noted to have soft neurological findings suggestive of minimal brain dysfunction. These soft signs included coordination defects, speech irregularities, reflex asymmetry, confused laterality, abnormal Bender-Gestalt results, short attention, and poor fine motor coordination. Forty of the students were found to have specific learning disabilities. Forty-two percent of the children were found to have primary reading problems. Thirteen of the adolescents were mental retardates whose deficiencies may not have been readily apparent, yet most of the parents were suspicious of intellectual deficits.

Behavior problems were not uncommon but were felt to be secondary to the specific learning disability. Ausebel (1968) suggests, "In any case, underachievers, as contrasted to achievers, tend to be characterized by more withdrawal behavior and by more negative self-concepts" (Shaw, Edson, Bell, 1960). These socially isolated young people appear as social misfits, and as such are looked upon as being less than ideal offspring in the eyes of their parents.

Hammar suggests that the onset of puberty frequently increased parental concerns, the principle ones being: (1) the need to make future educational and training plans for the teenager, (2) anxiety about sexual development and sexual behavior, and (3) questions regarding the management of temper outbursts and aggressive and destructive behavior, which often were marked problems. In light of these parental concerns, the risk of becoming an abused adolescent increases. School underachievement might well be used as one index for spotting potential abused adolescents.

THE DYNAMICS OF ADOLESCENCE

Having examined some of the indices of developmental deficits in abused children, it might be helpful to identify various elements of adolescent dynamics in order to highlight the complexity of dynamics and disability. Certainly the physical maturational changes that manifest themselves in adolescents are a major cause of concern to youths, especially in light of their developing sexual identity and the important role that physical prowess plays in the lives of this age group. Then there is the striving for independence with the accompanying alienation from the family and the strong identification with a peer group, much to the consternation of the parents. The onset of primitive sexual urges with some homosexual elements awakens anxiety in these young people, and in their attempts to master these anxious feelings, aggression is brought into play. This may find physical and/or verbal expression, such as swearing and boastfulness in boys. Communication between generations becomes a trial for all concerned. Educational stresses abound. The difficult task of assessing adolescent capacities for responsibility, coupled with parental feelings of unsureness regarding their roles, leads to mutual friction and alienation. The regressive state to which youths return when threatened causes further consternation. Sugar (1975) presents the picture for parents:

> From the point of view of adolescent development, we define the task of the family as the promotion of relative ego autonomy and individuation in the adolescent leading to identity consolidation and pyschological separation from his parents.

These then are a few of the subtle and varied changes that make adolescence a period of stress both for the adolescent and his family.

INTERVENTION

It now remains to work out an intervention strategy with special emphasis on the remediation of the adolescent's developmental deficits as a primary mode of alleviating the "at risk" quality of these individuals. In order to do this let us return to Travis, who identifies a series of premises regarding human life and child development that undergird the process of intervention with the battered adolescent. These premises have been adapted to fit the problem under discussion in this paper.

BASIC PREMISES ABOUT HUMAN LIFE

1. Childhood as a Period of Prevention: Human services personnel work to prevent in children the actuality and derivatives of terror arising from perception of parents as untrustworthy and of grown-ups as pain-inducers.
2. The Child as a Whole: This paper suggests a comprehensive approach to the process of intervention, i.e., somatic, psychic, social, and cultural.
3. Social Systems Theory: This paper would draw attention to the variety of cultural traditions, customs, social norms and beliefs existing within the family system so as to distinguish between familial patterns of discipline and battering.
4. The Determinants of Stress: This premise involves (a) the limits to which a parent or child can accommodate stress, (b) the effects of additional stresses on an overtaxed member of the family system, (c) the suddenness of stress.
5. The Concept of Crisis: There are developmental crises related to changes in age or role, e.g., the onset of adolescence, and situational crises which occur as a result of some catastrophe such as illness. The amount of anxiety during a crisis is related to earlier similar experiences, e.g., abuse in the caretaker's own childhood. There is nothing necessarily pathological about being overwhelmed and unable to cope, i.e., the onset of adolescence is so overwhelming at times that regression is an appropriate recourse. The crisis can be an opportunity for growth i.e., parents need to know that failures incurred by their adolescents can be growth producing. The helping person must reach out quickly with practical help, e.g., temporary foster care.
6. Dependence and Independence: These two instinctual drives existing in both the parent and the child create powerful forces and counterforces. The adolescent is especially reticent about manifesting dependency needs as he strives for independence.

BASIC PREMISES ABOUT CHILD AND ADOLESCENT DEVELOPMENT

1. Constitution as the Foundation for Growth and Development: An adolescent with a developmental deficit will have a more difficult time attaining his full potential. The thwarted development of the adolescent will have its impact on the caretakers.
2. The Inevitability of Growth and Change: The adolescent's growth is inevitable and may bring stress to the unprepared parent.
3. The Significance of Change: Periods of rapid change, e.g., adolescence, are uncomfortable for the child (and parent) as new experiences are being incorporated.
4. The Concept of Ages and Stages: The bio-psychological stages of growth create special needs which must be provided for. Critical needs during any stage must be met; the unmet needs of adolescence prepare a person poorly for adulthood.
5. The Family and the Transmission of Culture: The lower socioeconomic family, tormented by multiple stresses, may transmit a self-defeating way of life.
6. The Prevalence of Insecurity in Family Life: The family as an institution reflects the turbulent transition of the society. Care for a handicapped child poses a threat to the family when society fails to provide support systems.

Having laid a philosophical groundwork for the concept of intervention let us now return to the case of Jenny to see what steps were taken to alleviate the stresses in her life. Jenny's academic status was reviewed with school personnel and a more appropriate class assignment was made. Her seizure activity and her venereal disease were treated and monitored by a family medicine clinic as were the medical needs of her mother and brother. Dental care was arranged for the entire family. Jenny's hearing deficits were diagnosed and a hearing aid was made available to her, along with speech therapy. A Big Sister contract was renegotiated. Sex education was provided through the school, along with an attempt to enhance the quality of her peer social life.

The multiple needs of the other family members were identified. Her brother was provided with a needed male model, who helped him give up his semi-suicidal adventures with motorcycles. Strong efforts were made to remedy his truant tendencies.

Jenny's mother was offered assistance with her alcoholism. She became involved in long range counseling in a variety of areas including improved parenting skills, more appropriate social outlets for herself, and preparation for employment. Eight agencies were involved. This multiple impact on the family's deviant life style was essential in order to avoid the fallacy of seeing this problem simply as one of maternal neglect.

CONCLUSION

In closing, some effort needs to be made to develop a model of identification that will attend to developmental deviancy in the adolescent and to the multiple problems that harass family life to create crises that promote abuse. In terms of prevention, the developmental disability might be one of several factors that identify the adolescent who is "at risk". Attention to the following elements of a model appears essential (SW Problem Classification, 1975).

1. Problems related to the adolescent's growth and development. The bio-psychological impact of adolescence as the "no man's land" between childhood and adulthood is fraught with psychological "land mines" as the adolescent moves toward maturity.
2. Problems related to the adolescent's physical condition. These problems encompass the impact of disability on his own self image, his relationship with peers, and his parents' reaction to his physical condition.
3. Problems related to the adolescent's behavior and learning. The impact of repeated failure in school with few opportunities for success will exacerbate negative behaviors.
4. Problems related to child rearing and home management. The literature on child abuse is replete with warnings against excessive expectations on the part of parents. For a youth with a developmental delay these expectations can be devastating.
5. Problems related to stress and transient situations. Families in our society are vulnerable to unemployment, illness of family members, death, and marital discord. The threat of these crises can be debilitating to an adolescent and his family.
6. Problems related to the adolescent's environment. Bad neighborhoods, poor housing, delinquent peer models and the absence of appropriate leisure time activities create a climate of stress for youth.

This paper will end with the sage wisdom of one of the most noble interpreters of adolescence. Anne Frank notes that "In its innermost depth, youth is lonelier than old age." Interdisciplinary teams of human services workers must do more in order to make that stage more palatable and viable for the adolescent who has the potential to be battered.

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Group Therapy Intervention Strategies for Abusing Parents and Evaluation of Results

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More than 50 percent of the children who are abused will be abused again if there is no therapeutic intervention (Fontana, 1964). There are a number of therapeutic strategies of intervention in child abuse. The one we use features group therapy with abusive parents and an innovative method of setting goals and measuring effectiveness. One question about the traditional treatment given to parents who abuse is whether it is effective—whether the techniques employed actually work. We believe this is a compelling question to ask about psychotherapy for all kinds of problems and we place considerable emphasis on it in our approach.

The parents we work with are couples—the male and female adults in the household who are responsible for the child. Because the spouses are basically alike and are tied to each other in a symbiotic relationship like Siamese twins, it is essential to work with both spouses if the potential for abuse is to be defused.

If only one spouse enters therapy and the other remains in the household, the one at home will do all he can to maintain the symbiosis and to sabotage changes being made by the other. In any spouse subsystem it is impossible for one person to make changes without affecting the other, and the other will stoutly resist those changes as the symbiosis becomes threatened.

Thus, although our techniques also apply to work with single parents, we have held firmly to a policy of treating only couples. Other therapists agree with us. As Isaacs has noted, "Both parents are the same. They should be treated. It doesn't matter which one actually did the battering" (Isaacs, 1972). All couples in our parents' group are referred by local child welfare agencies (primarily, Harris County Child Welfare Unit in Houston). In 75 percent of the cases, there has been a court order removing the couple's child from the home. The couples are given to understand that their chances of getting the child back are likely to be greatly increased if they undergo therapy. Thus, couples enter the group with resentment—which is usually not openly expressed but manifests itself in subtle efforts to keep from cooperating, to remain passive while attending group, or to try to find excuses for not coming. This is strictly a temporary phase, which lasts from three to five weeks. After that the couples find that they are beginning to benefit from coming, that they are enjoying the experience of belonging to a group and being around others like themselves, and that the world is looking brighter.

Group cohesion, a sense of belonging, and positive individual changes can grow to the extent that many couples find reasons to continue therapy after they have been told that they can quit coming. We give a recommendation to child welfare authorities, who in turn present it to the court when evaluation of results shows that the criteria for termination have been met.

Termination does not come before the child returns home. After the child is returned, the parents remain in the group a minimum of one month to make sure that no new problems go unsolved, the changes made by the parents hold up, and the new techniques of child management are applied.

Average length of therapy for a couple in our group is between five and six months. Helfer (1974) reports working with abusing parents six to nine months. Kempe (1971) says, "much improvement is often seen in only three to six months and intensive care rarely lasts more than eight months." He says "80 percent of our patients have their children back in eight months' time" (Kempe, 1973).

A maximum of five couples make up our group at any one time. Four are preferable, but since there is a waiting list of parents who have been recommended for the group, we raised the limit to five. The group is conducted under the auspices of the Texas Research Institute of Mental Sciences, and meets once a week from 7 to 8:30 P.M. Couples become members of the group after they have been individually interviewed in depth by us and have had a separate interview with the chief of adult services, a psychiatrist, at the institute.

To encourage the couples to start reaching out to others in time of crisis or need, we give them our office and home telephone numbers and urge them to call. We also ask that they let us know anytime that they cannot attend group. Few couples in the group miss more than two or three times while in therapy. As they start to develop trust in others, they also begin calling us more frequently. As group cohesion grows, they start phoning and visiting with others in the group.

All of this contributes to ameliorating another problem of abusing parents—low self-esteem. The acceptance, the gaining of friends, the building of trust, the feeling that their opinions and ideas matter to others—all these are new experiences that greatly enhance self-image. As therapists, we encourage the contributions that the group makes to its members, knowing that for a person to change, he must feel he has "permission" to do so, that he will have "protection" while experimenting with new behavior and feelings, and that there is "potency" on the part of those encouraging the changes. One of our functions as therapists is to help provide the "3 P's" (Crossman, 1968). Our ability to do so is greatly enhanced by the backing of a cohesive group.

Group therapy is advantageous because it reaches more people than individual therapy does. One of our strategies has been to train others (such as child welfare supervisors and caseworkers) to conduct groups so that the many people in need of therapy can get help without waiting for an opening in our group. Nine additional groups have been started since we began such training in 1975.

The chief objective of group therapy for abusive parents is to promote changes in the parents and the family environment so that the safety of the child is assured when he is returned home. The steps necessary for gaining these objectives involve analyzing the psychosocial influences of the abusing family system and isolating the factors that can be best dealt with in parents group therapy. What this amounts to is (1) identifying the dynamics (psychological and social) of the spouses and their subsystem; (2) determining the deficits in the couple's knowledge of child development and management; and (3) assessing the role played by the environment. These steps are embodied in the theoretical framework that we use. As for the therapeutic methods employed for accomplishing the steps I have outlined, we rely chiefly on these: transactional analysis; behavior therapy, using techniques such as those developed by Lazarus (1972) and Wolpe, (1969) combined when indicated with hypnosis; Rational-Emotive Therapy; and child management techniques and information on the needs of children during specific developmental stages.

To determine whether our methods are working and the objectives being achieved, we use an evaluation technique called Goal Attainment Scaling (Kiresuk and Sherman, 1968), which measures outcome not only while the couples are in the group but also at follow-up intervals of every six months. We use GAS as a therapeutic tool as well as a method of evaluation. GAS requires identifying the main areas of concern of abusive couples and setting goals to be reached in therapy for each area. The way we identify the problem areas is by (1) having couples rank-order their problems on a checklist given to them when they enter the group; (2) doing individual in-depth interviews with each new person; (3) borrowing from our own experience in working with other abusive parents and their common problems; and (4) taking into account what the literature says about such parents.

The typical problem areas that we work on with each spouse are these: Symbiosis, Isolation, Talking and Sharing with Mate, Impatience and/or Temper, Child Development and Management, and Employment. A GAS Follow-up Guide is constructed for every person in the group, setting goals to be reached for each area of concern within a three-month period. The same guide is also used for follow-up every six months after the couple leaves the group. Figure 1 presents a Goal Attainment Follow-up Guide, showing the six scales to be labeled with the areas of concern and the five goal levels (-2 to +2) to be filled in for the client.

FIGURE 1--GOAL ATTAINMENT FOLLOW-UP GUIDE

Level at Follow-up: Goal Attainment Score (Level at Follow-up)

SCALE ATTAINMENT LEVELS	SCALE 1: Symbiosis (weight$_1$=)	SCALE 2: Isolation (weight$_2$=)	SCALE 3: Talking and Sharing with Mate (weight$_3$=)	SCALE 4: Temper/ Impatience (weight$_4$=)	SCALE 5: Child Manage-ment (weight$_5$=)	SCALE 6: Employment (weight$_6$=)
most unfavorable outcome thought likely (-2)						
less than expected success (-1)						
expected level of success (0)						
more than expected success (+1)						
most favorable outcome thought likely (+2)						

So that no one gets the idea that every parent we see in group therapy is always treated in terms of the same six problem areas, it should be pointed out that the Goal Attainment Scaling allows for adding new goals as more is learned about the person and other problems are uncovered. The six problems of symbiosis, isolation, talking and sharing with mate, temper/impatience, child development and management, and employment are the typical areas that we address. We have found that a number of other problems that a person complains of at intake usually have a way of clearing up when these problems are relieved.

For instance, quite a few abusing parents are depressed. As we work on the areas of isolation and talking and sharing with mate and help the person change his stroking profile, the depression often lifts. The same thing frequently happens in terms of low self-image, particularly when gains also begin to be made in the symbiosis and employment areas. Sex difficulties and marital conflict subside as symbiosis and talking and sharing with mate are worked on. Not always, however, do the six areas of concern cover subsidiary problems. In these

cases, the problem is listed on the Goal Attainment Guide as an additional area of concern and goals are set for being reached in three months. At the end of that time, evaluation is made and new goals are set for another period.

WHEN IT IS SAFE FOR THE CHILD TO RETURN

As noted, we use a quantitative method—a Goal Attainment score—for telling when a couple has made enough changes for the child to return home and our chief objective has been reached. What kind of "profile" does the couple have after such changes, in terms of the six problem areas we work on with them? The criteria used by Helfer (1974) for determining when a "home is safer" are these: "neighbor is helpful, sister or mother is helpful; husband is understanding; they have a telephone; they have someone to call; husband is helpful; mother sees herself as helpful; they have friends; role reversal is less; child is able to be a child; there is no scapegoat; there are fewer crises, etc." Kempe (1973b) says a child is safe to go home (1) "When the parents' self-image has improved...We can sense this by the way they dress and when they have any kind of social life." (2) "When they see the child in more positive terms." (3) "When they prove to us that they can use lifelines in moments of stress and they can use the telephone to call" someone to help bail them out. (4) "When on weekend visits they have shown that they can handle the child emotionally."

Although the criteria used by Helfer and Kempe are helpful, we wanted a more objective means of determining the amount of change parents must make for them to provide a safe home for the child. Clinical impressions are necessarily subjective, and the impressions of one therapist may not agree with those of another. With Goal Attainment Scaling, we try to set goals with the clients that are observable and confirmable so whether or not they are reached is not just a matter of our opinion.

The GAS lends itself to a composite Goal Attainment T score, based on a formula derived by Kiresuk and Sherman. This formula uses the numerical values attached to each level of outcome (from -2 to +2) and takes into consideration the weights designated for each scale. From follow-up data on the parents we have worked with since 1973, we have been able to confirm that when each spouse obtains a Goal Attainment score of 55 or more, it is safe for the child to return.

When the couples we work with leave the group and their child has been returned home, the overall changes they have made will have taken this general pattern: their symbiosis has changed to each meeting his or her own needs, and they provide mutual support for the other; the isolation has changed to mixing with people, phoning people and reaching out for help when needed; the talking and sharing with mate has moved from silence or criticism to regular exchange of positive strokes and mutual support; the impatience and/or temper has changed to more relaxed behavior, based on techniques learned in the group; child development and management have been worked on so that the parents understand the needs of their child at various ages and stages of development and know what response to make, using techniques of management other than physical discipline; employment changes center on getting a job, or learning to keep from getting uptight at work or using work to avoid relationships at home.

There have been twenty-seven couples in the abusing parents group since it was begun in May, 1973. Nineteen couples have completed therapy and there has been no recurrence of abuse in any of the families. Three couples dropped out and lost permanent custody of their children. Five couples are presently in the group. One of these is a couple who completed therapy in 1975 but is now having renewed marital conflict and has returned to the group. There has been no recurrence of abuse to their child.

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A Treatment Approach to Child Abuse and Delinquency

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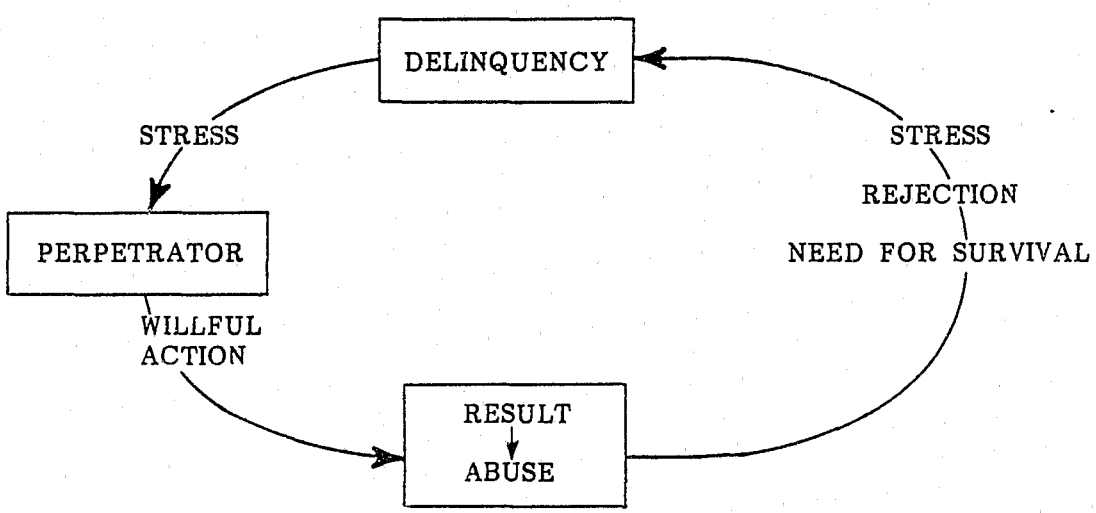
For the last several decades, practitioners in the field of human services have intensively examined a number of societal problems that result in dysfunctional human interactions; among these are drug abuse, alcoholism, child abuse, and delinquency. This paper focuses on two of the above, their relationship to each other, and their combined effect on group interaction.

The Model Child Protective Services Act (HEW, Office of Child Development) defines an abused or maltreated child as a child whose physical or mental health or welfare is harmed or threatened with harm by his parent or other person responsible for his welfare. The Act goes on further to define the ways in which harm can be inflicted upon a child. In the clarification of the terms, mental injury is described in relation to, but not limited to, such factors as control of aggressive or self-destructive impulse; acting out of misbehavior, including incorrigibility, ungovernability, or habitual truancy—all factors commonly associated with delinquent behavior. The following graphic illustrates what this author perceives as the cyclical nature of child abuse and delinquency.

Figure 1. Child Abuse and Delinquency Cycle



It is important to point out here that child abuse and delinquency do not always occur together, but recent research has noted the frequency enough to warrant looking at these problems jointly. Rutter (1972), after examining the literature on deviance, suggested that lack of parental warmth is not sufficient by itself to produce antisocial behavior. Instead, "active discord in the home, as well as lack of warmth are associated with antisocial disorders in the child."

It is helpful at this point to look at Maslow's (1951) "Hierarchy of Needs," which the author of this paper proposes as a useful framework in diagnosis and treatment planning in cases of child abuse and delinquency.

Table 1: Hierarchy of Needs

Self-Actualization

Identity/Integrity

Mastery/Achievement

Affiliation/Love

Safety/Homeostasis

Survival

The progression of man, individually and as a member of a group, begins with survival and works toward self-actualization. Let us trace the abused delinquent child through the stages; first, negatively, looking at possible factors causing the abuse/delinquency, and then considering the possible treatment plan.

Let us examine the perpetrator of the abuse. Molnick and Hurley (1969) matched a group of ten abusive and ten control mothers in terms of age, social class, and educational background. They found the abusive mothers to have lower self-esteem, less satisfaction in their families, less need to give nurturance, and greater frustration of dependency needs than the control mothers.

If we consider the abusing mother in terms of Maslow's list of needs we see that, while basic survival is not a problem, this person has not successfully passed through either stages two or three. Low self-esteem and little satisfaction in their families indicate that the level of safety has not been accomplished. Little need to give nurturance may indicate great difficulty with level three, and the lack of love results in the inability to give love and nurturance.

Next, let us consider the child victim and the result of parental rejection in the form of physical or emotional abuse, sexual abuse, or neglect. Many child victims will not become self-sufficient adults or achieve even the basic level of Maslow's needs: survival. Their ability to provide the basic necessities for continued existence has been sufficiently impaired to warrant endless outside support.

Other child victims who have survived a physical trauma are left without a sense of safety in their nuclear environment, whether it is the biological family, a foster family, or an institutional placement. They have a constant need to test members within that environment to get a fix on the degree of safety that exists. This testing may take one or several forms: dependency, withdrawal, aggression and hostility, theft, truancy, criminality, cruelty, destructiveness, rebelliousness, lying, and sexual promiscuity. They often have no group to affiliate themselves with as a member and, consequently, have no source of love, support, and nurturance. Yet, before they have mastered Maslow's lower levels, society often demands that these individuals make what ultimately becomes a futile attempt at an even higher level.

In my own past direct service experience as a school social worker in a large urban city, I constantly had referrals from school officials of delinquent and predelinquent adolescents. A majority of these referrals focused on "failure to master content materials," "slow-learner," and "constant behavior problem." Many of these children were from multi-problem families, where they had met with no successes but a very long line of failures. They had failed in levels two and three, and now there was a demand being placed on them to attempt level four and seek achievement and mastery in both academic and social areas. There was no foundation upon which to build. The result was most often failure, and failure in a critical period in their adult development.

The delinquent behavior that so often occurs as a result of parental abuse and rejection manifests itself in various ways, including hostility and aggression toward the parent as well as toward other adult authority figures.

The link between parental rejection and child aggression has been recognized for several decades. In a study by Symonds (1939), rejected children were significantly more rebellious than those who were accepted. In another study, by Wolberg (1944), two types of parented rejections were studied: rejection expressed in the form of parental hostility and rejection expressed as parental neglect. Eighty-five percent of the children in the sample had problems with aggression, including temper tantrums, fighting, and destructiveness.

TREATMENT PLANNING

Both the cycle and Maslow's hierarchy should be considered in treatment planning for families involved in child abuse and delinquency. As research in child abuse has shown, the cycle will continue unless meaningful intervention occurs. If society is not to produce generations of persons whose modus operandi in human interactions is aggression, hostility, and other forms of deviant behavior, then the abuse/aggression syndrome must be dealt with effectively.

When a suspected case of child abuse and neglect and/or delinquency has been identified, the following steps could be useful in developing both short and long term treatment plans.

Step One

An assessment of each person in the family, i.e., mother, father, child, victims, siblings, and significant others (grandparents, aunts, uncles, etc.) in terms of where that person is in the hierarchy of needs. It should be emphasized that a person may be attempting several levels at

one time without having achieved success in the preceeding levels. This information can be obtained from a number of sources:

1. Initial interviews;
2. Reports from other interviewers or examiners (doctor's report, police report, school reports);
3. The person's own account of how he is feeling about himself and significant others in his life;
4. Observation of family interactions in group interviews; and
5. A group experience with persons other than family members (e.g., a teenager in physical education class, football, academic competition, or other social group experiences).

Step Two

An assessment of the family as a whole in terms of the successful completion of the levels by each individual member. This process provides an indication of which levels each family member may be able to assist others in mastering. For example, one of the components of the Sexual Abuse Treatment Program in Tacoma, Washington, is a family council. The family council consists of a family meeting once a week where each member of the family has an opportunity to discuss his/her problems. The council provides a medium for communication among family members and is an extremely useful tool in assisting all members of a family in feeling safe in their environment, and successfully completing the second level in Maslow's hierarchy. The parents, in this situation, have the responsibility for assisting the child victim and other siblings in obtaining that level of safety.

Step Three

The development of short and long term treatment plans, which allow for sequential mastery of Maslow's hierarchy for each family member. Again, it should be stressed that, while a person may be attempting to function in several levels, treatment should be based on the sequential mastery of preceeding levels.

Treatment planning should also take into account the fact that mastery of the hierarchy of needs differs for the same individual in different settings.

Case Example: Dorothy G., a diabetic teenager in institutional placement due to the absence of an adequate foster home. Dorothy attended the public junior high school in that area. While Dorothy has fairly well mastered levels one and two, dealing with survival and safety within the institution, the feelings of affiliation/love did not last. Moreover, when forced into a public school setting, Dorothy actually felt threatened on all levels and would put herself into a diabetic coma as a way of "crying for help" from the adults as well as from her peer group. Other behavior included truancy, extreme withdrawal, and an absence of peer relationships. Dorothy has been severely neglected in her biological home. Treatment was a lengthy process and, through individual and group counseling as well as sessions with her institutional family, Dorothy was helped to master each level of Maslow's list in the institution, school, and finally with her biological mother when visiting. Eventually her return home was accomplished.

SUMMARY

Maslow's hierarchy can be useful to human service workers in developing treatment plans that take into account the different levels of needs of all the persons involved. Each person's needs in the family group interaction must be addressed if a family is to move from being dysfunctional to being functional and rewarding to its members.

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Treatment Program for Abused Children and Their Families in Conjunction with Nursing Education

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Child abuse isn't a new phenomenon. Descriptions of child abuse have been recorded since the earliest days of civilization. Child beating was an accepted practice in Classical times and continued through the Industrial Revolution. Only recently has child abuse been viewed as a medical and psychological problem.

The United States began to take steps towards solution of the child abuse problem in the 1950's. In 1962, Dr. Henry Kempe, a Colorado pediatrician, now an acknowledged leader in present treatment and prevention programs, undertook to publicize the crisis through studies of abused children and their families. He and his associates found that the parents of abused children often were themselves abused as children (Kempe, 1962). Therefore, the approach to treating the abused child necessitated treatment of his parents and siblings. Successful treatment of these families provided impetus for other professionals to study and provide treatment for the families of abused children throughout the country. In New York, Vincent Fontana (1973) has successfully maintained a parent-child treatment program since the 1960's. His group has made significant contributions to the treatment and prevention of child abuse through publications and educational workshops with community health workers. Groups such as Parents Anonymous have created parent self-help groups throughout the U.S., and report a fair amount of success.

The State University of New York, College of Nursing at Brooklyn, seeks to educate future nurses who will deliver direct health services at the grass roots level. Our community is comprised of poor inner-city minority groups, and child abuse is a major concern. Our curriculum is geared towards learning prevention, especially the psychosocial dimension. For the most part, application of such learning isn't done in hospitals but in health maintenance and illness prevention centers. These consist of day care centers, homes for the aged, prisons, schools, and hotels.

In 1973 a group of interested students in the College of Nursing in-patient pediatric setting requested an elective course which would give them the opportunity to work with abused children. A survey was conducted which revealed that although our affiliated community hospital treated at least 40 abused children each month, no treatment programs existed in our community for the families of these abused children. There were agencies which made referrals to the court and provided foster care for the abused children, but direct intervention in the family was nonexistent. We felt this stop-gap treatment resulted in profound feelings of loss and abandonment in the abused child, increased feelings of helplessness and desperation in many of the parents, inadequate foster homes and institutions (which often operated for profit), and resulting detrimental effects on the abused child's development. From the important work of psychoanalysts such as Anna Freud (1946), John Bowlby (1973), and Adelaide MacFayden Johnson (1941), we knew that separation of the abused child from his natural parents, regardless of their inadequacy, has far-reaching implications for the child's future mental and cognitive development.

The problem of child abuse is not exclusively the problem of the mentally ill or sociopathic. In fact, these people make up only 10% of the entire population of child abusing parents (Green, et al, 1974). Often, child abuse is an expression of desperation by parents overwhelmed by social, economic, and cultural problems. In a typology of 60 families studied by Arthur Green and his associates at the Downstate Medical Center in Brooklyn, it was found that child abuse occurred where specific conflicting situations existed. These types of abuse were:

1. Abuse of an extremely deviant child, often retarded or hyperactive with psychological and neurological impairment. The nurses have noted that such a child frequently creates feelings of guilt which result in conflict between family members, or is completely misunderstood by the family, who often considers the child is deliberately being "bad".

2. Abuse occurring when a parent is forced to resume child care responsibilities after sudden termination of long-te m arrangements with a substitute caretaker. This is a common situation in our community, where often the first generation lives in the rural south and the second generation lives in the urban north. During the effort to secure employment, parents may send their children back to their parents in the south. This frees them of the responsibility for a time, but often when the children are returned the parents have difficulty trying to accommodate them. At times they risk loss of employment and financial stability.
3. Abuse by a parent who identifies the child with a hated person or situation. A majority of families in our community are headed by a single female. Male partners may move in and out of the family system, frequently leaving the mother with an additional child or two to care for. Unresolved conflict between the parents is often released upon the child of that union.
4. Abuse by a step-parent of the spouse's child by a previous union. Many times the step-child is perceived as a threat to the step-parent's dependence on the mate. The nurses have noted that a step child may be abused for fights or arguments he may have with a step-sibling. This is often the child's way of releasing angry feelings intended for his parent, whom he is fearful of upsetting and who may retaliate by abandoning him.
5. The parent abuses a young child for age-appropriate behavior of a sexual or aggressive nature. The parent is often grossly ignorant of the normal growth and developmental needs of the child and often holds unrealistic expectations. A year old child may be beaten for not being fully toilet trained.
6. An older child is beaten for lying, stealing, misbehavior at school, etc. The parent often depends upon the oldest child to reduce some of the burden that the family situation creates. This need to "reverse roles", so characteristic of many of our parents, places high, unachievable expectations on the child. Due to lack of experience and lack of future orientation, the parents lack problem-solving skills: budgeting, child care (babysitting), etc. They simply place this responsibility on the oldest child as his expected duty. When things go wrong with this arrangement, the parents' feelings of inadequacy increase and they project their guilt onto the child.
7. The father or father-surrogate beats the mother and one or more children. The mother may or may not consciously provoke these beatings, and fails to protect herself or the children from repeated attacks. This situation has been interpreted psychodynamically as an unconscious reenactment of a masochistic childhood relationship with a hostile and punitive parent.

Knowing that abuse stems from conflicts in the home, we felt that intervention must take place within that system. Many abusive parents have serious, unresolved conflicts with their own parents. Attrition rates in clinic programs are therefore very high, since parents often view psychologists and doctors as authority figures and avoid them. Therefore, it was felt that intervention had to be accomplished by someone who wouldn't be perceived as a threatening authority figure, someone who could work with the parents at their own level of need. This role was tailor-made for our nursing students, who are upper division baccalaureate candidates, many of whom had careers in teaching, social work, and the fine arts before they came into nursing. They form a highly motivated group of young people with a wide variety of life experiences, eagerly striving to help others achieve a better life.

Since 1974 volunteer students, keenly interested in helping abused families, have been going into the homes of those families at risk, trying to reduce some of the stress within the family system. They find the program very rewarding. The students have weekly consultations with myself and with a child psychoanalyst. A social worker and a public health nurse are also available as consultants. The student spends approximately one day per week visiting the family, offering assistance. Their approach is simple and unthreatening—a "What can I do for you today?" There's absolutely no interference in the family life, only suggestions. We have noted that students have made significant progress in reducing frustrations within the family system. It appears they have increased the self-esteem of parents by teaching and joining them in homemaking activities such as cooking and sewing (it was interesting to find out how many of our mothers were at a loss to perform these usual parental tasks). By taking the family to clinics and playgrounds the students modeled a role of how to organize daily activities. Serving as liaisons between the family and other networks such as welfare agencies, employment agencies, etc., the students modeled concrete ways of negotiating ways these systems to the advantage of the

families, needs. Mothers and fathers welcome the support of an ambitious, effective individual who accepts them as they are, without making demands.

CASE STUDY

The C. family consists of Mrs. C., age 32; three boys: Richard, age 11, Charles, age 9, Steven, age 8; and a homemaker, Mrs. G. Mrs. C is blind and has a condition known as sarcoidosis. Socially she is quite isolated except for a steady relationship with the same man for the past five years. Mrs. C. originally came from a large rural family in the southern United States. She came to New York as an adolescent, met her estranged husband, and subsequently had children. Mrs. C. has never been employed and has supported her family for the past 12 years on public assistance.

We first had contact with this family when Richard was identified as hyperactive by his school teacher. He could seldom concentrate for any length of time, was aggressive towards his schoolmates, and generally exhibited the classic symptoms of a child with an emotional problem related to the family system. His teacher observed that Richard often arrived at school bruised, bearing welts from a belt buckle. Richard said his brother administered the beating: a common trait among abused children is to protect an abusive parent because psychologically they can't accept the fact of their parent's rejection and hostility. Many abused children, because of their age, are limited in abstract thought and feel it's their fault they are mistreated and neglected by their parents. (Consequently, we consider it important not to compound such feelings of conflict by openly criticizing the parents.)

Richard was his mother's "seeing eye companion", seldom allowed to join the other children at play. His mother expected him to return from school immediately to help her with shopping and cooking. Here we observed in practice the "role reversal" concept described by Green. Mrs. C. was attempting to meet her own needs at the expense of her son's development. Soon other children in the family began to act out at school and Charles (the next-to-the-oldest) was unable to sleep through the night, often getting up and playing with matches in the kitchen. He subsequently required several weeks psychiatric hospitalization.

Our plan was to supply Mrs. C. with an adult helper-companion to assist with chores and to help Richard become more secure in an independent role. A homemaker was secured and she and the student nurse collaborated to implement this plan. Now freed of these responsibilities, Richard could go out and play and do other things typical of his age group. This helped dissolve the "symbiotic" parent-child relationship, removing pressures on both Mrs. C. and Richard. The process was one of beginning separation and individuation (Mahler, 1969). The student nurse continued to make weekly or bi-weekly home visits. All the children were tested by developmental psychologists. Their findings were conveyed to the school and to individual therapists assigned to the two older boys. The younger child is continually assessed by the student nurse (Gladston, 1965).

Change came after three months of home visits by the nurse. Mrs. C. began to show more interest in solitary pastimes, such as crocheting and sewing, which were taught her by the nurse. A problem arose when the homemaker sometimes reacted as a jealous sibling to the needs of Mrs. C. and would become critical of Mrs. C.'s feelings of depression. "She has an easy life," the homemaker reasoned, "gets welfare, can go shopping, and has me." These feelings of resentment of dependence had to be worked out in order to avoid a countertransference situation reminiscent of Mrs. C.'s own rejecting mother. Gradually the homemaker became more cooperative and joined our efforts to support Mrs. C.'s independence. She now feels better about her input, especially since we compliment her good work often, and cooperates with us by escorting Mrs. C. to group therapy once a week. Occasionally Mrs. C. participates in the group, verbalizing her conflicts.

The child abuse has ceased. Mrs. C. has been heard to holler and threaten, but her ability to tolerate frustration and deal effectively with her children's demands has increased considerably. We do not expect a 100% change in this case, but we feel we have made a contribution towards preventing the family situation from deteriorating further.

It's generally believed that child abuse is a symptom of a desperate family, a family in conflict about lack of money, employment, parents, etc. (Elmer, 1971). These problems aren't easily solved, but support and coping skills can be an effective means of dealing with the resulting frustrations. Using the social mode to intervene in the home, the student nurse, by virtue of her non-authoritarian role, can supply additional support and strength to a weakened and often closed family system. Flexibility, persistence, open-mindedness, and security within oneself are essential factors for the nurse involved with abused families. We consider the best mode of operation to be simple and unthreatening, merely, "What can I do for you today?"

Thus far, we have student nurse volunteers visiting 10 families. We see about 15 mothers in group. All are working together and are making considerable progress.

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Student Nurse Home Intervention Program for Abusing Families

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This paper will describe a new and innovative therapeutic modality for the rehabilitation of families involved in child abuse. The major participants in this program are senior students of the State University of New York College of Nursing at Brooklyn.

I. Background

The launching of this program was stimulated by the following set of circumstances. We had been impressed by the steadily increasing incidence of child abuse on the national and local levels. In 1975, 26,000 cases of maltreatment were reported in New York City, with 8,700 of these in the borough of Brooklyn. A group of our students was interested in working with abused children in an in-patient pediatric setting. To our surprise, we discovered that Kings County Hospital, our community affiliate, treated about 25 abused children each month in its pediatric in-patient service. To our further surprise, it was apparent that no treatment programs existed in our community for the families of these abused children. Agencies and hospitals reported cases of suspected abuse to the Bureau of Child Welfare, whose involvement with the families was usually limited to investigation, observation, and placement of children, if deemed necessary. There was a glaring absence of direct therapeutic involvement with the children and their families, who were in great need of psychiatric, social, and health care services.

At this time we heard about the establishment of a pilot treatment program for child abuse in our medical center, directed by Dr. Arthur Green under the auspices of the Division of Child and Adolescent Psychiatry. This program provided out-patient psychiatric treatment and counseling to abused children and their families. This program, operating without funding, with a volunteer staff, encountered difficulty motivating many of its patients to keep their appointments. It was felt that the addition of an outreach component to this program would increase its effectiveness.

We decided to establish the student nurse volunteer program in collaboration with Dr. Green's out-patient treatment unit. The student nursing program was to provide crisis-oriented home intervention with appropriate abusing families who were receiving out-patient care.

II. Description of the Program

The students are upper division baccalaureate candidates, many of whom had careers in teaching, social work and the arts before they entered the field of nursing. As a result, they are a highly motivated group of young people with a wide variety of life experiences which can be shared with the abusing families. Each student spends one year assigned to a family from the out-patient treatment program. The students spend approximately one day per week visiting the families and offering assistance.

Their interaction with the families is simple and non-threatening, a "What can I do for you today?" approach. They accept the parents as they are without making demands. The young student nurse has a special advantage over an older nurse or paraprofessional, as the latter are more readily identified with "critical" mother figures by the abusing parents. Each student receives supervision by the director of the nursing program, the community health nurse, a psychiatrist, and a social worker during weekly team conferences.

III. The Community Health Model

The student nurse's plan of intervention is based on the model of Community Health Nursing, which focuses on the prevention of disease. In this case "child abuse" is the disease entity. Unlike many physical diseases, it has no simple etiology. The crucial factors contributing to child abuse are parental abuse-proneness, environmental stress, and a special vulnerability of the child.

An experienced community health nurse was added to the health team of the project. Her expertise as a generalist in terms of nursing practice throughout the life continuum, with its full range of health problems, made her particularly valuable as a team consultant and instructor to the students. She was available for home visits and her familiarity with community agencies proved advantageous in dealing with the health needs of the entire family. Four steps were carried out with each family:

A. Nursing Health History

The student uses her skills in assessment to elicit health needs of the family. Gathering this information is viewed as non-threatening and allows the student to establish the role of "care giver." Through these assessments the students have identified numerous health problems. The students monitor these health needs and often provide the link to a health facility and follow-up. We feel this holistic approach to our families helps educate them and fosters independence toward caring for their own health needs.

B. Identification of Family Needs

In weekly meetings with the team, all information collected is analyzed and the strengths and weaknesses of each family are used to design a plan of treatment.

C. Developing and Implementing a Plan of Action

Based on family needs, the students' primary role includes (1) performing physical assessment of members, (2) supervising the medical regime (medical appointments, medication, etc.), (3) observing the family interaction during the visit, (4) teaching basic facts of child development and child care, (5) assisting in the implementation of the therapeutic strategy devised by the treatment team, (6) making referrals to community agencies such as day care centers, camps, after school programs, etc. to broaden the support systems for the family.

D. Evaluation of Plan

Results of the intervention are shared in weekly meetings with the team, and alternative plans are developed as necessary. During these meetings the home observations by the student provide important information about the current functioning of the family which is valuable to the other members of the treatment team. For example, the student can assess the degree of risk for further maltreatment of the children. She is also in a position to evaluate the quality and rate of therapeutic change. Data from home observation may be crucial in altering treatment plans or determining the timing of termination.

IV. Results

Our program is now in its third year. From 8 to 10 students have participated each year. Most of the families involved with us have demonstrated significant improvement, not only in terms of a cessation of physical abuse but in being able to give more to their children and to enjoy them. The presence of the nursing student in the home helped cement family relationships with the other members of the treatment team. The effectiveness of student nurse intervention may be explained by its ability to modify the three major factors underlying the child abuse syndrome:

1. Characteristics of the abuse prone parent such as low-self esteem, social isolation, mistrust, and lack of dependency gratification with a tendency to turn toward the child for nurturance, are eased by the supportive, non-critical attitude of the student nurse. By providing child rearing and homemaking advice, the student satisfies some of the parent's dependency needs and replaces the abused child as the object of role reversal.

2. Environmental stress. The discrepancy between the child rearing burdens of the family and its child care resources is reduced by the helpful presence of the student nurse in the home. The students have been especially helpful at times of stress with families that respond to crises with paralysis and confusion. During emergencies, parents frequently telephone the students, using them as a "hot line."

3. The vulnerable child. It is often the "special child" in a family who is singled out for abuse. The child usually exhibits a physical or behavioral deviancy, is provocative, and requires extra care and attention. The students have been helpful in identifying such children and referring them for appropriate evaluation and treatment. They are often able to convey to the parents that the abnormal functioning of the child might be beyond his voluntary control, and offer concrete suggestions for management.

We hope that our success in improving the child rearing climate and quality of life in the families involved in our program will stimulate other schools of nursing to develop similar outreach programs in which their students might act as community-based members of comprehensive child abuse treatment teams.

Family Resource Center: A Family Intervention Approach

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When we speak of preventing the incidence of child abuse and neglect, we are projecting a most awesome goal. In the state of Missouri alone, over 50,000 reports of suspected abuse and neglect have been received since August, 1975, when the state hot-line was established. The tasks of investigating and of providing treatment services to families where child abuse is a problem are mandated to the Missouri Division of Family Services. However, child abuse is a community problem; private as well as public agencies, lay as well as professional people share its awesome burden. This paper will explore the role of one small private agency in preventing child abuse.

The Family Resource Center has been attacking the problem of child abuse since 1974 when it was created as a demonstration project. The Center's focus is the family unit. Its goal is to reduce the incidence of abuse and strengthen the family unit through the establishment of a rich therapeutic and educational environment for both parents and children.

The perspective of child abuse as a symptom of family dysfunction has provided the basis for the Center's program design. This program has evolved as a comprehensive but flexible system of direct and indirect interventions to reduce family stress and restructure parenting behavior.

Housed in an old Victorian residence in the Central West End of St. Louis, the Family Resource Center provides the centralized facility for counseling, support, and educational services to family members which it believes is essential to a successful program. By eliminating the necessity for families to weave through a maze of different community programs, this design increases the effectiveness of the service the Center can provide and prevents the loss or further fragmentation of families who are in dire need of help. In addition, by reducing "service separation" of parent and child, it increases the possibility of more effective use of specialized community services.

STAFFING PATTERN

The Center's staffing pattern is designed to include professionals in social work, special education, and psychology, and multidisciplinary consultants and volunteers. The present staff consists of 13 paid staff members and 45 volunteers. The Center's experience demonstrates that volunteers are highly effective in the areas of direct services to families and community education.

Staff fulfill three basic roles with families: (1) As supporters, workers are available on a 24-hour basis to provide nurturing, care, and assistance when parents are submerged with overwhelming stress. When parents reach out, the support worker's job is to let them know someone is available to help. Another aspect of this role is to give parents the reinforcement they need in instances of positive action and achievement. (2) As teachers, the focus is to instruct either by providing essential information or by modeling with family members the process of identifying needs and the means of meeting these needs within the family unit. (3) As facilitators, workers aim to increase the quantity and quality of interaction within the family and between the family and the community system.

POPULATION DESCRIPTION

One third of the families participating in the Center's programs are self-referrals; approximately 40 percent are referred by the Division of Family Services and the remainder by other social agencies. Although the Center receives referrals of all types of abuse and neglect cases, the majority are those which exhibit mild to moderate physical abuse plus emotional abuse or neglect. Of 28 physically abused preschool age children seen at the center, 89 percent have been diagnosed as emotionally abused, while 57 percent are both emotionally neglected and emotionally abused.

The statistical characteristics of the abused family have remained consistent during the Center's three years of operation. The average family has 2.3 children, 51 percent of whom are above age five, and 60 percent of whom are male. Fifty-six percent are legally married two-parent families; the remainder are divorced, single, or families where one marriage partner is

absent. One-third of all families are minority, two-thirds are Caucasian. Approximately a third of all the parents or parent substitutes have not graduated from high school; 43 percent have high school degrees and 24 percent are college graduates. Age differences between spouses are minimal in the 20-24 age category, but between the ages of 25 and 29, the women are 20 percent younger than the men. The level of income for most families is under $10,000.

DESCRIPTION OF SERVICES

No one service at Family Resource Center is unique in and of itself. Rather, the format of services and the population served distinguish the Center's program as unique. Upon referral, the Center's professional staff initiates "intake" contact with the family in order to determine the type of immediate service needed. Family problems, stresses and strengths, the family relationship, and the parents' feelings regarding the child are among the issues discussed at intake.

Initial visits with parents may be either at the Center or in the home. Home visits provide essential information on the family. They are often scheduled on an extended basis to parents who are fearful and/or resist committing themselves to a therapy program. For some parents, the intake office visit serves to confront the parents with their responsibility and initiate within them a genuine investment in treatment. Although the majority of families are voluntary referrals, active participation in treatment is not guaranteed. Missed appointments are not uncommon. Parents are fearful of trusting, of being labeled as child abusers, and of believing that anyone will really help them.

Beyond assessment, the intake phase is critical in terms of establishing a level of trust and safety with the parents. Time is taken with parents to explain the services, tour the Center, and meet other parents and staff. The intake phase often lasts several weeks. This is done to provide the parents with a gradual introduction to the treatment program.

In the past three years, a three-phase treatment program has emerged, which is applicable to most families seen at the Center. When the parent is ready the first phase of treatment, group therapy, is initiated. Beyond developing self-awareness, the group is a forum for providing emotional support and reducing the parent's self-description as a "bad parent". Through the group process and through helping others, parents become aware of techniques to solve their own problems and to increase their self-esteem. Group styles vary depending upon the therapists and the composition of the parent group. Some group leaders use Transactional Analysis, Gestalt and/or Reality Therapy techniques to focus on self-awareness, problem solving, and social skills.

At the same time the Center has a variety of services to offer the abused child. All children under 6 years of age identified as abused or "target" are assessed through observation and testing to determine their developmental levels of functioning. Those children exhibiting a delay in motor, language, or cognitive skills are scheduled for the Center's remedial half-day classroom.

This program focuses upon increasing the children's developmental skill areas through group activities and an individual prescription format. Some children do not exhibit the developmental delays but do exhibit behaviors which present moderate to severe management problems for their parents and/or their preschool teachers. This group of children participates in a behavior management classroom which is designed to reduce the problematic behaviors. Added to the educative focus of these programs is the development of a safe and nurturing environment for children who frequently know only an unpredictable and hostile environment. Initially, the children are fearful of trusting peers and adults, engaging often in solitary play. Through participation in a program that includes consistent behavioral expectations, a daily routine, and large doses of affection, children begin to lose their fear and to adjust to the classroom program. There is also an opportunity for non-target and school-age children to participate in play therapy and group therapy. The second phase of treatment is characterized by expanding the services to the family and by a commitment on the part of the parents to improve family relations. Six to nine months after referral, the participating parent, generally the mother, begins to express concern about the relationship of the family members to each other. The explanation for this new dimension of concern lies in the fact that once the mother's needs are beginning to be met through therapy, she is able to focus on the needs of other family members and to invest in a program to initiate change within the family.

Services at this juncture could include family or behavior management counseling. Most often the program consists of a combination of these services, such as a rotating schedule of family and marital counseling. Workers often utilize a contract system wherein the parents

agree to establish and work towards specific behavioral goals. Progress and goals are assessed informally, in routine contacts with parents, and formally, through periodic family conferences.

During the entire treatment program the family receives support services. Transportation to and from the Center for parents and children and child enrichment sessions not only provide access to services which are otherwise unobtainable but also serve to remove the barriers to participation by parents in treatment programs.

The Family Resource Center maintains a 24-hour hotline to enable parents to reach out to a counselor, not only in stressful situations which could trigger potential abusive incidents, but also during periods of loneliness or depression. Parents are also encouraged to use the hotline to share their successful management of a stressful situation.

Recreational outings such as picnics, family excursions, and children's camping trips are activities which have been developed to help families: (1) learn to experience fun within the family, (2) develop social skills, and (3) increase their experience level in social relationships. For staff, these also provide an opportunity to observe family interaction and to relate to parents on an informal basis.

In addition to counseling services, parents participate in agency meetings, fund raising events, and television and radio programs, and assist in training the Center's volunteers. Parents' participation contributes significantly not only to their own self-esteem and to the progress of their treatment but to the well-being of the Center.

Volunteers are assigned as parent counselors to mothers who are in need of a nurturing person to provide friendship and to help her develop trust and social skills. The parent counselors usually visit the parent on a weekly basis for a home visit or outing. Counselors are accessible to parents on a 24-hour basis. Parents have identified the counselors as their "special friend" and often continue with the counselor after they have graduated from the Center.

The last phase of treatment is termination. This process takes three to six months, during which the family as a unit reduces the number of services. For example, a mother who is in group therapy and has also become involved in marital counseling or behavior management counseling may choose to reduce her participation in group therapy. She may attend only once a month or when she feels she needs additional support (most groups will permit the mother to participate on an irregular basis for a specific reason but not as the result of ambivalance or lack of investment).

As the need for help diminishes, the Family Resource Center embarks on a gradual program to reduce the level of service to the family as it increases its support of the family's strength and ability to solve its problems and to support and sustain each other. For some families, the level of involvement and dependence has become sufficiently extensive and intensive to make it difficult for them to view initial discussions of termination as positive indicators of growth. They may feel rejected; temporary reversion to problematic behaviors of the past are not uncommon. However, with continued assurances by the staff that the family is doing well and that help from the Center is only a phone-call away, families begin to accept and to benefit from the termination process. On the suggestion of a parent, the Family Resource Center now identifies termination as "graduation" for parents as well as for children.

The last step in the family's "graduation" process is a family conference in which workers, parents, and children summarize their experiences and reaffirm their goals as a family unit. Parents are invited to participate in their children's last day in the classroom in order to share in the festivities and to learn projects for home use.

Graduation is not a final separation for Family Resource Center families. Family Resource Center staff encourage parents to call in case of need, or simply in order to share family events.

How Should Families be Involved in Service Delivery: A Public Agency's Point of View

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As a representative of a public agency, my work with the abusive or neglectful parent is governed by my agency's policies and practices, as well as community standards.

In my community, as in most, we do not have the benefit of the team approach to child abuse and neglect. The primary source of service to the parent in my community is the protective service worker. Not only does the worker investigate allegations and report to the court, he also initiates the majority of services a parent receives.

Because some services are unavailable in my community, it is imperative the protective services worker involve the parent in every aspect of the diagnostic and treatment processes.

The parent must be involved in every aspect of the case management process in order for him to receive the services his particular situation demands.

The involvement of the parent in the staffing process is not presently provided for in my agency's policies, but in the literature we find numerous accounts of the advantages of this procedure.

My agency also does not presently provide for the direct involvement of the foster parent in the treatment process. Our foster parents do, however, play a vital role in reparenting the child. Their work with the children in their care is indispensible to the family treatment process.

Because the abusive or neglectful parent knows his needs better than anyone, it must surely follow that he must be consulted in formulating a treatment plan.

Due to the lack of comprehensive services available in my community, my agency has adopted extensive parent involvement in case management and treatment. It is not the same approach used with teams, but in those cases where the parents make any effort at all to work with us we, in turn, make every effort to involve the parent in helping alleviate the problems as he perceives them. Because the concern for the child must be paramount in all cases, the worker must also independently assess the problem, and take whatever action warranted in order to insure the child's safety. When the parent and worker jointly arrive at these decisions, we have taken a big step toward full cooperation in the treatment process.

The public agency or the department of social services is perhaps the best known of all agencies that deal with child abuse and neglect. The public identifies us in terms of "welfare," a term which they generally do not fully understand. We often are seen as another bureaucracy, impersonal and powerful. The public agency worker is often viewed as a "baby snatcher." This grows, in large part, due to a lack of public awareness concerning the extensiveness of child abuse and neglect in America.

From the public agency or protective service point of view, part of the service we provide to families is our attempt to dispel these misconceptions. Once we achieve some understanding with the parent as to the role of the protective service worker, the parent views us as less threatening. At this point, we begin working toward the "helping" relationship.

In assessing the public agency's role, it is important to remember that we operate in every county in the nation. Additionally, we often are the only resource available in the majority of communities. In most communities we have no teams, crisis nurseries, lay therapists, or family treatment centers. In most communities we have only a few dedicated medical, counseling, and legal personnel available to work with protective services in managing the problems of abuse and neglect.

The type of treatment provided for the abusive or neglectful parent is controlled totally by the availability of services in the community. The second factor determining the service a family receives is the family's decision to participate in treatment. Because of the lack of comprehensive treatment programs in most communities, the worker, while acting as treatment coordinator, lay therapist, legal referral service, child development specialist, and social worker, may attempt to refer the parent to every available program. This is necessary in most cases until a service plan can be arranged and referral services completed. Except in cases where the court orders the parent to enter specific forms of treatment, the referral and primary counseling role is carried out by the protective service worker.

Due to the size of the problem in the courts and the public agency, the parent may be all but forced into determining if and how he will involve himself in treatment. He knows he must meet certain court demands in the form of counseling or parent education, and may seek out those programs he believes will meet his needs. This situation can devastate the parent who, because of emotional or mental incapacities, cannot make the necessary decisions. It is this person who suffers or benefits from the quality of service provided by the public agency.

The first evaluation of the extent of need and type of treatment the abusive or neglectful parent requires is made during initial contact. This analysis is made based on the needs of the family as a whole and as individuals. If we view child abuse and neglect as a failure in the parenting process, then the prescribed remediation must be directed toward that process. At the time of intake, an assessment of the abusive or neglectful acts must be made in terms of the respective emotional and physical conditions of the parents and child. These conditions may well reflect patterns of failure in the parenting process. These conditions also will prescribe the initial steps needed for remediation or treatment.

In the case of an injured child, where the first step requires finding medical care, the family should be involved in the decision-making process. At this time, when parents are suspicious, angry, resistant, or even hostile, involving them in defining the child's needs as well as their own can help pave the way for the working treatment relationship. This involves parents in making parental judgments, and in many cases will make the introduction of less tangible services easier.

The treatment of the abusive or neglectful parent is perhaps the most difficult task we face as protective service workers. With some field experience, we become somewhat proficient in the detection or diagnosis of abuse or neglect. Also, we usually learn to deal effectively with courts and other agencies. Treatment, on the other hand, presents a challenge because parents are never exactly alike, not even in the same family. Treatment, to be effective, must fit the needs of the individual. The recipient also must perceive it to be some tangible benefit.

Not only must the mode of treatment fit parental needs, it must also fit a person's capabilities. We often encounter a parent we initially believe to be resistive, only to learn later that he does not have the cognitive ability to understand what he is being told.

There are perhaps two lessons a protective service worker learns early in his career. The first: there is no one plan of treatment that fits every patient. The second: the protective service worker cannot do the job alone.

Because the protective service worker must play such a variety of roles throughout his involvement with a family, he must, in every instance, be a "helper" if he is to deliver effective treatment. In those agencies where the case goes to a treatment group after intake is completed, the respective tasks of the various workers are somewhat less contradictory. This does not lessen, however, the importance of each contact with the family, and the worker's role as a "helper" or "facilitator."

At intake, though the primary focus is on the child and his safety, parental involvement must also be emphasized. At this time, the worker must fulfill his role as investigator, while educating the family about the need for involvement and action on their part. At this point, the worker has started introducing alternative parenting behaviors, and also is initiating the referral process so that the family can receive the needed "one-to-one" care. While explaining the need for further services, the worker must provide information on how services can be obtained. This enables the parent to make some choices, depending upon availability, as to what services he will use.

Because of the high level of emotional stress present at intake, the client may only be able to agree that the child is, indeed, injured. Though this may be little with which to work, the worker must continue reinforcing the parent's decision-making efforts. Though every following decision may be made by the worker or other professional, the parent should be included, and every attempt made to gain his total involvement. To do this, the worker must encourage the parent's positive parenting behavior.

Because a majority of abusive or neglectful parents initially deny the existence of a problem, the process of case evaluation and family treatment may be extremely difficult. However, if the protective service worker has no other leverage with the family than to offer some totally unrelated service, this may provide entry into the home. The offer of some tangible service is usually perceived by the parents as useful, and this further simplifies the entry into the home. This technique is also useful in dealing with the mentally disturbed parent because it will help lessen his suspicion.

As the worker observes the family dynamics, he can further assess the family's needs. Just as the worker's emotional reaction to a situation can influence his judgments concerning a parent, so will his perception of the parent's interest and level of willingness to cooperate. This determines, in large part, the role the parent will play during intake. It will also determine the extent to which the worker elicits input from the parent in initiating a treatment plan. If the parent is uncooperative or hostile, the worker may request a court's assistance in prescribing treatment.

Just as the worker judges the parent during initial contact, the parent also judges the worker. If the parent views the worker as an individual who is honestly concerned and is attempting to alleviate the crisis, this can make a crucial difference in the parent's receptiveness to treatment.

In situations where the removal of the child from the home is unnecessary, treatment must include care for the person both as an individual and as a family member. Treatment for the child is not automatic. This is especially true in cases where the child is placed in foster care. If the child lives in a good foster care situation, the care he receives may be sufficient treatment. If, however, he lives in an inadequate foster home, his problems may only intensify. For this child, counseling may only become available when he creates enough problems to warrant outside attention. In some cases, though, the child may be moved from one home to another, or to an institution. This is not as common as it once was. When it does occur it usually results from inactivity on the part of the parent, agency, or both. In some cases where every effort with the parent has failed, the worker may have decided to work with the "treatable" parent. This problem may be compounded further by overloaded courts and counseling agencies.

A worker must always decide how much effort he should devote to a family. A recent trend, at least in some communities, is for the court to place the full burden of remediation upon the parent. This lessens the legal but not the moral dilemma every worker faces. Experience teaches us there is a way to work with almost any family. We have all seen sudden movement and complete remediation in the most hopeless of family situations. This pragmatic attitude, while encouraged in workers, can also prolong the child's foster care to the point the court hesitates to terminate parental rights because the child is considered unadoptable.

Even in the most extreme cases of parental resistance, one can usually agree that there is a specific standard of care for all children. This fact can be a useful measure of the parent's perception of his child's needs. In attempting to provide even minimal treatment, the worker must elicit the parent's perception of the family's needs, progress, and goals.

Because of the present orientation of most public agencies, the protective service worker cannot be the sole source of treatment. We must rely, when possible, upon counselors, doctors, visiting nurses, and parenting programs. Because of the high turnover rate of public agency workers, we approach treatment in a less than ideal manner. The protective service worker cannot become a "good mother" to the parent who may be reassigned to another caseworker tomorrow. If the protective service worker encourages emotional dependence in the parent, then he must carry out the parenting role. In many agencies this would require the worker to parent 40-80 individuals. The protective service worker must present himself as a parent model, however, if the parent is to see him as credible.

The protective service worker must carefully balance his work with the family by acting as a positive parenting model, while encouraging the parent to assume as much of the parenting role as possible. We are often made aware of the parent's fears and inadequacies early in our relationship. Sometimes, tragically, these become apparent only after repeated abuse or neglect.

Because there are no sure cures for child abuse or neglect, we cannot predict which parents will succeed in treatment, and which homes will be safe for the child. If there is one criteria by which we can gauge success, it is the amount of family involvement and effort made for the benefit of the child.

IN RETROSPECT

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One usually leaves a conference with immediate impressions, specific ideas, new acquaintances, and feelings of shared successes and frustrations. However, an entirely different perspective is provided when reflecting upon a conference several months after it has taken place, when the initial enthusiasm is gone and one is again involved in the same efforts as those prior to the conference. In retrospect, if the Second Annual National Conference on Child Abuse and Neglect is viewed as an event on a continuum of child abuse and neglect activities, where does it fit in relation to past, present, and future child abuse and neglect efforts?

Although some Conference participants may have been discovering the field for the first time, the problem of child maltreatment has existed throughout all eras of humanity. Historians trace child abuse and neglect from biblical times to the abused and neglected foster child, Mary Ellen, to C. Henry Kempe's identification of the battered child syndrome. The passage of the Child Abuse Prevention and Treatment Act in 1974 brought child abuse and neglect further into the national limelight. The establishment of the National Center on Child Abuse and Neglect (NCCAN) and its demonstration projects added new emphasis to ongoing efforts in the field.

The First National Conference on Child Abuse and Neglect, cosponsored by NCCAN and the Region IV Resource Center in Atlanta, occurred soon after passage of the 1974 Act and the establishment of the NCCAN demonstration projects. Excitement and anticipation prevailed, and innovation in the field would best describe the emphasis of this first conference. Serious attempts among participants were made to seek answers to the causes of, and new approaches for prevention and treatment of, child abuse and neglect.

Some territorial tensions emerged as various disciplines began to learn how to relate to one another and as tenured child protective services workers interacted with young and enthusiastic, but often naive, persons recently involved in the field. However, there was significant anticipation among participants that with the continued focus on innovation, great strides could be made to strengthen families and to eliminate much of the child abuse and neglect occurring in the country.

At the Second National Conference, participants presented a more sophisticated and realistic stance. Representing a wider variety of disciplines, most were aware that there is no single answer or model to combat child abuse and neglect. Although some attempts were made to focus on innovation, the primary focus on this conference seemed to be implementation. Emphasis on both innovation and implementation related primarily to the "how-to's" of service delivery, prevention and treatment, and discussion of specific ideas as to which existing approaches are most effective. Conversations overheard at the Conference involved much sharing of program ideas and, to a lesser extent, issues primarily relating to service delivery and treatment, all a departure from the previous emphasis on innovation.

Also evidenced was increased rapport among the primary disciplines involved in the field, with recognition of the involvement of much-needed additional disciplines. The preconference workshop on emotional abuse included representatives from the fields of mental health and child development. These individuals, in some instances new to the child abuse and neglect terrain, grappled with complex issues such as the development of a precise definition of emotional abuse. However, they indicated a welcome willingness to become further involved and to expand their efforts.

In addition to the cooperation among disciplines, increased dialogue was noted among research and treatment groups, among academicians and practitioners, and among seasoned child protective services workers and newcomers to the field. There was a joint commitment; a recognition that child abuse and neglect are far too complex for any one group to deal with singly; and a recognition that each group needs the others, even to begin to formulate questions relating to the issues, let alone to determine any answers.

Participants acknowledged that child abuse and neglect are no longer areas involving only a child and a parent, or even a single family unit, but must include the broader ecological aspects of culture, community and society. Inclusion of greater numbers of local politicians and government officials, mental health and child development personnel, and increased participation

from various cultural groups were therefore welcomed, and participants stressed the need for inclusion of groups such as economists at the next conference. Individuals involved in service delivery and treatment called for more direct research efforts, recognizing that there is some doubt as to whether "treatment" even exists in the field of child abuse and neglect. They also requested further inquiry as to what modalities of treatment or intervention are appropriate in differing abuse and neglect situations. Academicians acknowledged the direct services experiences of practitioners. In turn, practitioners indicated that academicians are valued for their objective scrutiny of the answers being sought. This mutual acceptance was most evident at the surprise breakfast held for Vincent De Francis, retired Director of the Children's Division of the American Humane Association, when participants from many areas of the field gathered together to honor a person whose lifetime commitment to the child abuse and neglect arena signified what the Conference hoped to engender.

The proceedings of the Conference indicate that much experience has been gained from the many child abuse and neglect efforts undertaken. Resource centers established throughout the country have developed a vast knowledge of the total protective services delivery systems that exist and have identified their strengths and constraints. State child protection agencies not only offer a historical perspective, but also a comprehensive understanding of issues relating to intake, investigation, and the multi-problem families which usually remain the sole responsibility of the child protection agency. Demonstration treatment projects have identified a diversity of alternate approaches: volunteers and lay therapists, multidisciplinary teams, service contracts, crisis centers, hotlines, and self-support groups. Researchers have determined a variety of possible significant factors relating to causality.

However, the knowledge gained to date is at best cautionary. We have learned that we cannot seize upon one approach or one particular model in attempting to resolve the many issues which are integral components of this complex problem. The Conference demonstrated the need to refine the issues and to develop more sophisticated approaches in formulating the many questions and in seeking the subsequent answers. Specific areas in which knowledge has been expanded and services to families have been improved were identified by participants, but multitudinous gaps were also acknowledged.

The broad issues presented at the Conference were alluded to many times; however, they were not explored with substantive intensity. More sophisticated exploration of the issues is necessary to seek the many solutions needed in the field. Only then can we effectively strengthen services to maltreated children and their families: specific exploration of philosophical or theoretical bases for prevention and intervention strategies; what constitutes effective parenting and child rearing practices; what constitutes healthy child development and specific needs of children and families; cultural differences in child rearing, child development and family interactions; individual and family autonomy; children's versus parents' rights; and the implications of in loco parentis must all be studied.

More research must be done, particularly relating to the etiology of child abuse and neglect, utilizing an ecological approach incorporating societal, economic, and cultural factors associated with family interaction, child rearing, and child maltreatment. Longitudinal studies focusing on the impact which alternate intervention strategies have on children and their families must also be undertaken.

Legal and societal issues relative to individual and family autonomy must also be explored. The positive and negative consequences of governmental intervention must be examined as the state moves into areas previously considered the sacred domain of the family. Past roles of the state have been to guard the rights and to uphold the beliefs of individual families and, in particular, parents. New emphasis to protect and enhance a child's development and needs must be balanced carefully with added issues such as individual family and cultural differences. The extraordinary importance of the role of the state as parent must be regarded prior to the enacting of legislation and the creation of institutions. In many instances, efforts to deal with the immediacy of the issues relating to child abuse and neglect have created legislation and established institutions that have had numerous flaws and have at times been less than effective in understanding and dealing with the complexity of the problems.

In addition, the feasibility of expanding the service delivery system to prevent and to more effectively treat child abuse and neglect must be considered realistically. Because of budgetary constraints, availability of competent staff and staff time, and additional priorities of mandated child protective services agencies, maximum and effective utilization of these agencies as resources must be achieved. Thus, it is imperative that alternative service approaches be considered, with the recognition that child maltreatment is truly a community

problem. This means not only that additional community agencies assist the child protective services agency, but that natural helping networks of community individuals also must become involved.

Prevention is an issue that was barely focused on at the Conference, as the majority of present resources are being utilized to strengthen families who have already abused or neglected their children. Further emphasis must be placed on defining prevention, developing research efforts related to determining what constitutes effective prevention, and focusing on developing preventive efforts in communities.

Finally, although many cultural groups were asked to serve as presenters at the conference, concern was expressed among some participants about the hesitation to deal openly and constructively with cultural issues in child abuse and neglect. There have been some innovative efforts to provide culturally relevant services to specific cultural groups; however, such efforts, for the most part, have utilized models originally developed to serve the dominant culture, with only minor modifications to serve specific ethnic groups. In many instances, the major difference in service provision seems to be only the fact that the service providers are also members of the specific ethnic group. The investigation of cultural diversity and ethnic differences would lead to clarification of knowledge pertaining to child rearing practices and cultural attitudes and values. This knowledge would better enable us to determine the nature of the need for totally unique models of service delivery to be developed by specific cultural groups for those groups.

In retrospect, then, it becomes clear that because of the number of issues that need to be further explored, and the recognition of the diverse populations being served in child protective services, a singular approach is not the answer. A variety of alternative services and approaches, with a freedom of choice offered to consumer/clients as well as the creation of competitive service delivery programs, needs to be considered. At this time, it is difficult to determine where the field of child abuse and neglect will go from here. It is hoped that the spirit, the commitment, and the excitement that prevailed at the Second Annual National Conference will continue as we move to an extension of the Child Abuse Prevention and Treatment Act and a new era of NCCAN funding. The "honeymoon" now appears to be over for the field, and many of the issues are moving from the limelight and being replaced by others. Realistically, some of us will burn out, or move on to other fields. However, in spite of the complexity of the issues, if the spirit of the Conference is any indication many persons will remain with an increased commitment to face the issues, to refine the existing knowledge and expertise, and to continue to strengthen services to potentially and presently abused and neglected children and their families.

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