

RESEARCH INTO VIOLENT BEHAVIOR: DOMESTIC VIOLENCE

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TREATMENT OF ABUSED CHILDREN:
SEARCH FOR A MORE ADEQUATE FOUNDATION FOR CLINICAL PRACTICE

Testimony presented before the Subcommittee on Domestic and International
Scientific Planning, Analysis, and Cooperation, Committee on Science and
Technology, U.S. House of Representatives

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There is reason to question the nature and quality of knowledge about child abuse. Formal recognition of an age-old phenomenon, demonstrated by an enormous increase in the number of official case reports annually since the mid-1960s, has created a difficult dilemma for professionals concerned with children. Notwithstanding a century's experience in the American child welfare movement and more recent medically based contributions from Kempe and others, we have a service system that, despite humane rhetoric, is unable to promote the safety and well-being of many children. This is in large part due to a paucity of such essential family supports as counseling, medical, homemaker, child-care, and nursing services and to a heavy reliance on foster-home care. A tightfisted social policy toward families and children means, simply, that when a professional person files a child-abuse case report, the services that follow may be incapable of dealing with the needs of family and child.

Inadequate or incomplete service is only part of the problem. Our basis for practice is flimsy. We have a commonly accepted humane philosophy (if not in reality programs that can translate that philosophy into humane action): to protect parents and children from repeated physical consequences of family crises. But because we lack a solid theoretical and practical understanding of the origins of child abuse, our clinical work is at best intuitive and kind, at worst reflexive and mean. We read a literature in each of the professions characterized by homilies, bromides, and few scientific investigations of substance. And we look at child abuse as a phenomenon originating in the psychology of individuals, frequently ignoring the social and cultural realities that frustrate our treatment of particular families and impose formidable obstacles to the prevention of child abuse.

Because of the contradictions between philosophy and practice and our incomplete knowledge, we find ourselves wondering whether the following are

unanswerable questions when cases of child abuse are identified. Is the child at risk? Can the family be helped? Are competent intervention resources available? Will I do more harm than good by reporting the case?

I do not mean to suggest that the clinician should throw up his hands in despair when the next case of child abuse is brought in. Within the framework of existing knowledge and resources, possible answers and helpful clinical guidelines can be drawn up, and these are the subject of a review, "Child Abuse: Principles and Implications of Current Pediatric Practice," which is attached as an appendix to my testimony.

"Child Abuse," "Child Neglect," and "Accidents"

Definitions of child abuse vary, from Henry Kempe's "battered child syndrome," which identifies injuries inflicted by care givers; through Vincent Fontana's "maltreatment syndrome," which includes child neglect; to the current D.H.E.W. model reporting statute, which embraces many physical and emotional symptoms attributable to parental failure; and to David Gil's concept of any force that compromises a child's capacity to achieve his physical and psychologic potential. Virtually all definitions identify the child as victim, and most identify parent or family as perpetrator.

Important value concepts are built into the vocabulary, and in the words themselves are postulated etiologic mechanisms that logically imply diagnostic and intervention procedures. The terms "battered child syndrome" and "maltreatment syndrome" have strong implications. They indicate that a child's injuries were caused by his care giver, either actively or passively.

To make such "diagnoses" requires an investigation to determine whether or not there is parental culpability. Inquisitions of parents to ferret out the facts have been characterized as clinically unhelpful, ethically absurd,

and intellectually unsound. Faced with ambiguous data, conflicting accounts of how the child may have received his injuries, and a need to make a definitive diagnosis, the clinician may find himself playing a detective game for which he is professionally unprepared.

Stoked by the strong feelings that child-abuse cases promote in all of us, the diagnostic process may further alienate an isolated, frightened, and confused family and fulfill the preconception of parental failure: aggressive inquiry eliciting evasive response, angry affirmation of suspicion leading to confirmed diagnosis, and subsequent estrangement of family from clinician and separation of child from family.

Different professional people respond in different ways to the personal and ethical conflicts imposed by contact with troubled families. Some physicians find it difficult to believe that parents could injure children. Many characterize all children's injuries as "accidents" (the term connotes an isolated, random event).

Although traumatic injury to children is the major cause of morbidity and mortality after the first year of life and is predictably associated with familial and child developmental crises, the nature and organization of child health practice do not usually permit exploring and acting on the causal antecedents of childhood "accidents." Physicians and nurses may not have the time to interview parents or to make detailed child development observations, and such backup diagnostic services as social work and psychiatry are most often situated in separate institutions and practice settings. No treatment other than of the presenting symptom is implied by the diagnosis of an "accident."

Further, because of the onerous significance of making a judgement that a particular family is "abusive" or "neglectful," it is often easier to ignore these "diagnoses." The finding that the great number of reported victims of child abuse are poor and disproportionately represent ethnic minor-

ity groups, suggests that the more heavily value-laden diagnoses for childhood traumatic injuries (child abuse and neglect) are made more easily when the clinical setting is public and there is great social distance (social class or ethnic discrepancy) between clinician and family.

We clearly need a more scientific taxonomy of childhood "social illness," one that would organize clinical data in such a way as to stimulate helpful and effective practice. Until we have it, however, we shall have to labor with the existing words.

Study of Social Illness in Children

In June, 1972, with the support of a grant from the Office of Child Development, now the Administration for Children, Youth, and Families, my colleagues and I organized at Children's Hospital in Boston a systematic study of the familial, child developmental, and environmental antecedents and concomitants of pediatric social illness. This epidemiologic study has explored the interrelationships among child abuse, accidents, failure to thrive, and poisonings, in children under four years of age. Results of the first phase of the project, in which 560 children were ascertained, are summarized on second and third appendices, "Pediatric Social Illness: Toward an Etiologic Classification," and "Environmental Correlates of Pediatric Social Illness: Preventive Implications of an Advocacy Approach." A second phase of the study examined with a more detailed set of investigative instruments the life circumstances of an additional 402 children, focusing on parent-child attachment in a laboratory observational setting, as well as on the ecologic substrate of the children's presenting symptoms. These data are now being prepared for publication.

In brief, our findings demonstrate significant overlap in prior and

current family stresses across the social illness categories, suggesting that the circumstances associated with child abuse are widespread and generally ignored in clinical practice. Families "at risk" for child abuse cannot be predicted with precision. Child abuse is more commonly associated with poverty than are the other social illnesses. Family isolation and mobility are the most important concomitants of child abuse. Stresses originating in the life context, such as poor housing and inadequate access to health and child care, distinguished cases of social illness from the comparison group. An advocacy program designed to address these stress issues, utilizing community based individuals who work aggressively to change -- to better -- the ecologic setting for child-rearing, was successful in enabling parents more adequately to cope with the needs and demands of their offspring.

The study supports the concept of child abuse as a symptom of family distress. Child abuse is not, in my view, a discrete and encapsulated medical syndrome. These data enable us to see child abuse less as the intersection of a sick perpetrator and a passive victim than as a human response to severe stress in the nurturing context. Treatment, and ultimately, prevention, of this symptom is best conceived in relation to the social ecology of family life.

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