CHILD ABUSE - AN EDUCATING LOOK

AN HONORS THESIS (ID 499)

BY

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PREFACE

Child Abuse-An Educating Look was undertaken to fulfill a requirement necessary for graduation from the Ball State Honors College. As background, I used my previous knowledge gained through various classes and reading. To begin my project I went through a listing of 284 books concerning child abuse. From this list I selected approximately thirty books for further study. Finally, I narrowed my research to twenty of those books that I thought would be the most enlightening. I also arranged to do four hours of volunteer work per week at A Better Way. I thought that this work would be somewhat significant to my study. However, my volunteer work did not have the expected impact on my research.

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To Mom and Dad without
whose help this would
not have been possible

In the little world in which children have their existence, whosoever brings them up, there is nothing so finely perceived and so finely felt as injustice.

Dickens

CHAPTER 1

INTRODUCTION

Child abuse is a problem that has been with society as long as society has existed. However, it is only in this century that child abuse has gained much attention let alone national attention. Child abuse is composed of three interacting components 1) abuse prone personality of parent, 2) abnormal child or one who "accidentally" resembles significant other persons in abusive parent's life that abuser has strong negative feelings for, and 3) environmental stress (Evans 1981).

Another way of describing the interacting model of child abuse is by saying the parent has high expectations (Tower 1987). The child cannot meet those expectations because of developmental level and the cycle continues resulting in abuse (Tower 1987). Tower (1987) illustrates this cycle beautifully as can be seen on the next page.

The following chapters will focus on the history of child abuse, characteristics of an abuse prone parent, characteristics of an abuse prone child, general effects of child abuse, effects of child abuse on learning, prevention of child abuse, and conclusions.

The Physically Abusive Parent

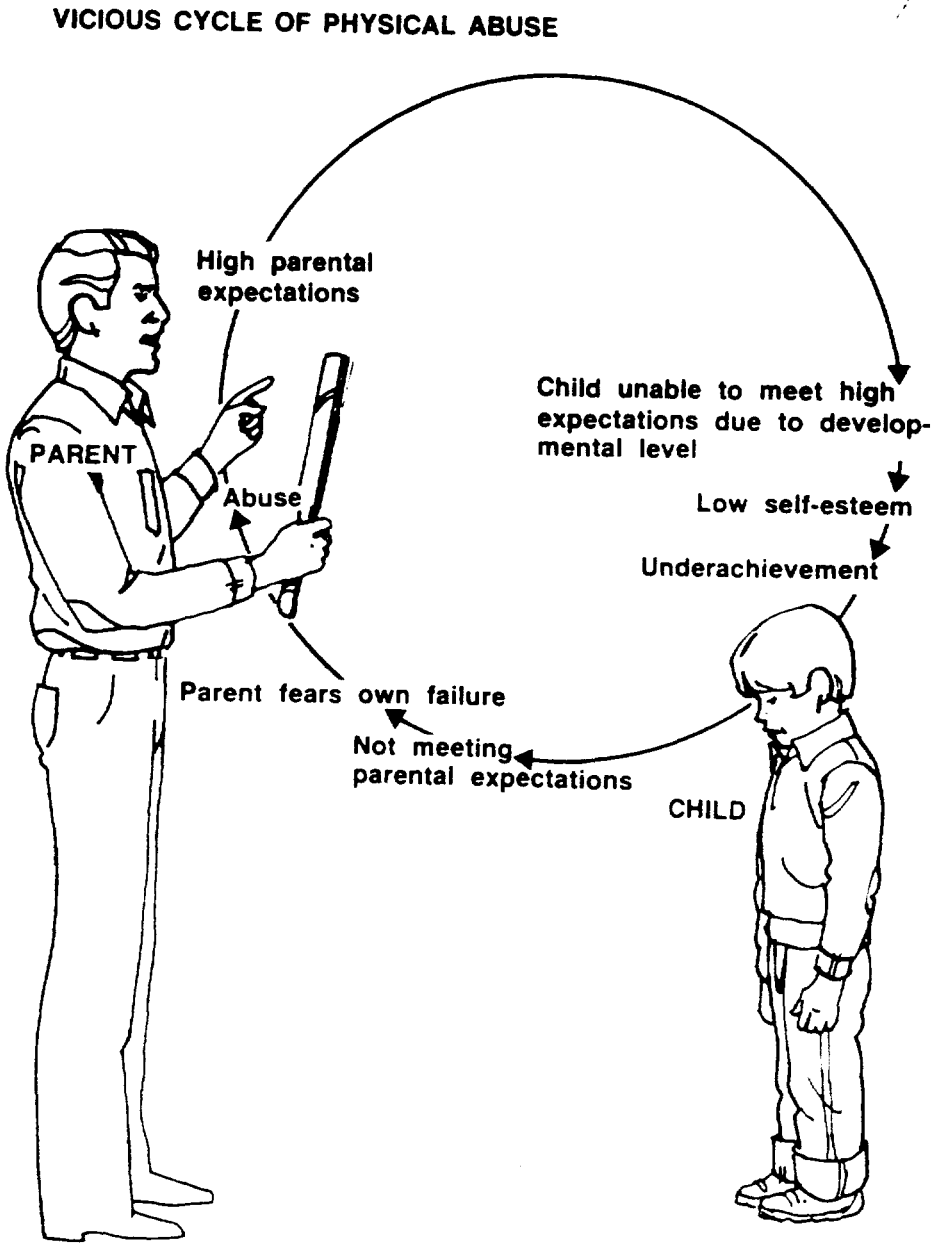


Figure 1 (Tower, 1987, p.97)

CHAPTER 2

HISTORY OF CHILD ABUSE

The history of child abuse may be divided into four periods. The first period is prior to 1946 (Kadushin and Martin 1981). Before 1946, child abuse was virtually unrecognized. It was commonly thought that a parent had a right to do whatever he pleased with his child without penalty or question (Kadushin and Martin 1981).

During the second period, there are a number of reportings of bleeding, bruising, broken bones and burns that follow no predictable pattern of childhood illnesses or accidents. This period was between 1946 and 1962 (Kadushin and Martin 1981). At this time, it is evident that the world was awakening to the problem of child abuse. The waters of the iceberg were being tested.

The third period began in 1962 when professional awareness and concern really became evident (Kadushin and Martin 1981). During this time, the public realized that child abuse is a problem. However, still not much was done except to recognize the problem and to start looking for the battered

child syndrome. The fourth period began in the 1970's (Kadushin and Martin 1981). This period is the current period and it focuses on protection and therapy. Child abuse legislation is being and has been widely introduced and implemented. Social workers, lawmakers, and the general public are forming bonds to detect, prevent, and treat child abuse (Kadushin and Martin 1981).

Even though tremendous progress has been made, a fifth period is needed, a period of widespread prevention (Kadushin and Martin 1981).

Child abuse has been with us since society began. Many societies used infanticide as an accepted method of family planning (Gordon 1988). Also, earlier cultures used to let the handicapped or maimed babies die (Gordon 1988). It was believed that slain infants would benefit the sterile woman, kill disease and confer health, vigor, and youthfulness. To ensure the durability of important buildings, children were sometimes buried under the foundations (Kadushin and Martin 1981).

During the Industrial Revolution, children provided cheap labor. At the time the laws did not prevent children from working. After such laws were passed, children were still allowed to work in factories with parental consent (Gordon 1988).

It was not until the late 1800's that moves were made to protect children's rights. Fontana (1964) tells the story of Mary-Ellen Wilson, the eight year old girl who lived in New York City. Her guardian was beating her savagely and cruelly. The abuse was reported to the authorities. The authorities, however, said nothing could be done as parents or guardians were allowed to punish their children as they saw fit (Fontana 1964). An appeal was then made to the New York Society for the Prevention of Cruelty to Animals. This society acted under the edict that Mary-Ellen was a member of the animal kingdom (Fontana 1964). Mary-Ellen's legal guardian was sentenced to one year in prison and Mary-Ellen was placed in the care of Mrs. Wheeler (the woman that reported the abuse). This incident prompted the founding of the Society for Prevention of Cruelty to Children in New York City in 1871 (Fontana 1964). The founders were Henry Bergh and Ellridge Geary. The medical features of child abuse were chronicled as far back as 1860 (Kadushin and Martin 1981).

Even though abuse was considered acceptable for quite some time, after the incident concerning Mary-Ellen abuse received more publicity. The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) was one of the more prominent societies that emerged in the early 1900's. The MSPCC photographed many children and began a campaign to

help abused children (Gordon 1988). Their photographs showed abused children as well as MSPCC's idea of a healthy child. MSPCC was one of the agencies that contributed to for increased public interest in child abuse (Gordon 1988). The following six photographs are prime examples of the early battle against child abuse (Gordon 1988).

EARLY CHILDHOOD PROTECTION

A girl performer, by definition an abused child to the 19th-century child protectors. Undated. *Courtesy of MSPCC, Boston.)*

By contrast, this was the MSPCC's image of a healthy childhood. *Courtesy of MSPCC, Boston.*

Figure 2 (Gordon, 1988, p.51)

The MSPCC posed boys in chains and in bonds, reconstructing cases of sensational child abuse, for publicity and money-raising purposes. Undated. *Courtesy of MSPCC, Boston.*

Figure 3 (Gordon, 1988, p.52)

Figure 4 (Gordon, 1988, p.53)

Neglected children on the streets, 1905. *Courtesy of MSPCC, Boston.*

Interior, circa 1938. This kind of [illegible] offender was often an outward emblem of depression-era child neglect. [illegible]

Figure 5 (Gordon, 1988, p.125)

Medical neglect, about 1920, visited by members of MSP [illegible]

Figure 6 (Gordon, 1988, p.127)

The six children of a widow, allegedly a drunkard, found occupying one bed in a filthy and unheated house, the youngest with its foot frozen, February 14, 1905. The children, ages 2 through 11, are posed in a studio, or possibly at the MSPCC Temporary Home, cleaned and dressed up according to the tastes of the MSPCC matrons. *Courtesy of MSPCC, Boston*

Figure 7 (Gordon, 1988, p.100)

CHAPTER 3

CHARACTERISTICS OF AN ABUSE PRONE PARENT

The abusive parent has been said to be many things. Some of the labels that have been attached to an abusive parent are "normal", schizoid, aggressive psychopath, psychotic, brain damaged, labile, irritable, emotionally explosive, depressed, sadistic, vicious brutes, inadequate, impulsive, unable to bind or contain tension, insensitive, unempathetic, alcoholic, alienated, worried, inferior, ego deteriorating or breaking down in self-direction (AMA National Conference 1985, Evans 1981, Kadushin and Martin 1981, Christiansen 1980, Fontana 1964). These labels may fit a great many people that are not in fact child abusers.

The following characteristics are more likely to be indicative of a child abuser. Some of the following characteristics and those above have been displayed in chart form listing the characteristics of abusive parents by Wolfe (1987). Wolfe (1987) composed one chart from early clinical studies and one chart from recent empirical studies. The abuser is isolated from society at large, does not belong to

Psychological Characteristics of Abusive Parents

Psychological Characteristics of Abusive Parents
Reported in Early Clinical Studies

I. *Behavioral Dimension*
- Chronically aggressive (9)
- Isolated from family and friends (11)
- Rigid and domineering (9, 11)
- Impulsive (3, 4, 7, 11, 12)
- Experiencing marital difficulties (7)

II. *Cognitive-Emotional Dimension*
- Emotional immaturity (11)
- Low frustration tolerance (4, 7, 11, 12)
- Difficulty expressing anger (4, 7, 11, 12)
- Role reversal: looks to child to gratify own needs (2, 4, 5, 6, 10)
- Child misbehavior triggers feelings of inadequacy, worthlessness, frustration (11)
- Deficits in self-esteem (1, 2, 5)
- Inability to empathize with children (6, 8)
- High expectations of child; disregard for child's needs and abilities (6, 8, 10)
- Defends "right" to use physical punishment (12)
- Deep resentment toward own parents for failing to satisfy dependency needs (8)

NOTE: The following references to original studies are representative and not exhaustive. Most findings involved inferences drawn from clinical samples, without control group comparisons: (1) Bell (1973); (2) Blumberg (1974); (3) Elmer (1963); (4) Green (1976); (5) Green et al. (1974); (6) Helfer (1973); (7) Kempe et al. (1962); (8) Melnick & Hurley (1969); (9) Merrill (1962); (10) Morris & Gould (1963); (11) Steele & Pollock (1968); (12) Wasserman (1967). Also, see reviews by Green (1976); Kelly (1983); Parke & Collmer (1975); and Spinetta & Rigler (1972).

Table 1 (Wolfe, 1987, p.71)

Psychological Characteristics of Abusive Parents
Reported in Recent Empirical Studies

I. *Behavioral Dimension*
- Isolation from family and friends (19, 20)
- Less communication and less child stimulation (7, 8)
- Disproportionate rate of negative to positive interactions with other family members (3, 4, 11, 13, 16, 17)
- Failure to match disciplinary methods to child's transgression: intrusive, inconsistent (16, 23)

II. *Cognitive-Emotional Dimension*
- Self-described as unhappy, rigid, distressed (11, 15)
- More self-expressed anger (15, 20)
- Child's behavior perceived as stressful (9, 14, 22, 25)
- Low frustration tolerance, that is, greater emotional (psychophysiological) reactivity to child provocation (7, 9, 24)
- Inappropriate expectations of child: disregard for child's needs and abilities; for example, belief that child intentionally annoys parent (1, 2, 12, 20; exceptions: 18, 21)
- Greater *perceived* life stress (5, 14, 18)
- Flattened affect during parent-child interactions (16)

III. *Other Findings Related to Psychological Functioning*
- More physical health problems (5, 11)

IV. *Empirical Findings that Did Not Differ from Controls*
- *Amount* of stressful life events (10, 21)
- Self-expressed emotional needs; for example, feeling unloved; dependency; emotional problems, or personal adjustment (5, 10, 21, 26; exception: 11)
- Denial of problems (10)

NOTE: The following studies used matched control groups to compare responses of abusive parents to nonabusive parents from similar backgrounds (see review by Wolfe, 1985a): (1) Azar et al. (1984); (2) Bauer & Twentyman (1985); (3) Bousha & Twentyman (1984); (4) Burgess & Conger (1978); (5) Conger et al. (1979); (6) Crittenden & Bonvillian (1984); (7) Disbrow et al. (1977); (8) Dietrich et al. (1980); (9) Frodi & Lamb (1980); (10) Gaines et al. (1978); (11) Lahey et al. (1984); (12) Larrance & Twentyman (1983); (13) Lorber et al. (1984); (14) Mash et al. (1983); (15) Milner & Wimberley (1980); (16) Oldershaw et al. (1986); (17) Reid et al. (1981); (18) Rosenberg & Reppucci (1983); (19) Salzinger et al. (1983); (20) Spinetta (1978); (21) Starr (1982); (22) Susman et al. (1985); (23) Trickett & Kuczynski (1986); (24) Wolfe et al. (1983); (25) Wolfe & Mosk (1983); (26) Wright (1976).

Table 2 (Wolfe, 1987, p.70)

any formal social group, has few informal relationships with neighbors, changes residence frequently, is maritally unstable, was brought up in a harsh cruel environment, was abused himself/herself as a child, lost a parent in early life, was subjected to intense parental demands at an early age, did not experience maternal love, has poor work records, and has alcoholic bouts Evans 1981). Gordon's (1988) chart (see Table 3) shows that indeed at least until 1960 in cases of violence alcohol was involved at least fifty percent of the time. Other characteristics of the abuser are poor military performance, frequent mental hospitalization, major physical illness, criminal conviction, low intellectual ability, behaviorally unusual offspring, disturbed sexual development, poor housing and poverty (Evans 1981). All of these characteristics do not have to be present for child abuse to occur. However, there is usually a preponderance of these characteristics if the background of the abuser is searched.

Some other basic characteristics of an abuser are that the abuser is more often the mother than the father and education, occupation, and income all tend to be low (Evans 1981). Helfer and Kempe (1987) prepared a chart that indicates even with no stress, the mother is more likely to be the abuser. Only in times of extreme stress will the father be the more likely abuser.

3. DRUNKENNESS IN FAMILY-VIOLENCE CASES, BY YEAR

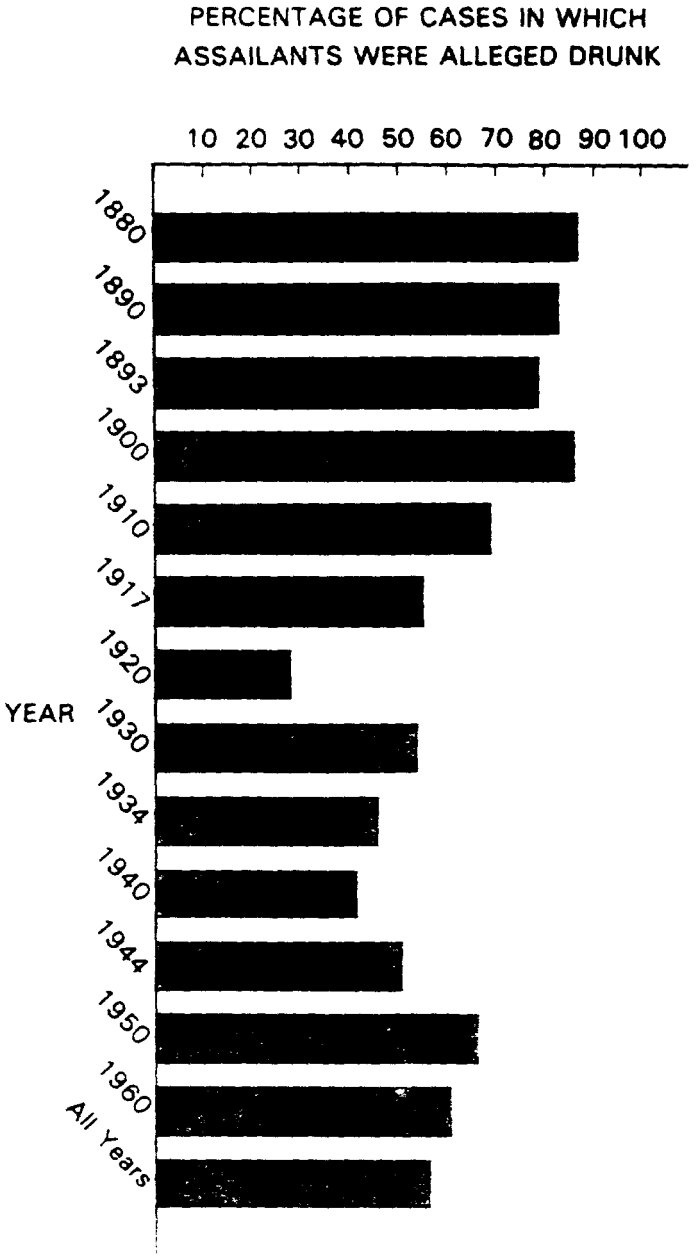
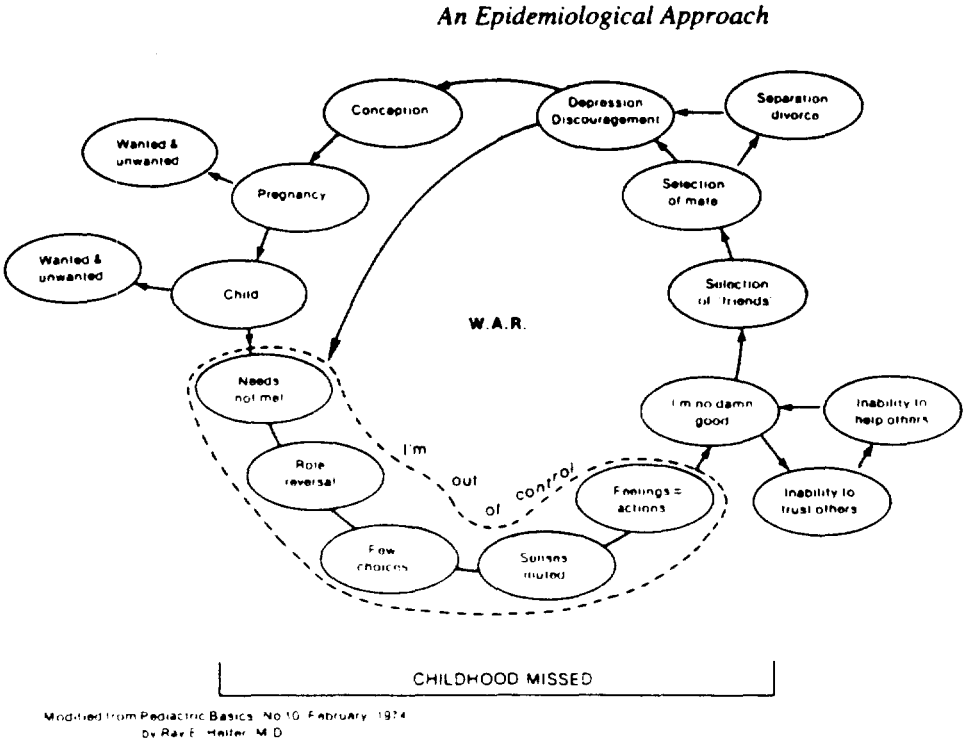


Table 3 (Gordon, 1988, p.143)

The abuser also tends to be young. Seventy-five percent of abusers are under twenty-five (AMA National Conference 1985). The abuser enters a role reversal, he expects the child to be the parent. When the child does not meet the high expectations, abuse occurs. The abuser also tends to use the defense mechanism of denial (denies that abuse is occurring) often (Helfer and Kempe 1987).

These characteristics are by no means the only basis for labeling a person an abuser but are definitely a starting point in making such determination Helfer and Kempe (1987) have developed a model (see Table 5) to show that some of these characteristics may result in abuse. Helfer and Kempe (1987) call this model the World-of-abnormal-rearing cycle (W.A.R.). The model sheds light on the abuse cycle which includes the necessity of the parent being abuse prone. Gordon (1988) contributed a chart to show how some of the discussed characteristics result in abuse (see Table 6). Wolfe (1987) developed two charts that further explain the abuse cycle. The charts mainly explain how certain factors lead to abuse (see Tables 7 and 8).

The abuse prone parent can develop into one of five types of abusers (Carmi and Zimrin 1984): the intermittent abuser, the one-time abuser, the constant abuser, the child as one side of an emotional triangle or the ignorant abuser (Carmi and Zimrin 1984). The intermittent abuser swings between periods of good



World-of-abnormal-rearing cycle. Modified from Helfer (22)

Table 5 (Helfer and Kempe, 1987, p.71)

HEROES OF THEIR OWN LIVES

FORMS OF STRESS AND FAMILY VIOLENCE

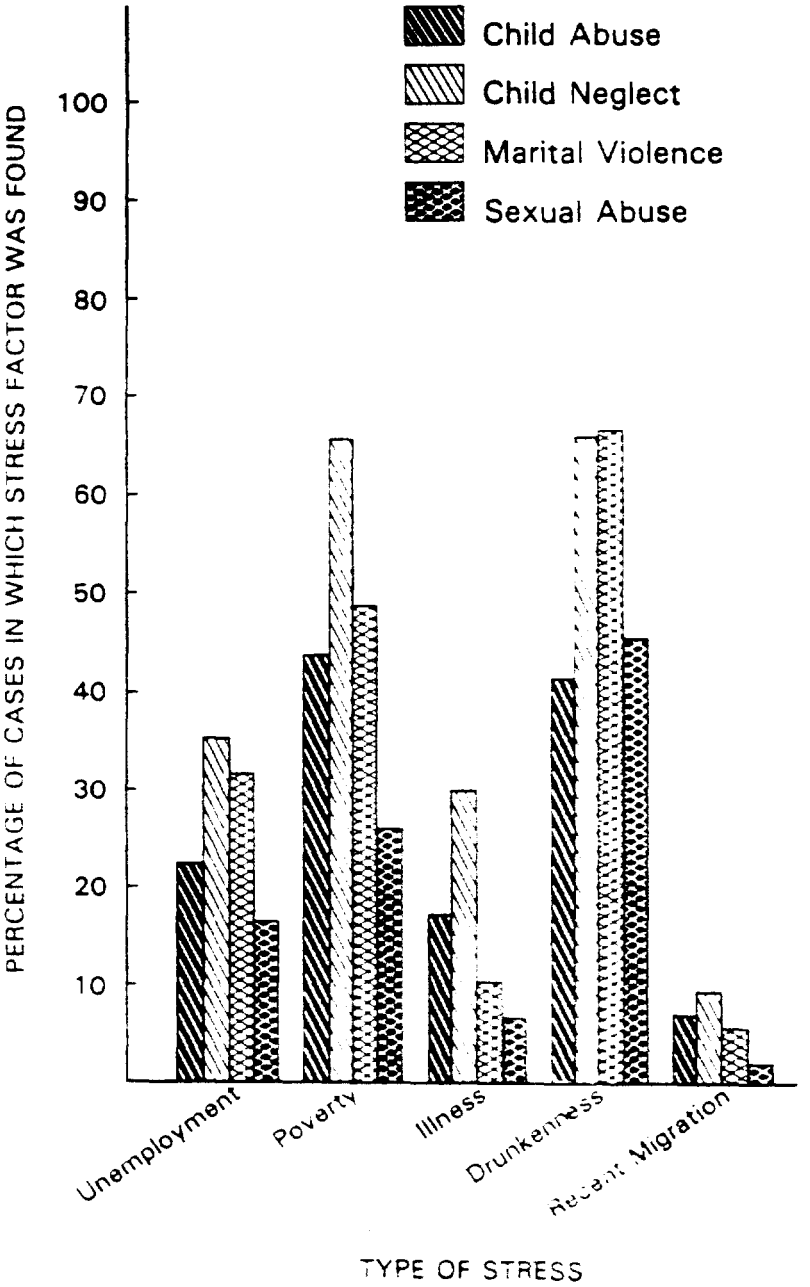


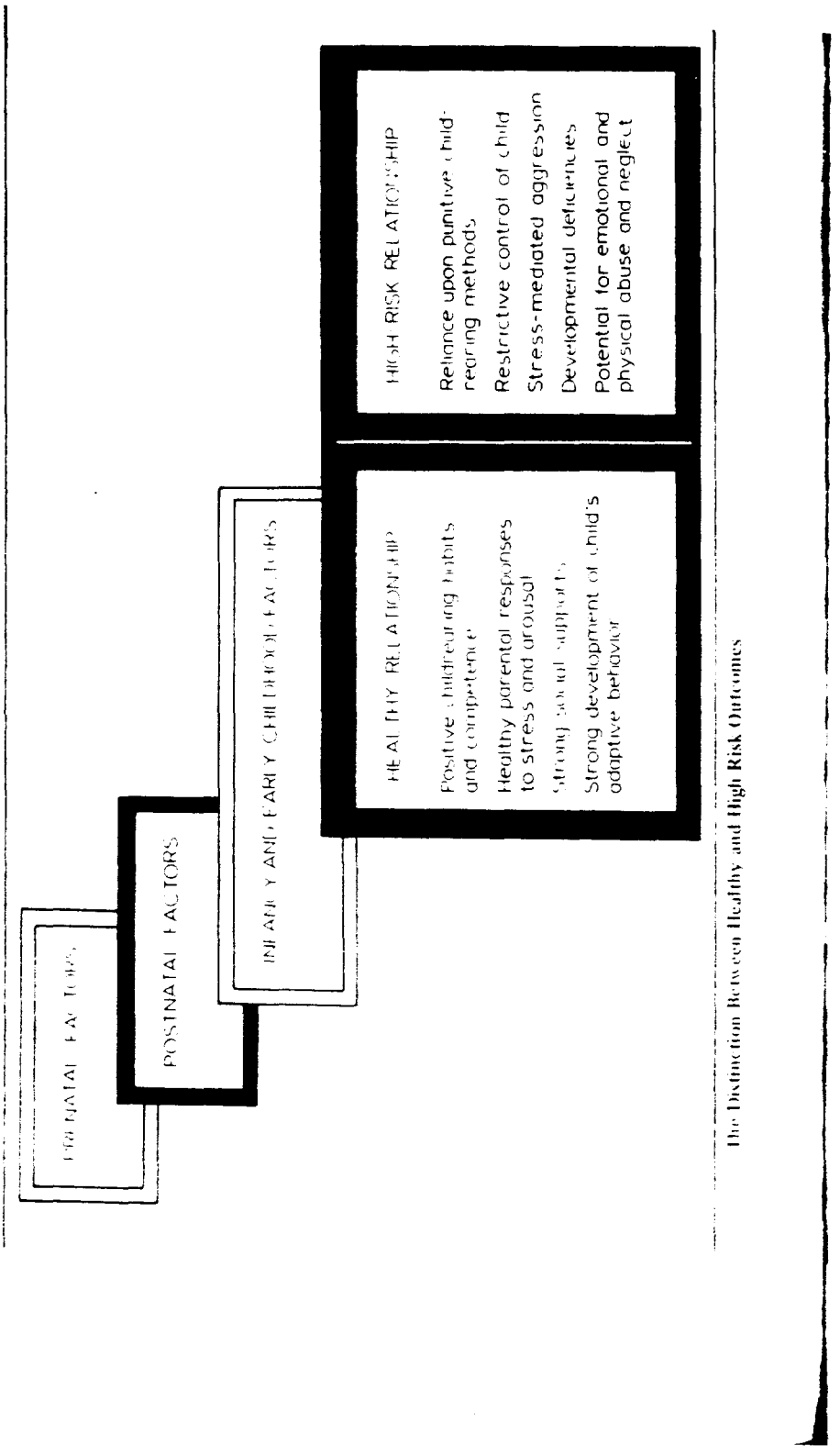
TAble 6 (Gordon, 1988, p.174)

Development of Severe Parent-Child Conflict and Abuse

DESTABILIZING FACTORS	COMPENSATORY FACTORS
STAGE I: *Reduced Tolerance for Stress and Disinhibition of Aggression*	
• Weak preparation for parenting • Low control, feedback, predictability • Stressful life events	• Supportive spouse • Socioeconomic stability • Success at work, school • Social supports and models
↓	
STAGE II: *Poor Management of Acute Crises and Provocation*	
• Conditioned emotional arousal • Sources of anger and aggression • Appraisal of harm/loss/threat	• Improvement in child behavior • Community programs for parents • Coping resources
↓	
STAGE III: *Habitual Patterns of Arousal and Aggression with Family Members*	
• Child's habituation to physical punishment • Parent's reinforcement for using strict control techniques • Child's increase in problem behavior	• Parental dissatisfaction with physical punishment • Child responds favorably to noncoercive methods • Community restraints/services

A Transitional Model of Child Abuse

Table 7 (Wolfe, 1987, p.59)



The Distinction Between Healthy and High Risk Outcomes

Table 8 (Wolfe, 1987, p.42)

parenting and periods of abuse. After abusing the child, the abuser genuinely feels remorse (Carmi and Zimrin 1984). This type of abuser attempts to correct the abusive behavior, with success, if the child survives long enough (Carmi and Zimrin 1984). The most common form of abuse for the intermittent abuser is to shake the child forcefully by an arm or leg (Carmi and Zimrin 1984).

The one-time abuser is a potential intermittent abuser. However, the one-time abuser is either stopped by killing the child or by a sudden surge of self-restraint (Carmi and Zimrin 1984). Carmi and Zimrin (1984) use a terrifying example.

> A 23-year-old mother of two young children, under the care of a psychiatrist for postpartum depression, appears to be in good control of herself, and is taking proper care of her two young boys. One sunny June morning, she kisses her husband good-bye when he goes to work as if nothing is wrong. She then shoots her older boy in the chest with a rifle, and places his 2 ½-month-old brother in the refrigerator freezer, neatly wrapped in a blanket. This grisly task completed, she shoots herself in the mouth with the rifle, and the whole family is discovered by the husband when he returns home from work that evening. What happened to this woman after her husband left for work that morning to make her behave with such an excess of violence is still a mystery (page 158).

The constant abuser hates the child and hence the abuse is deliberate (Carmi and Zimrin 1984). This type of abuser rationalizes the abuse by saying the abuse only occurs in order to make the child mind (Carmi and Zimrin 1984). Once again Carmi and Zimrin (1984) provide an example that is far better than any explanation.

> A 20-year-old father regularly beats his 14-month-old son with a leather belt, for the slightest infractions. The mother, either too weak or to frightened to protest, reluctantly cooperates with this parental savagery, caring for the frequently moribund toddler until the next infraction and beating. After one particularly harsh beating the child lapses into a coma, and this time does not survive. The parents then concoct an elaborate kidnapping plot in an effort to dispose of the body, complete with a ransom note (demanding $500 in two weeks). They bundle the other two children into their car, and bury the remains of their son. The ransom note is discovered, and because of its nature the local police suspect a hoax. On interrogation the mother breaks down, and between tears tells of the child's death and their subsequent attempt to hide the remains in a wooded area not far form their home. When arrested, the father seemingly shows no remorse (page 159).

The child as one side of an emotional triangle is a bit different. In this case, a single mother has a live-in boyfriend. The boyfriend takes good care of the child or children for he most part (Carmi and Zimrin 1984). However, when tension builds in the relationship between the mother and the boyfriend, the

boyfriend takes out his frustrations on the child (Carmi and Zimrin 1984). The boyfriend then either becomes an intermittent or one-time abuser (Carmi and Zimrin 1984).

The ignorant abuser is the last type. This parent means well but has no parenting skills. The lack of parenting skills results in injury or death to the child (Carmi and Zimrin 1984). Carmi and Zimrin (1984) provide a succinct example.

> A young mother hears from another mother on bus how this second mother corrects her children's behavior. The second mother tells the first that if her child cries too much, an easy solution is to pour pepper down the child's mouth, and the child stops crying immediately. The first mother gets home to her whining 4-year-old, and tells her to be quiet. When the child continues whining, she pours about two teaspoons of pepper down her throat, and the child stops. On several other occasions, the child misbehaves and the mother is quick to apply the pepper treatment. Late one afternoon the child is cranky, and the mother, irritated, pours about "half a dixie cup" of pepper into her daughter's mouth. This time, the daughter becomes agitated, runs around the house making grunting noises, starts to convulse, and dies in agony. The frantic mother tries to resuscitate her, but is unsuccessful. At the coroner's inquest, the mother is genuinely remorseful, but apparently doesn't understand the lethal potential of pepper (page 159).

CHAPTER 4

CHARACTERISTICS OF AN ABUSE PRONE CHILD

There are many characteristics of the child that contribute to the likelihood of the child being abused. Once again the characteristics are numerous and not every child who exhibits a certain characteristic will be abused. As was stated earlier, three things must be present for abuse to occur: 1) abuse prone personality of parent, 2) abnormal child or one who "accidentally" resembles significant other persons in abusive parent's life that abuser has strong negative feelings for, and 3) environmental stress (Evans 1981). An abused child may have a physical or developmental abnormality, be in the bottom tenth percentile for height and weight, have been premature, be illegitimate, be male, be the last born sibling, be less than three years old, have subnormal speech development, be mentally retarded, not be easy to toilet train, exhibit feeding problems, have brain damage, have an irritating cry, lack appeal, be withdrawn, have academic failure, be uncoordinated, show fear when contacted, cry

excessively, seem shallow, be compliant, show hostile behavior, do not look for assurance, show no expectation of being comforted, be less afraid than other children of admission to hospital wards, be alert to danger, keep asking what will happen next, do not want to go home, assume a "poker face" when discharge from the hospital is approaching, be aggressive and show a tendency for self-mutilation (AMA National Conference 1985 Evans 1981, Kadushin and Martin 1981, Fontana 1964).

As can be seen, the child does not have control of all of the above characteristics. For instance, a child cannot pick when he will be born or what sex he will be. Also, a child cannot help it if he reminds the parent of a significant other that the abuser has negative feelings towards. The last born sibling may be more likely to be abused because he is more often unwanted, frustrating, and/or financially ruinous. Child identified as abused is more likely to be under three years old because abuse of an infant is more clinically significant than similar abuse to an older child. Therefore, abuse to an older child is not always discovered. This can be seen in Helfer and Kempe's (1987) chart that depicts the ages between five and nine as the most likely time for abuse to occur with abuse at the ages of fifteen to seventeen a great deal less (see Table 9). Perhaps the abuse of the older child is just no longer detected.

Violent Acts and Child Abuse Index Rates by Age of Child (per hundred children)

Conflict Tactics and Child Abuse Index	Age 3–4 (N=179)	5–9 (N=347)	10–14 (N=365)	15–17 (N=238)	Total (N=1129)
Kicked, bit, punched	6.1	3.2	2.2	2.5	3.3
Hit with an object	19.6	19.7	9.6	4.2	15.4
"Beat up" child	1.1	0.9	1.1	1.7	1.2
Used a knife or gun	0.0	0.0	0.3	0.0	0.1
Child Abuse Index	19.8	20.9	10.2	5.6	14.0

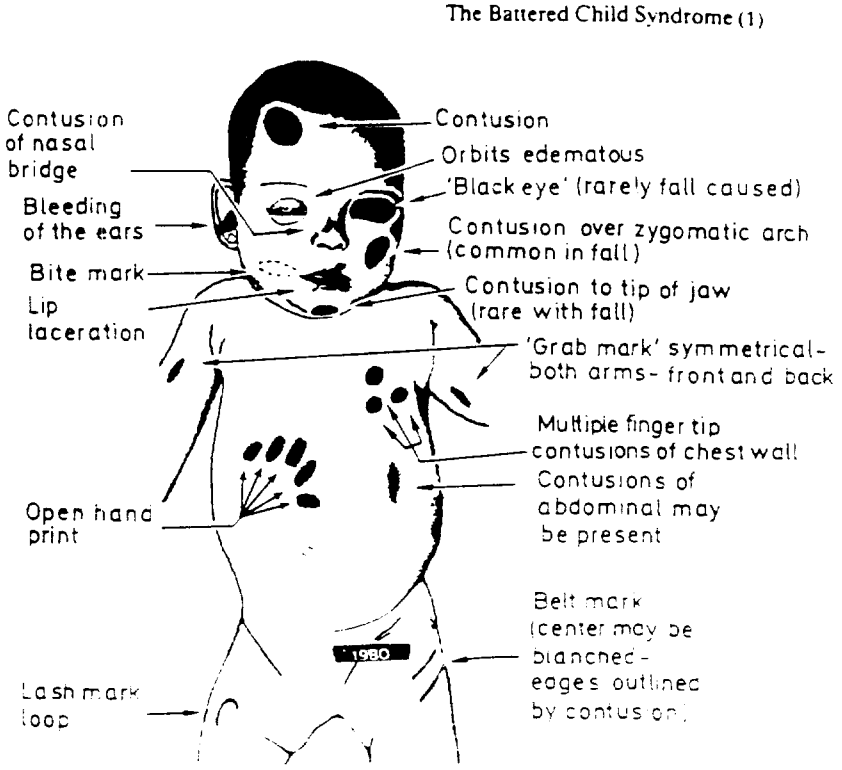
TAble 9 (Helfer and Kempe, 1987, p.49)

CHAPTER 5

GENERAL EFFECTS OF CHILD ABUSE

The effects of child abuse are widespread. The baby (see Figure 8) with a listing of possible indicators of abuse attests to this (Carmi and Zimrin 1984). In general, physical damage may be the result of beating or other forms of physical abuse. Emotional damage can be the crippling result of living in an atmosphere created by abuse (Baxter 1985). In some cases, however, the child appears to escape unscathed.

Physical abuse may result in damage to the brain, vital organs, eyes, ears, arms or legs (Baxter 1985, Kadushin and Martin 1981). Some of the possible indicators of abuse are listed in Helfer and Kempe's (1987) charts (see Tables 10, 11, 12). Anyone in contact with children should be on the lookout for these signs. Those in the medical profession should refer to the chart checklist when treating children (see Table 13). The injuries from physical abuse may result in mental retardation, blindness, deafness, or loss of a limb. Sadly, physical abuse may also result in death. Helfer and Kemps (1987) have a chart (see Table 14) that lists the types of abuse that most often end in death. Often, physical abuse shows up



Some possible indications of abuse

Figure 8 (Carmi and Zimrin, 1984, p.167)

Child with Nonaccidental Trauma

Human Hand Marks

1. Grab marks or fingertip bruises (e.g., extremities or face)
2. Trunk encirclement bruises
3. Linear marks or finger-edge bruises
4. Slap marks
5. Hand print
6. Pinch marks
7. Poke marks

Table 10 (Helfer and Kempe, 1987, p.183)

Child with Nonaccidental Trauma

Inflicted Abdominal Injuries (in order of frequency)

1. Ruptured liver or spleen
2. Intestinal perforation
3. Intramural hematoma of duodenum or proximal jejunum
4. Ruptured blood vessel
5. Pancreatic injury
6. Kidney or bladder injury
7. Chylous ascites from injured lymphatic system

TAble 11 (Helfer and Kempe, 1987, p.189)

Dating of Bruises

Age	Color
0–2 days	Swollen, tender
0–5 days	Red, blue, purple
5–7 days	Green
7–10 days	Yellow
10–14 days (or longer)	Brown
2–4 weeks	Cleared

Table 12 (Helfer and Kempe, 1987, p.192)

Medical Evaluation Checklist

1. History of injury
2. Physical examination of patient
3. Trauma X-ray survey on selected patients
4. Bleeding disorder screen on selected patients
5. Color photographs of selected patients
6. Physical examination of siblings
7. Official medical report in writing
8. Behavioral screening
9. Developmental screening

TAble 13 (Helfer and Kempe, 1987, p.191)

Forms of Fatal Child Abuse

I. Physical Trauma
   A. Blunt trauma (beating)
      1. multiple episodes (battered baby syndrome)
      2. single episode beating
   B. Firearm injuries
   C. Stabbing and cutting
   D. Burning
   E. Asphyxia
      1. smothering and choking
      2. strangulation
      3. drowning
      4. carbon monoxide or other gases
      5. hanging
      6. chest compression
      7. exclusion of oxygen
   F. Miscellaneous (electricity, explosives, falls from height, etc.)

II. Chemical Assault
   A. Poisoning
   B. Force feeding noxious substances

III. Neglect
   A. Starvation (malnutrition)
   B. Exposure to dangerous environment
   C. Failure to provide medical care when needed
   D. Exacerbation of natural disease by neglect

IV. Munchausen Syndrome by Proxy

Table 14 (Helfer and Kempe, 1987, p.248)

in the form of fractures or bruises. Shaking may result in subdural hematomas. This results from the repeated acceleration-deceleration and rotation forces caused by the shaking (Kadushin and Martin 1981). Shaking may also cause eye damage, in particular retinal hemorrhages (Kadushin and Martin 1981). Burns are a common form of physical abuse. Burns from a hot stove or scalding water are the more common forms of burning a child. Burning may scar a child for life. Some of the more unusual injuries are subgaleal hematomas caused by hair-pulling and injuries to the genital area (Carmi and Zimrin 1984, Kadushin and Martin 1981). Yet another unusual form of physical abuse is poisoning. The parent actually poisons the child little by little. Eventually, the child is hospitalized. The mother encourages the doctors to find the cause of the illness while continuing to poison the child (Kadushin and Martin 1981).

Emotional abuse is no less important just because it cannot be seen. An abused child may have little or no self-concept or ego. The child may have difficulty coping with reality because he may escape to a fantasy world to avoid his reality (Baxter 1985). In short, the child's overall thought processes may not be up to par.. The child may think that he deserves to be abused. The child may exhibit undue shyness, excessive daydreaming, anxiety states,

hysteria, suspiciousness, selfishness, excessive moodiness, exaggerated emotions or exhibitionism (Gordon 1988). The child may be restless, easily distracted, a side-liner or a hypochondriac (Gordon 1988). The child will often have a chip on his shoulder. Hence, emotional abuse can be as crippling as physical abuse.

There are some other effects of abuse that are difficult to classify. For example, children are often prevented from extrafamilial activities that are normally acceptable to parents (Evans 1981). Children are often prohibited from receiving rehabilitative services. In other words, some children could be helped (perhaps in speech development) but the parents do not allow the help.

Discipline is often haphazard for the abused child (Evans 1981). Therefore, the child lives in constant fear of how the parent will react to his (the child's) behavior. Parents are often jealous of any attention that the child receives. Hence, the child tries to draw as little attention as possible to himself so as not to arouse the wrath of the parent. The effects speak for themselves. Child abuse is destructive to children both physically and emotionally. A child may be crippled permanently due to maladaptive parenting. It is difficult to grasp the horror of child abuse without seeing the photographs. The next several pages

should give the reader feeling of disgust for the child abuser (Helfer and Kempe 1987, Carmi and Zimrin 1984).

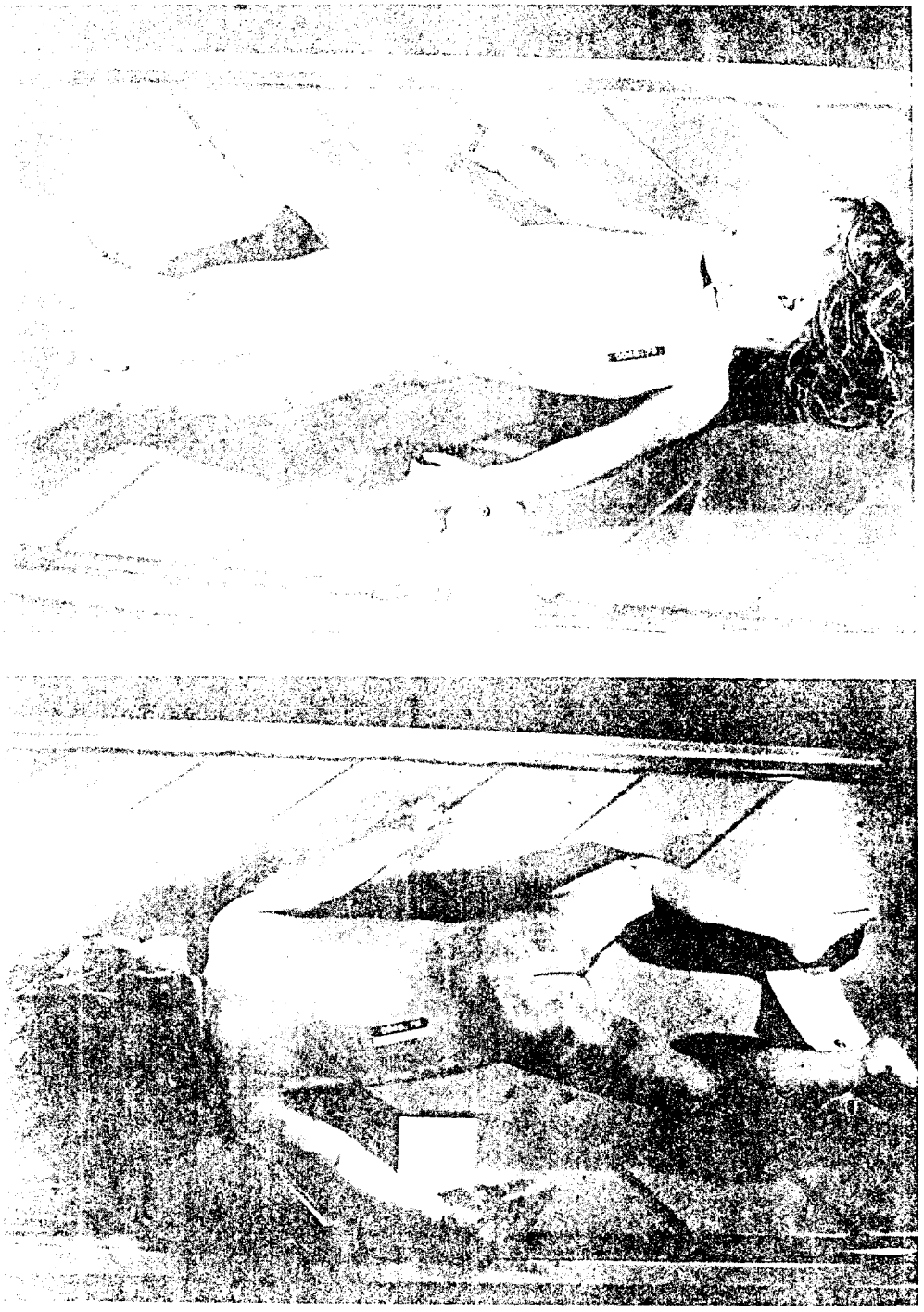


Figure 9 Victim of child abuse.
(Helfer and Kempe, 1987, p.250)

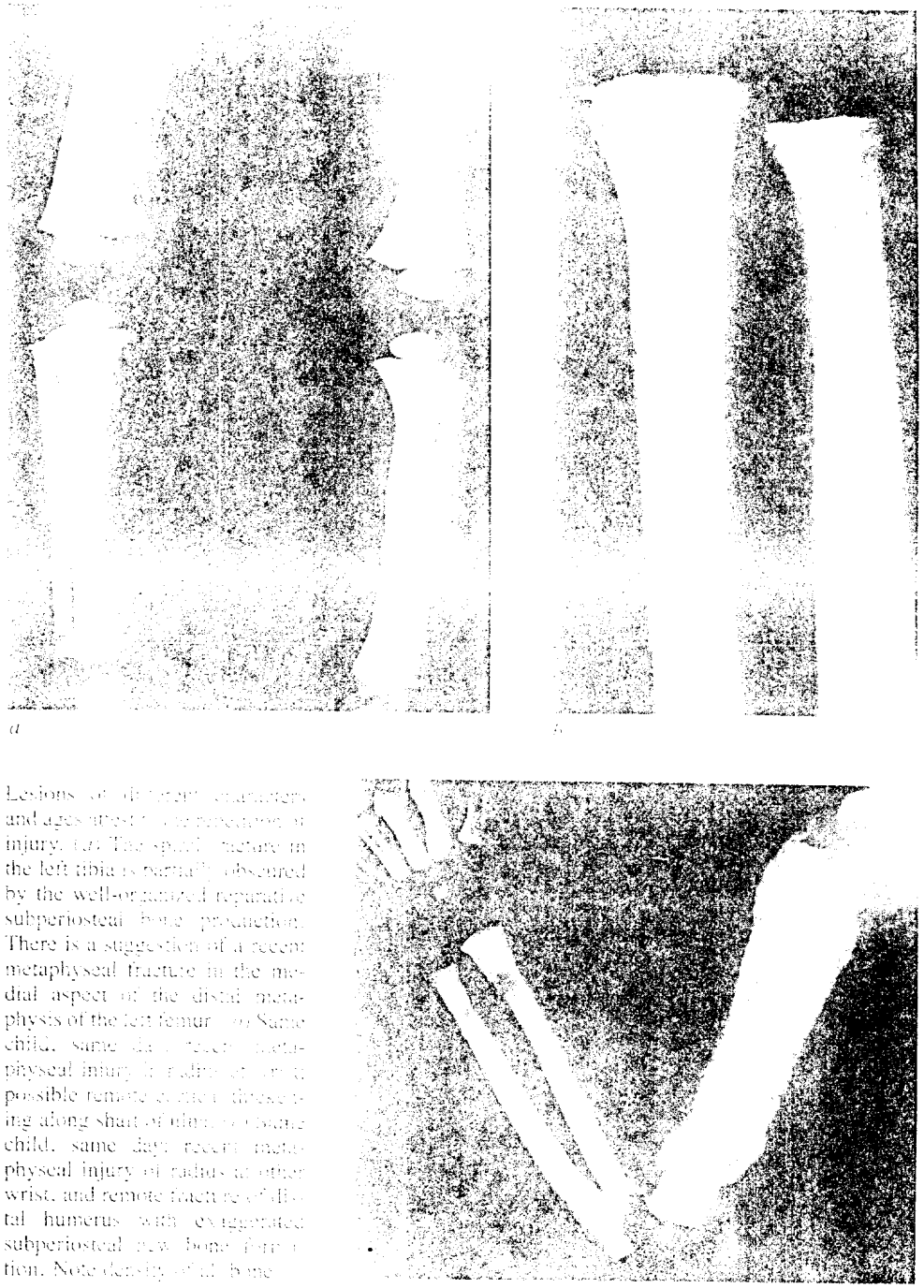
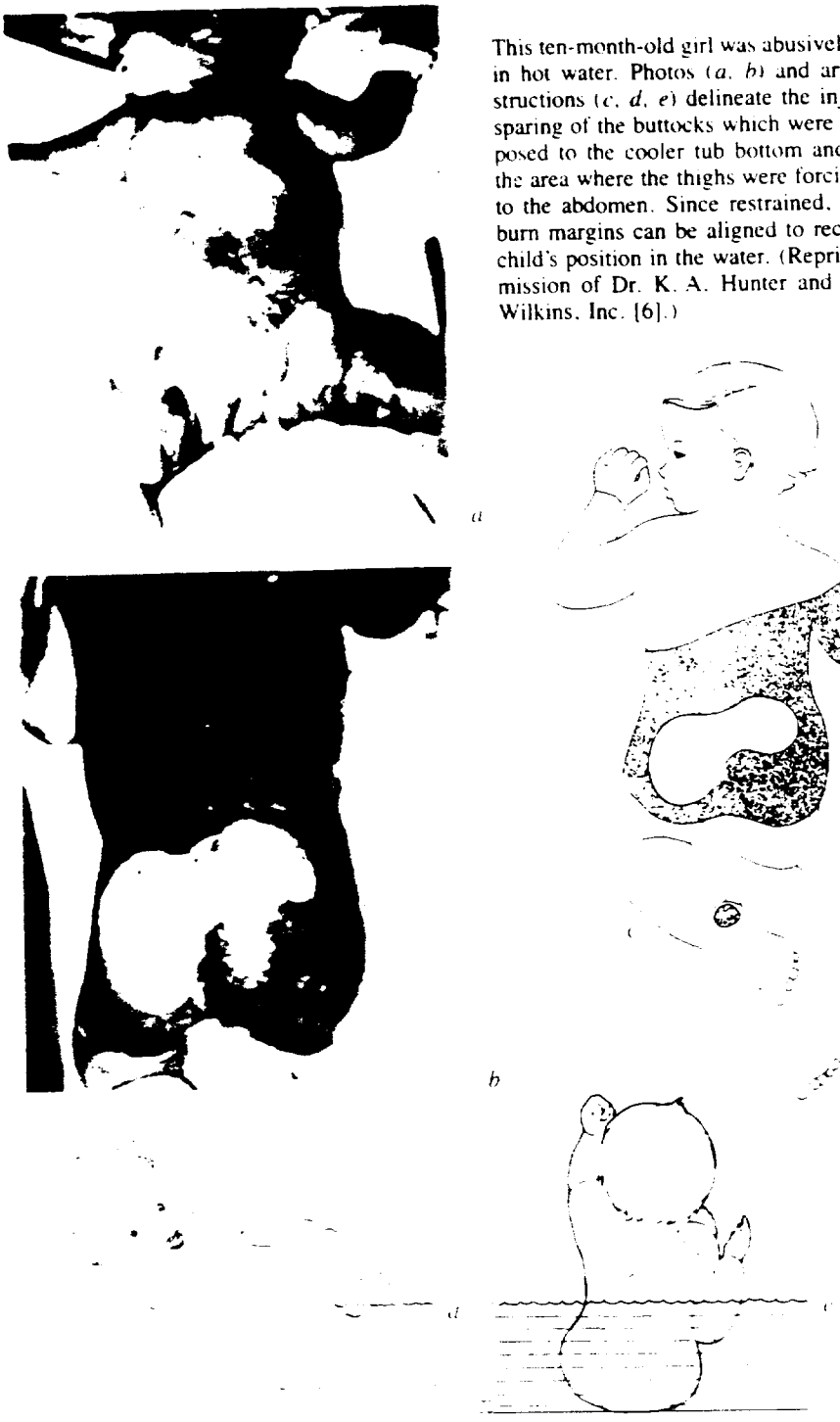


Figure 10 Victim of child abuse.
(Helfer and Kempe, 1987, p.219)

This 11-month-old girl was "found" in her crib with multiple electrical burns on her face. Visitation failed to reveal the source of the burns.

Figure 11. Victim of child abuse.
(Helfer and Kempe, 1987, p.207)

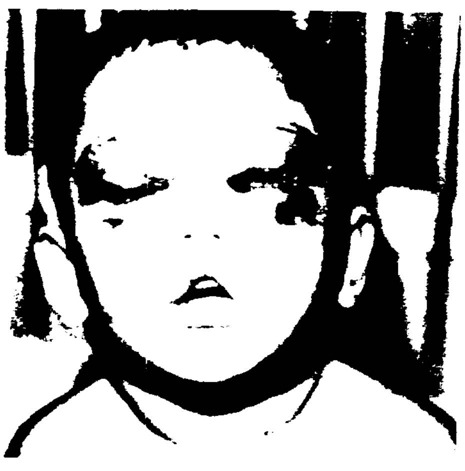


This ten-month-old girl was abusively immersed in hot water. Photos (*a*, *b*) and artist's reconstructions (*c*, *d*, *e*) delineate the injuries. Note sparing of the buttocks which were forcibly opposed to the cooler tub bottom and sparing of the area where the thighs were forcibly opposed to the abdomen. Since restrained, sharp upper burn margins can be aligned to reconstruct the child's position in the water. (Reprinted by permission of Dr. K. A. Hunter and Williams & Wilkins, Inc. [6].)

Figure 12 Victim of child abuse.
(Helfer and Kempe, 1987, p.202)

Multiple human bite marks (bitten by another child). Note the individual tooth marks.

[illegible]



[illegible]

Figure 13 Victim of child abuse.
(Helfer and Kempe, 1987, p.185)

Grab marks, squeeze marks on the upper and lower arm

Squeeze marks on the face one on the right cheek and two or three on the left.

Linear finger edge bruise on the upper arm

Figure 14 Victim of child abuse.
(Helfer and Kempe, 1987, p.184)

Pinch mark bruise of glans penis

Multiple bruises and cuts of penis, scrotum, and abdomen

Slap mark of cheek. The outlines of three fingers are visible with increase [illegible] the lower one.

Figure 15 Victim of child abuse.
(Helfer and Kempe, 1987, p.181)

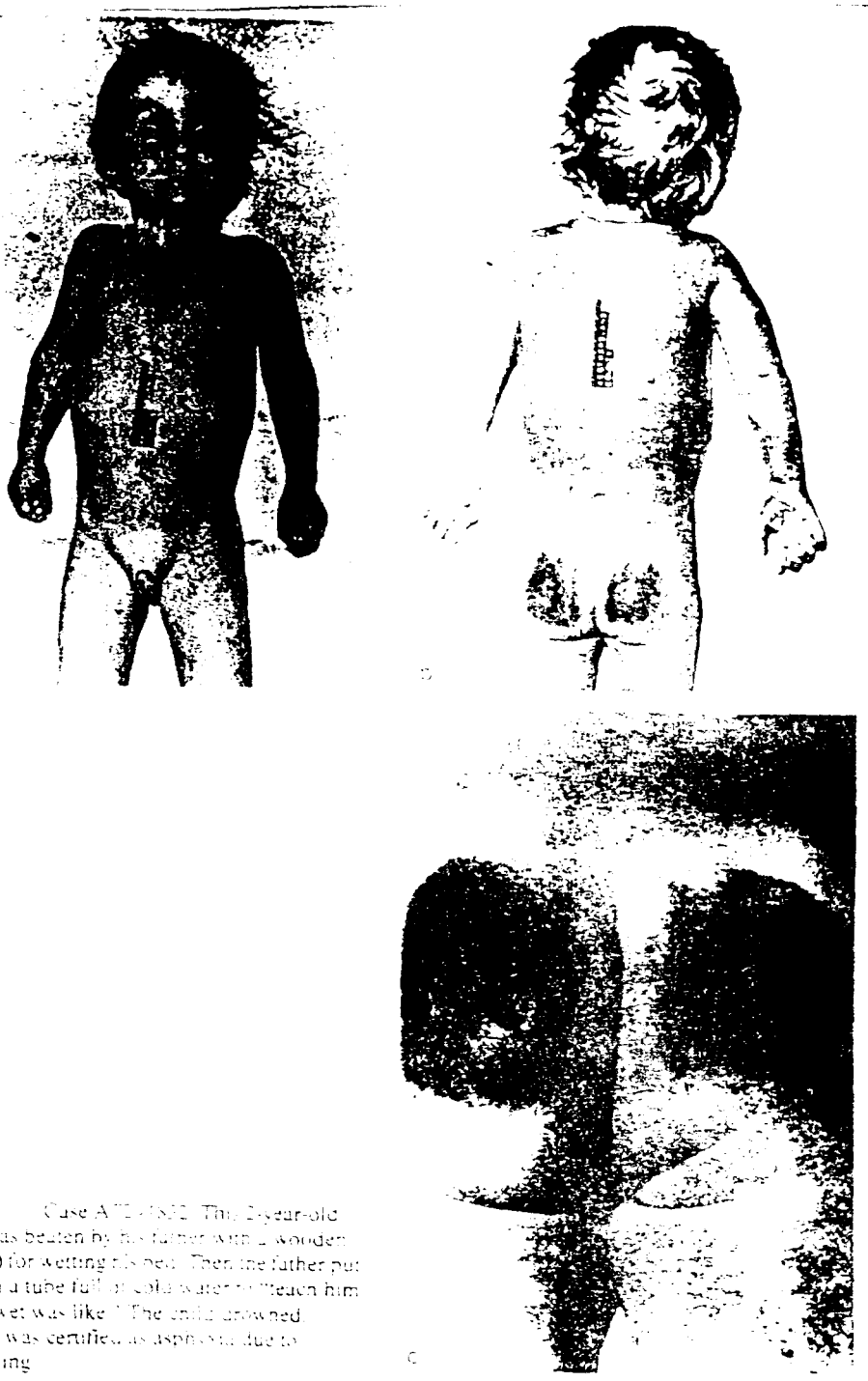


Figure 16 Victim of child abuse.
(Carmi and Zimrin, 1984, p.175)

Figure 17 Victim of child abuse.
(Carmi and Zimrin, 1984, p.173)

CHAPTER 6

EFFECTS OF CHILD ABUSE ON LEARNING

The literature describing the effects of child abuse on learning is severely lacking. From the available data it is evident that learning is affected. There are a number of ways the abused child will act in the learning environment. The child may overcomply, withdraw, be sleepy all the time, act out or engage in disruptive behavior (Tower 1987). When the teacher starts seeing these behaviors, she may want to start keeping a record. An example is Halperin's (1979) sample case conference presentation (see Table 15). The teacher should then keep an eye open for some of the following behaviors: destructiveness to self and others, cheating, lying, stealing, accident proneness, fearfulness, low achievement, coming to school too early or leaving late, inability to form good peer relationships, wearing inappropriate clothing, distaste for physical contact and/or immature behavior (Tower 1987). The abused child does not relate well to his peers or teachers (Volpe, Breton, and Mitton 1980). The child often has academic, social, truancy,

SAMPLE CASE CONFERENCE PRESENTATION

Physical description

Billy Jones is seven years old, male, white. His build is slight, his skin is very pale, and he has about him the gaunt look of malnutrition. On his left arm are three marks: two bruises and a sore. All three appear to have been recently acquired.

Major concerns

Billy worries me for the following reasons:

1. At lunchtime he frequently asks for a second helping and, when asked about his large appetite, explains that he does not eat breakfast at home.
2. He is listless in class and often just wants to sit during recess. Billy has fallen asleep on three different occasions in the last month.
3. Billy's schoolwork is below average and more appropriate to a first grader than to a child in the second grade.
4. The marks on Billy's arm give me some concern. The sore continues to ooze. I wash and bandage it daily because he is receiving no treatment for it at home. Billy explains the injuries as the result of a fall he took last week. He says his parents say that bumps are a part of growing up and that they will heal soon.
5. Billy has worn only two different shirts all year, and often his clothes are dirty.
6. Mr. and Mrs. Jones, Billy's parents, have failed to respond to either of the two letters I wrote to them explaining that Billy needs a good breakfast daily. I would call the home, but they have no telephone. From my observations and discussions with Billy, I believe his parents are neglectful people. Billy has needs, specifically in regard to medical care, clothing, and food.

Background information

Billy has been in attendance at his school since the beginning of this school year. The records indicate that the Jones family moved here from Opelika, Alabama, during July and that Mrs. Jones registered Billy on [illegible]. The records from Opelika indicate that

Cont'd next

TAble 15

(Halperin, 1979, p.107)

SAMPLE CASE CONFERENCE PRESENTATION—cont'd

Billy received C and D grades and behaved well in class. The comment on the permanent record folder states, "Billy gets along with the other children, but needs lots of encouragement to finish his work." His medical records indicate that all required immunizations have been completed and that no major illnesses or injuries are present. His achievement tests, administered in April of last school year, indicate readiness level in mathematics and reading. No IQ test data is available. Last year Billy attended school 123 days out of the required 180 days and was promoted to the second grade. He did not attend a public or private kindergarten. This year he has been absent 14 days out of the first 45-day marking period, but not for more than 3 days at any one time.

Social history

I have not had personal contact with Billy's parents but have asked Mrs. Auburn, the school secretary who registered Billy, what she can recollect from that experience. Mrs. Auburn clearly recalls that Mrs. Jones was not able to read all the directions on the registration sheet and asked for assistance. She also indicates that Mrs. Jones was "sloppy" in dress, seemed unsure of herself, and had difficulty managing the other children in her family. Billy was present at the registration and was asked to take care of the younger children by Mrs. Jones. Mrs. Auburn also remembers that the children were not very clean and were not wearing shoes. She did not remember whether there were two or three other children, but a review of the records indicates three younger siblings: John, age 4; Mary, age 3; and James, age 18 months. The only other relevant information that I have been able to acquire relates to the father's work. He is listed as a day worker; the mother is not employed. Records do not indicate their educational attainment.

Present performance

The summary statements presented in earlier sections of this review are indicative of Billy's present performance. Academically, he is achieving on the readiness level in reading and making progress in math. At the beginning of the year he could not count past nineteen or recognize letters in the alphabet other than those in his name and then only in sequence. He can now count to 100 and recognize fourteen letters in the alphabet. He also has acquired a word recognition ability with four words other than his name. His writing is poor. He cannot write on lines nor recollect letters from memory. He can write the numbers 1 to 20 from memory but inverts the numbers 2, 3, and 5.

Socially, Billy seems to be fairly well accepted by the other children. He never bothers other children and tries to be friends even though a few of the children have made fun of him because his clothing was torn on several occasions. Also, when he came to school one cold day without a coat, some of the children kidded him. Billy simply walked away, hung his head, and was upset for about 30 minutes. Afterward, he went back to his work as if nothing had occurred. The children also have teased him about sleeping in class and have called him "slow poke" because he does not get his work done on time.

Emotionally, Billy seems fairly well adjusted. In light of the criticism from other children, he seems to withstand it much better than other children with whom I have worked. He does not [illegible] correct his work but tries to do better. I have also noticed that he responds [illegible] to the children and me after lunch than in the morning when he seems to be [illegible] class and that while comments are made to him that cause him to be upset and withdrawn in the morning, the same comments made after lunch do not elicit withdrawal. Instead, he seems to ignore them.

Mrs. [illegible] has observed him on two 15-minute occasions, one in the morning and once in the afternoon. She reports [illegible] behavior in the morning with little accomplished [illegible] lesson, but [illegible] more attentive behavior with greater accomplishment [illegible]

Table 15
(Halperin, 1979, p.108)

SAMPLE CASE CONFERENCE PRESENTATION—cont'd

Actions

Actions taken by me to help Billy can be summarized as follows:

1. I realized that my comments to Billy needed to be made in private because the other children were picking up on them.
2. I have given him candy on two occasions in the morning and have noticed that his activity level and work performance increased considerably.
   ave given him a little more individual attention than the other children, and he seems have responded to this treatment.
4. I have begun to establish a warm relationship with Billy. On three days he came to me and asked for some more candy, and he has also requested my assistance with his work.
5. For now, I believe that I have made some progress with Billy in his work and will begin to emphasize his achievements to the other children so that negative criticism from them can be reduced.

Tentative conclusions

1. Billy is not getting adequate care at home, particularly in areas of medical treatment, sufficient food in the morning, and the appropriate clothing, particularly on cold days.
2. Billy appears to be of average or low-average intelligence, as evidenced by the fact that he responds reasonably well to the teaching of new information. If in attendance for one weeks without a break, he makes substantial progress.
3. Because Billy responds much better socially, emotionally, and academically after lunch or on the occasions when given food in the morning, it is likely that the lack of breakfast is affecting his performance.
4. Billy appears to have a reasonably good self-concept. He accepts criticism and rebounds well from such treatment by the children.
5. The loneses are either unaware of or not able at this time to care for the needs of the child.

Recommendations

1. Because the relationship with Billy is developing along positive lines, it is desirable to discuss with him a little more about his family. Focus particularly on the breakfast situation: who gets up when he does, if it is possible for Billy to make his own breakfast, etc. Also, ascertain the reasons for his absences.
2. Continue to provide individual attention and reshape peer attitudes.
3. Send positive notes, with accompanying work papers, to parents and invite parents to school as an open invitation.
4. Make a home visit after school to establish relationship with the parents. This effort should be a preliminary introduction and a rapport-building session that could be followed up soon after by a parent visit to the school.
5. Discuss with Billy his medical experiences, particularly times when he has gone to the doctor, and the reasons for his visits.

TAble 15
(Halperin, 1979, p.109)

and drug problems (Christiansen 1980, Volpe, Breton and Mitton 1980, Martin and Kempe 1976).. The child tends to be aggressive at school. This aggressiveness usually results in yet more punishment. The abused child has delayed language development (Christiansen 1980, Volpe, Breton, and Mitton 1980, Martin and Kempe 1976) and performs gross motor tasks poorly (Christiansen 1980, Martin and Kempe 1976). Basically, the abused child is at a severe disadvantage in the school setting.

More often than not abused children end up in special education classrooms or in institutions (Volpe, Breton, and Mitton 1980, Martin and Kempe 1976). The abused child often has a low intelligence quotient. Therefore, these children need extra attention from the teaching staff. However, more research must be conducted before the educational system will know how to act for the best interests of the abused child.

In the meantime, teachers are required by law to report suspected child abuse and neglect. Following is a sample reporting form from Tower (1987) and a chart depicting who must report from Tower (1987). States vary on who must report. However, in Indiana every person that suspects child abuse must report the suspicions to the proper authorities (Tower 1987). In Indiana the address is Indiana Department of Public Welfare - Child Abuse and Neglect, Division of Child Welfare - Social Services, 141 South Meridian Street, 6th Floor, Indianapolis, Indiana 46225.

Appendix H

Sample Reporting Form*

REPORT OF CHILD(REN) ALLEGED TO BE SUFFERING FROM SERIOUS PHYSICAL OR EMOTIONAL INJURY BY ABUSE OR NEGLECT*

Massachusetts law requires an individual who is a mandated reporter to immediately report any allegation of serious physical or emotional injury resulting from abuse or neglect to the Department of Social Services by oral communication. This written report must then be completed within 48 hours of making the oral report and should be sent to the appropriate Department office.

Please complete all sections of this form. If some data is unknown, please signify. If some data is uncertain, place a question mark after the entry.

DATA ON CHILDREN REPORTED:

	NAME	CURRENT LOCATION/ADDRESS	SEX	AGE OR DATE OF BIRTH
1)	Thomas Smythe, Jr.	195 East St., Westville, MA	☒ Male ☐ Female	10/09/7?
2)			☐ Male ☐ Female	
3)			☐ Male ☐ Female	
4)			☐ Male ☐ Female	
5)			☐ Male ☐ Female	

DATA ON MALE GUARDIAN OR PARENT:

Name: Thomas (First) Brown (Last) _____ (Middle)

Address: 195 East St (Street and Number) Westville (City/Town) MA (State)

Telephone Number: 555-4567 **Age:** 40(?)

DATA ON FEMALE GUARDIAN OR PARENT:

Name: Gloria (First) Brown (Last) _____ (Middle)

Address: 195 East St. (Street and Number) Westville (City/Town) MA (State)

Telephone Number: 555-4567 **Age:** 32

DATA ON REPORTER/REPORT:

10/12/83 (Date of Report) ☒ **Mandatory Report** ☐ **Voluntary Report**

Reporter's Name: Francine (First) Garcia (Last) (teacher)

Reporter's Address: (If the reporter represents an institution, school, or facility please indicate.)

South Westville Middle School (Street) Westville (City/Town)

MA (State) _____ (Zip Code) 555-1456 (Telephone Number)

Has reporter informed caretaker of report? ☐ YES ☒ NO

ABUSE NEGLECT REPORT - 3 (Revised April, 1983)

*Form reprinted with permission of Massachusetts Department of Social Services. *Filled-in data is fictitious and used only as an example*

TAble 16

(Tower, 1987, p.202)

Sample Reporting Form

What is the nature and extent of the injury, abuse, maltreatment or neglect, including prior evidence of same? (Please cite the source of this information if not observed first hand.)

Tom has become increasingly withdrawn this school year. He apparently has no friends, eats alone, and has been seen crying on several occasions. In addition, the boy's grades are deteriorating and he is in danger of failing all subjects. According to other teachers, last year he did well in school and had many friends. Also, the school nurse reports that Tom appears to be losing weight.

What are the circumstances under which the reporter became aware of the injuries, abuse, maltreatment or neglect?

I called Tom's mother who reported that Mr. Brown has recently returned from a temporary assignment in Germany (he works for an oil company). The couple has been arguing about Mr. Brown's methods of discipline, which Mrs. Brown thinks are too harsh. They include isolating Tom from his half-brothers and sisters (Tom is from an earlier marriage of Mrs. Brown). For days at a time the boy is locked in his room from the time he gets home from school in the afternoon until he goes to school the next morning.

What action has been taken thus far to treat, shelter or otherwise assist the child to deal with this situation?

In my conversation with Tom's mother, she said there was nothing she could do. A parent-teacher conference was requested with both parents, but they refused this request. Tom was referred to the guidance counselor.

Please give other information which you think might be helpful in establishing the cause of the injury and/or the person responsible for it. If known, please provide the name(s) of the alleged perpetrator(s).

Tom told the guidance counselor that on some days the only meal he gets is lunch at school.

I would like to be contacted by the social worker.

Francine Garcia
Signature of Reporter

ABUSE/NEGLECT REPORT - 3 (Revised April, 1983)

Table 16
(Tower, 1987, p.203)

Appendix C

Who Reports*

States and Territories	WHO MUST REPORT																
	"Any Person" or "Any Other Person"**	Physician	Nurse	Surgeon	Osteopath	Dentist	Resident	Intern	Hospital/Institution Personnel	Practitioner of Healing Arts	Chiropractor	Optometrist	Podiatrist	Pharmacist	Mental Health Professional	Coroner/Medical Examiner
Alabama		X	X	X	X	X			X		X	X	X	X	X	X
Alaska		X	X	X	X	X			X	X	X	X			X	
Arizona		X	X	X	X	X	X	X			X		X		X	X
Arkansas		X	X	X	X	X	X	X	X						X	X
California		X	X	X		X	X	X	X		X		X			
Colorado		X	X	X	X	X		X	X		X		X		X	X
Connecticut	X	X	X	X	X	X	X	X			X	X	X		X	X
Delaware	X	X	X		X	X	X	X		X					X	X
District of Columbia		X	X			X					X				X	X
Florida	X	X	X													
Georgia		X	X		X	X	X	X					X		X	
Hawaii		X	X		X	X				X						X
Idaho	X	X	X				X	X								X
Illinois		X	X	X	X	X			X		X		X			X
Indiana	X															
Iowa		X	X	X	X	X	X	X	X	X	X	X	X		X	
Kansas			X			X	X	X		X					X	
Kentucky	X	X	X		X	X	X	X	X		X	X			X	X
Louisiana	X	X	X				X	X	X							
Maine		X	X		X	X	X	X			X		X		X	X
Maryland		X	X	X		X	X	X		X					X	
Massachusetts		X	X			X		X								X
Michigan		X	X			X										X
Minnesota									X	X					X	
Mississippi		X	X			X	X	X							X	
Missouri		X	X			X	X	X	X	X	X	X	X		X	X
Montana	X	X	X													
Nebraska	X	X	X						X							
Nevada		X	X	X	X	X	X	X	X		X	X			X	
New Hampshire	X	X	X	X	X	X	X	X	X		X	X			X	X
New Jersey	X															
New Mexico	X	X	X				X	X								
New York		X	X	X	X	X	X	X	X		X	X	X		X	X
North Carolina		X	X	X	X	X	X	X	X		X	X	X		X	X
North Dakota		X	X			X						X			X	X
Ohio		X	X	X		X	X	X					X		X	X
Oklahoma	X	X	X	X	X	X	X	X								
Oregon		X	X			X	X	X			X	X			X	
Pennsylvania		X	X		X	X		X	X		X	X	X		X	X
Rhode Island	X															
South Carolina		X	X			X				X		X			X	X
South Dakota		X	X	X	X	X	X	X			X	X	X		X	X
Tennessee	X															
Texas	X															
Utah	X		X													
Vermont		X	X	X	X	X	X	X	X		X					X
Virginia			X				X	X		X					X	
Washington		X	X	X	X	X				X	X	X	X	X	X	
West Virginia						X									X	
Wisconsin		X	X	X		X			X		X	X			X	X
Wyoming	X															
America Samoa		X	X	X	X	X	X	X	X		X	X	X		X	X
Guam		X	X	X	X	X		X	X	X	X	X	X		X	X
Puerto Rico	X	X	X			X	X	X	X	X	X			X		
Virgin Islands		X	X			X			X						X	

*Adapted from *Child Abuse and Neglect State Reporting Laws*. Washington, D.C.: NCCAN, Children's Bureau, 1979

**A state that does not specify categories of professionals that must report, but instead requires that every person or any person report, is checked only in this column.

TAble 17

(Tower, 1987, p.188)

Who Reports

WHO MUST REPORT													WHO MAY REPORT	
Teachers	Other School Personnel	Social Services Worker	Law Enforcement Officer	Peace Officer	Police Officers	Probation Officer	Parole Officer	Religious Healing Practitioner	Child Care Institution/Worker	Clergymen	Attorney	Others	States and Territories	Permissive Reporting
X	X	X	X	X					X			X	Alabama	•
X	+	X		X				X				X	Alaska	•
X	X	X		X								X	Arizona	
X	X	X	X	X					X				Arkansas	•
X	X	X		X		X		X	X	X		X	California	•
X	X	X						X	X			X	Colorado	•
X	X	X			X				X	X			Connecticut	
X	X	X											Delaware	
X	X	X	X						X				District of Columbia	•
X	+	X										X	Florida	
X	X	X	X						X				Georgia	•
X	+	X											Hawaii	•
X	+	X							X				Idaho	
X	X	X	X					X	X			X	Illinois	•
+	+												Indiana	
X	X	X		X					X				Iowa	•
X	X	X	X										Kansas	•
X	X	X		X					X			X	Kentucky	
X	+	X										X	Louisiana	•
X	X	X	X					X	X				Maine	•
X	X	X	X		X	X	X					X	Maryland	
X	X	X			X	X						X	Massachusetts	•
X	X	X	X						X			X	Michigan	•
X	X	X	X						X				Minnesota	•
X	X	X	X						X	X			Mississippi	
X	X	X	X	X		X	X	X	X	X		X	Missouri	•
X	+	X	X								X		Montana	
X	X	X											Nebraska	
X	X	X							X	X	X		Nevada	•
X	X	X	X					X	X	X		X	New Hampshire	
+	+												New Jersey	
X	+	X	X										New Mexico	
+	X	X	X	X				X	X				New York	•
X	X	X	X					X				X	North Carolina	
X	X	X	X		X				X			X	North Dakota	•
X	X	X						X	X		X	X	Ohio	•
+	+												Oklahoma	
X	X	X		X					X	X	X	X	Oregon	
X	X	X	X	X				X	X			X	Pennsylvania	•
+	+												Rhode Island	
X	X	X	X		X			X	X				South Carolina	•
X	X	X	X										South Dakota	•
+	+												Tennessee	
+	+												Texas	
+	+												Utah	
+	+				X							X	Vermont	•
X	X	X	X			X		X	X			X	Virginia	•
X	X	X						X	X			X	Washington	•
X	X	X	X	X				X	X			X	West Virginia	•
X	X	X	X		X				X				Wisconsin	•
+	+												Wyoming	
X	X	X	X	X				X	X				American Samoa	•
X	X	X	X	X				X	X			X	Guam	•
X	X	X							X				Puerto Rico	
X	X	X	X	X					X			X	Virgin Islands	•

+Teachers and other school personnel are required [illegible] state mandate of "any person" or "any other person" or "others"

TAble 17
(Tower, 1987, p.189)

CHAPTER 7

PREVENTION OF CHILD ABUSE

The prevention of child abuse needs to be directed at many levels. Individual, familial, community, and societal and cultural levels need to be addressed (Wolfe 1987).

At the individual level the prevention of child abuse needs to be targeted at psychological problems concerning the parent's history of abuse. Hence, the cycle needs to be broken. Individuals need to be given coping skills and strategies and means for relieving stress (Wolfe 1987). Parents need to be taught what to expect from a child so they do not act too harshly when a child does something that displeases the parent. The individual needs work on self-esteem, motivation, and social competence. The individual needs contact with society. The more contacts an individual has, the more checks there are on an individual's behavior (Wolfe 1987). Financial and household management skills need to be addressed (Wolfe 1987).

At the familial level, people need to be educated as to how to cope with marital problems. In other words, couples need help learning how to solve problems (Wolfe 1987). Family members need to learn

how to conduct positive familial relations. And, a family needs to know that there is help in handling a difficult child (Wolfe 1987).

At the community level, socioeconomic conditions need to be addressed. The poor need relief from the stress of everyday living so abuse does not result. Educational services need to be available for disadvantaged people (Wolfe 1987). Last, the community needs to provide employment opportunities for its community (Wolfe 1987).

At the last level, society needs to change its attitude concerning corporal punishment. If corporal punishment is not accepted by society, then child abuse would be less likely to occur (Wolfe 1987). Our culture needs to place a high priority on parenting education and preparation. Prepared families will be less likely to fall into the deviant clutches of child abusing (Wolfe 1987). Society needs to even out the burden of child-rearing responsibilities. Currently, women shoulder the brunt of child-rearing responsibilities (Wolfe 1987). Perhaps this is why more women are reported to be abusers.

There are many things that can be implemented in an effort to prevent child abuse: competency enhancement, public awareness campaigns, support groups, child management training, education groups and public health nursing (Wolfe 1987, AMA National Conference 1985). Competency enhancement involves

teaching parenting skills and coping strategies. This could be done by using television or by requiring a class in parenting in mandatory schooling (Wolfe 1987). This goal could also be accomplished by requiring people to take a class in parenting before a marriage license is issued. These plans would basically serve the individual needs mentioned previously.

Public awareness campaigns are aimed at educating the general public about child abuse and the help available for abused children (Wolfe 1987). Support groups are aimed at providing parents with an outlet for stress other than child beating (Wolfe 1987). Parents Anonymous is the best example of a successful support group. Perhaps a group of Parent Aides could be more widely used. These areas would focus on the familial, community, and societal and cultural levels that need to be addressed.

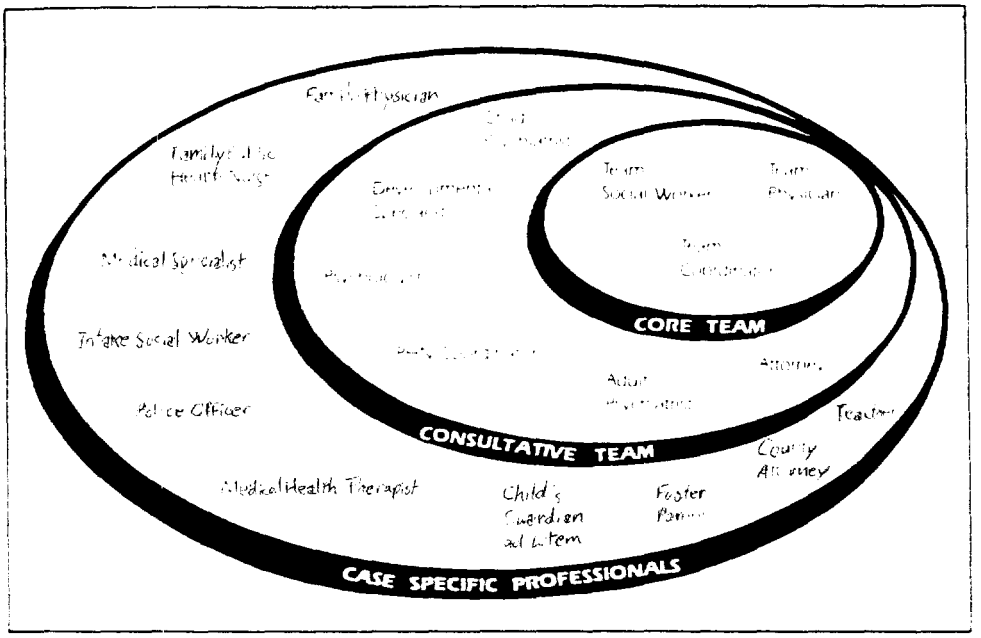
Child management training could be offered through welfare programs, high schools, and colleges. This idea would help educate parents as to acceptable methods of getting a child to behave (Wolfe 1987). Education groups themselves could conduct some aspects of management training. However, the education groups need to work at changing societal beliefs, to affect our culture until there is widespread disapproval of child abuse and corporal punishment (Wolfe 1987).

Public health nursing could be utilized in preventing child abuse (Wolfe 1987). Home nurses could become an accepted part of our culture. Hence, nurses would deter child abusing.

Helfer and Kempe (1987) have approached prevention from a similar tack. They have identified seven components as necessary for prevention of child abuse:

> 1. A community consortium committed to the dictum that family violence in their community is unacceptable;
> 2. A never-ending mass media campaign to educate the public on this dictum;
> 3. A major change in our health services to include some form of training for all new parents in the art of communicating with one's baby;
> 4. A home health visitor program for all new parents for the one to two years after the birth of their firstborn child;
> 5. An early child development program for all preschool children run by churches, schools, community colleges, or whomever;
> 6. An interpersonal skills program (how-to-get-along curriculum) in the public schools (k-12) built upon interpersonal skills in grade school, advancing to courses in sexuality and parenting in high school; and
> 7. An adult education program for two levels of young adults -- those who had a positive childhood experience themselves and want a refresher course on childhood before they become parents, and those whose childhood experiences were negative who need a "crash course in childhood" before parenting is undertaken (page 426).

Helfer and Kempe (1987) also provide an illustration of all the people who are involved in ensuring the safety of each and every child. Wolfe (1987) provides a chart that further details prevention. Wolfe outlines the method, target population, timing of program, target behaviors and examples of content.



Child Protection Team Composition (provided by Joan Senzek Solheim).

Figure 18 (Helfer and Kempe, 1987, p.128)

TAble 18
(Wolfe, 1987, p.131)

Approaches to Child Abuse Early Intervention and Treatment

Method	*Target Population*	*Timing of Program*	*Target Behaviors*	*Examples of Content*
Parent and Family Centered Approaches				
Child management training	Parents with serious conflict with child, parents requiring concrete demonstration and rehearsal	Early childhood, upon referral to clinic	Effective parenting skills, for example, positive reinforcement, attending, commands, affect and voice tone; nonviolent discipline methods	Therapist demonstrates for parent how to use social and tangible rewards for positive child behavior
Parent education and support groups	Socially isolated, parents in need of group support, information, and sharing of feelings	Transition to parenthood, following crises or self-referral	Understanding of parental responsibilities and different approaches to child rearing; self-esteem; social skills and competence	Community resource person speaks to group about services for small children
Anger and stress management	Self- and court-referred parents demonstrating anger control problems	Upon recognition or admission of problem	Excessive anger, arousal, impulse control problems, inappropriate coping reactions	Parent is taught to use positive imagery or relaxation while dealing with a difficult child
Treatment of antecedent conditions in the family	Any family member(s) with major psychological or health related problems	Upon recognition or admission of problem	Stress related health problems; marital problems or violence; financial problems related to job skills, and so on	Paraprofessionals or therapists conduct marital counseling, relating to issues that affect parenting
Child Centered Approaches				
Developmental stimulation	Children showing delays in major developmental areas, parents who show inadequate stimulation	Infancy, toddlerhood, and early childhood	Expressive and receptive language, compliance; sensory motor development; attachment	Therapist demonstrates visual, auditory, and tactile activities with child; parent imitates
Consultation with school, day care, or foster care settings	Children who may present problems across different settings and placements	Upon recognition, at start of new placements	Aggression, social isolation, peer problems; academic delays	Professional meets with teacher and others to suggest ways of improving child's behavior

CHAPTER 8

CONCLUSIONS

As can be seen, child abuse still has many gray areas. Society believes that child abuse is wrong. However, society perpetuates a violent image. In order to prevent child abuse, more research must be done. Prevention must be aimed at the individual, familial, community, and societal and cultural levels. Ray E. Helfer looks towards the future the best. He sums up the future of child abuse prevention in a commentary of his from December 1985 entitled "Where to Now, Henry?" Helfer identified eight priorities for the future (Helfer and Kempe 1987):

1. National and international professional societies must make child abuse, neglect, and sexual exploitation a major priority and demonstrate such with both philosophical and financial commitment.
2. Medical specialties, such as psychiatry, family practice, pediatrics, and medical examiners, must require training experiences in child abuse cases for residents and practitioners in their respective disciplines.
3. A thorough review and reassessment of our protective service programs is mandatory, giving high priority to the dismantling of the unidisciplinary system of service and the building of multidisciplinary assessment and long-term follow-up teams.
4. The political walls which surround service programs and prevent the dissemination of good ideas must be eliminated.
5. Research-- truly a re-search-- of scores of unanswered questions must be expanded. These include such issues as: an in-depth study of survivors of apparent abuse; the true

5. relationship between family violence of all types and future antisocial and antifamily behavior; the long-term effect of sexual exploitation during a child's developmental years; the rather simple, but unfunded, study of how normally reared children respond to anatomically correct dolls; and the improvement of research techniques to measure interpersonal skills in order to study the effects of prevention programs.
6. The ineffectiveness of the court system for handling child abuse, neglect, sexual exploitation, custody, adoption, and spouse abuse must be faced. Radical change is mandatory if all the members of these families are to be treated fairly and adequately.
7. Currently no existing bureaucratic agency has the responsibility to develop, fund, and implement prevention programs. This void must be recognized and eliminated at the federal level. Great debate will ensue when the question is asked, "Who should be so mandated?" Compelling reasons exist to argue against giving this charge to any of the existing state or federal agencies. I have a prevailing fantasy that children's trusts will be developed at the state and federal level with the funds being used solely for prevention. These trusts would be administered by boards outside the existing bureaucratic system with an overall federal board setting basic policy and direction.
8. The education of our professions and the public about child abuse and its outcomes has only begun. Were we to spend a fraction of our advertising dollars on these educational efforts, our country would be well informed about the problem and surely solutions would soon follow (page 458).

A listing of the many agencies that are interested in the welfare of children (Tower 1987) is presented on the following pages.

The list of organizations that follows is reprinted from "Child Abuse and Neglect: An Informed Approach to a Shared Concern" (NCCAN Clearinghouse, 1986).

Action for Child Protection
202 E Street, NW
Washington, DC 20002
(202) 393–1090
Contact: Diane DePanfilis

American Academy of Pediatrics
141 Northwest Point Road
P.O. Box 927
Elk Grove Village, IL 60007
(800) 433–9016, ext. 7937
Contact: James Harisiades

American Bar Association
National Legal Resource Center for Child Advocacy and Protection
1800 M Street, NW, Suite 200
Washington, DC 20036
(202) 331–2250
Professional and institutional inquiries only.

American Humane Association
American Association for Protecting Children
9725 East Hampden Avenue
Denver, CO 80231
(303) 695–0811
Contact: Kathryn Bond

American Medical Association
Health and Human Behavior Department
535 North Dearborn
Chicago, IL 60610
(312) 645–4523

American Public Welfare Association
1125 15th Street, NW, Suite 300
Washington, DC 20005
Contact: A. Sidney Johnson III, Executive Director

Association of Junior Leagues
825 Third Avenue
New York, NY 10022
(212) 355–4380
Contact: For legislative information, Sally Orr, Public Policy Unit
Re: local chapter CAN programs, Lisa Farrell

Boys Clubs of America
611 Rockville Pike, Suite 230
Rockville, MD 20852
(301) 251–6676
Contact: Robbie Callaway

C. Henry Kempe Center for Prevention and Treatment of Child Abuse and Neglect
1025 Oneida Street
Denver, CO 80220
(303) 321–3963
Contact: Gail Ryan (for bookstore and publications)

Child Welfare League of America
440 First Street, NW, Suite 310
Washington, DC 20001
(202) 638–2952

Childhelp USA
6463 Independence Avenue
Woodland Hills, CA 91367
Hotline: 1-800-FOR-A-CHILD (367-2-24453)

General Federation of Women's Clubs
1734 N Street, NW
Washington, DC 20036
(202) 347–3168
Contact: Legislative Office

Institute for the Community as Extended Family (ICEF)
P.O. Box 952
San Jose, CA 95108
(408) 280–5055

National Association of Social Workers
7981 Eastern Avenue
Silver Spring, MD 20910
(301) 565–0333
Contact: Leila Whiting

National Black Child Development Institute
1463 Rhode Island Avenue, NW
Washington, DC 20005
(202) 387–1281

TAble 19 (Tower, 1987, p. 198)

National Organizations

National Center for Child Abuse and Neglect (NCCAN)
Children's Bureau
Administration for Children, Youth and Families
Office of Human Development Services
Department of Health and Human Services
P.O. Box 1182
Washington, DC 20013
(301) 251-5157–Clearinghouse

National Center for Missing and Exploited Children
Education, Prevention, and Public Awareness Division
1835 K Street, NW, Suite 700
Washington, DC 20006
(202) 634-9821

National Committee for Prevention of Child Abuse
332 South Michigan Avenue
Chicago, IL 60604

National Council of Jewish Women
Children and Youth Priority, Program Department
15 East 26th Street
New York, NY 10010
(212) 532-1740

National Council of Juvenile and Family Court Judges
P.O. Box 8978
Reno, NV 89507
(702) 784-6012
Contact: James Toner

National Council on Child Abuse and Family Violence
1050 Connecticut Ave., NW
Suite 300
Washington, DC 20036
1-800-222-2000
Contact: Mary-Ellen Rood

National Crime Prevention Council
733 15th Street, NW, Room 540
Washington, DC 20005
(202) 393-7141
Contact: Allie Bird, Director of Public Information

National Education Association
Human and Civil Rights Unit
1201 16th Street, NW
Room 714
Washington, DC 20036
(202) 822-7711
Contact: Mary Faber

National Exchange Club Foundation for Prevention of Child Abuse
3050 Central Avenue
Toledo, OH 43606
(419) 535-3232
Contact: George Mezinko, Director of Foundation Services

National Network of Runaway and Youth Services
905 6th Street, NW, Suite 411
Washington, DC 20024
(202) 488-0739
Contact: Renee Woodworth

Parents Anonymous
7120 Franklin Avenue
Los Angeles, CA 90046
800-421-0353 (toll-free)
(213) 876-9642 (business phone)
Contact: Margot Fritz, Acting Executive Director

Parents United/Daughters and Sons United/Adults Molested as Children United
P.O. Box 952
San Jose, CA 95108
(408) 280-5055

SCAN Associates
P.O. Box 7445
Little Rock, AK 72217
1-800-482-5850, ext. 1310–in Arkansas only
(501) 661-1774–outside State
Contact: Norma Smothers, Training Director

TAble 19 (Tower, 1987, p.199)

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