Child Maltreatment:
Contemporary Issues in Research and Policy 1

Richard D. Krugman
Jill E. Korbin *Editors*

C. Henry Kempe: A 50 Year Legacy to the Field of Child Abuse and Neglect

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Contemporary Issues in Research and Policy

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This series provides a high-quality, cutting edge, and comprehensive source offering the current best knowledge on child maltreatment from multidisciplinary and multicultural perspectives. It consists of a core handbook that is followed by two or three edited volumes of original contributions per year. The core handbook will present a comprehensive view of the field. Each chapter will summarize current knowledge and suggest future directions in a specific area. It will also highlight controversial and contested issues in that area, thus moving the field forward. The handbook will be updated every five years. The edited volumes will focus on critical issues in the field from basic biology and neuroscience to practice and policy. Both the handbook and edited volumes will involve creative thinking about moving the field forward and will not be a recitation of past research. Both will also take multidisciplinary, multicultural and mixed methods approaches.

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Foreword

July 7, 1962 was a typical warm and sunny Denver summer day; the temperature reached 91°F, it was clear, dry, and only slightly windy. There was no outward clue that a massive tectonic plate shift was occurring that would eventually have an impact in all corners of the world and on the lives of billions of children. The epicenter was in Denver; Henry Kempe, Fredric Silverman, Brandt Steele, Henry Silver, and William Droegemueller together published an article in the *Journal of the American Medical Association* that day describing a survey of 71 hospitals and a second survey of 77 district attorneys asking about inflicted trauma in children (Kempe et al. 1962). As described in this volume, they were not the first to describe the problem, the credit for the first medical description is given to a French article published in 1860 (Tardieu 1860). Their article was not even the first US article; Caffey (1946), Woolley and Evans (1955), and others had published about intentional trauma inflicted on children. The problem of child abuse had been attended to in the western hemisphere as early as 1929, a Colombian physician, Jose Martinez, described abuse of children and linked this abuse to subsequent delinquency (Villaveces and DeRoo 2008). But what Kempe with his colleagues did was simple and elegant. As Kempe described it in his 1971 article in the *Archives of Diseases of Children*: "I coined the term 'The Battered Child Syndrome' in 1962 despite its provocative and anger-producing nature. I had for the preceding 10 years talked about child abuse, non-accidental, or inflicted injury but few paid attention" (Kempe 1971).

Abraham Bergman's chapter in this volume describes the blind eye that allowed child abuse to be misdiagnosed in the finest hospitals in the country before 1962. Dr. Kempe's turn of a phrase was a powerful stimulus and a lesson in packaging for all of us. Reporting laws followed in every state and in many countries. Active efforts at assessment and surveillance of the problem followed first by individuals and then by states and countries. Dr. Kempe described an "extended" syndrome and estimated the occurrence at 6 per 1,000 children or 0.6%. Population surveys of parents in the USA put the rate at nearly 10 times the rate of his estimate (Theodore et al. 2005) and the rates in some slum communities in low-income countries appear to be 4–10 times higher than the USA! (Runyan et al. 2010)

Dr. Kempe was more than awareness and numbers. While his call for universal home visiting with lay visitors may have underestimated workloads and need, Daro in this volume describes how his work advocated for a system of home visiting combining universal services and mentoring of parents. His early suggestions led to the nurse-family partnership model and other home visiting efforts. As described in this volume, his work lead to examination of the intergenerational patterns, of parental psychopathology, and of interventions.

Dr. Kempe's European roots showed with his embracing of the home visiting approach but even more in his other efforts to draw European attention to child abuse. Kempe organized a conference in Bellagio that led to the founding of the International Society for the Prevention of Child Abuse and Neglect. The tectonic plate shift that he and his colleagues triggered can be observed in other ways as well. As Jaap Doek indicates in this volume, Kempe's work led to the UN Convention on the Rights of the Child and a mechanism for monitoring it. The UN General Assembly mandated an international study of violence against children that resulted in a dramatic international report in 2006. Evidence was compiled that no country was immune to child abuse and all countries were challenged to develop responses and interventions. Data on child abuse and about child protective services have been added to the data countries must report periodically as signatories to the Convention on the Rights of the Child.

Yet another area of impact has been on science and the evolution of knowledge. Until Dr. Kempe and colleagues wrote their article, there was no MESH heading on child abuse at the National Library of Medicine. Now, there are over 31,500 articles in the medical literature tagged with that MESH heading. A National Center on Child Abuse and Neglect has come and gone, and federal research dollars at the Centers for Disease Control and Prevention and the National Institutes of Health have been expended to support research into the origins, treatment, and prevention of child abuse. A new subspecialty in pediatrics, child abuse pediatrics, was founded in 2009 after pediatricians following in Dr. Kempe's footsteps made the case to the American Board of Pediatrics that the body of knowledge and expertise was wide and deep enough to merit clinical specialists.

Dr. Kempe turned public attention to a hidden problem, child sexual abuse, in 1977 when he published what was to have been a speech at the American Academy of Pediatrics. Dr. Jones, in this volume, describes both the article and its impact on the field. Another testament to the power of a careful and prescient publication, systems, and organizations for the prevention and treatment of child sexual abuse have grown up all over the world, and we now have new understanding and expertise in measurement, treatment, and prevention. More importantly, the number of cases of child sexual abuse is convincingly falling. Not a bad legacy for a speech that was not actually delivered as a speech.

As the reader will note, among the discussions of the science that Dr. Kempe led or initiated in this volume, the development of laws and multidisciplinary teams, and his leadership in pediatrics and at Colorado, there are descriptions of a remarkable man, leader, and father. Annie Kempe describes a careful and engaged father and how he came to be the leader he was. Gail Ryan describes a man who knew the power of food and made sure that a child serially punished for picking apples had apples available to him.

The challenge of this volume, and the challenge of the man, is how to do better. Dr. Kempe was a scientist, a physician, and leader. I think he would be proud of what he started but joins us in being impatient; impatient with government leaders, impatient with funders, and impatient with providers. His vision of founding a center that provides clinical care, mental health care, support, research, and advocacy lives on. We are challenged to do our best to make his family, his department, his university, his center, and his patients proud.

Director, Kempe Center Desmond K. Runyan

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C. Henry Kempe, M.D.

Contents

Author Biographies

Arnon Bentovim is a child and adolescent psychiatrist. He also trained as a psychoanalyst and family therapist. His training in child and adolescent psychiatry commenced in 1962 coinciding with the publication of Kempe's Battered Child Syndrome and Bateson's Double Bind Theory. These two developments have had a key influence on his professional career. After training at the Maudsley Hospital and Institute of Psychiatry, he practiced at Great Ormond Street Hospital, Institute of Child Health, and the Tavistock Clinic. He was responsible for child protection at the hospital and the development of the family therapy service and national training. He founded the Child Sexual Abuse and Child Care consulting service and researched extensively in these fields. After retirement from the NHS, he founded the Child and Family Practice and Training organization with his wife and practice partner Marianne Bentovim and is a visiting professor at Royal Holloway, University of London. He continues to be interested in the development of evidence-based approaches to assessment, analysis, and intervention in the child protection field. His most recent book is "Safeguarding Children Living with Trauma and Family Violence" with Antony Cox, Liza Bingley Miller, and Stephen Pizzey, published by Jessica Kingsley in 2009.

Abraham B. Bergman a Seattle native, graduated from Reed College in 1954 and received his medical degree from Western Reserve University in 1958. He was a pediatric resident at Boston Children's Hospital and St. Mary's Hospital (London) and a fellow in pediatrics at the Upstate Medical Center in Syracuse. He joined the pediatric faculty of the University of Washington in 1964, serving from 1964 to 1983 as director of outpatient services at Seattle Children's Hospital and from 1983 to 2004 as chief of pediatrics at Harborview Medical Center. He has carried out research in health services, sudden infant death syndrome, and injury prevention. Throughout his career, Dr. Bergman has practiced "political medicine," defined as using the political process to improve the public's health. For the past 10 years, he has been involved in efforts to improve health and early learning services for children in foster care and in creating the Seattle Children's PlayGarden, a facility for children with special needs.

Donald C. Bross, Ph.D., J.D., is professor of pediatrics, University of Colorado School of Medicine, and director of education and legal counsel for the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect. Brought by Dr. C. Henry Kempe to the faculty in 1976, Don served as lawyer for the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), founded the National Association of Counsel for Children (NACC), represented children in court, and conducts research on child protection agencies and professionals, pediatric policy, and pediatric law. Don received an NIMH Traineeship in Medical Sociology at the University of Wisconsin that resulted in a Ph.D. (1979), which followed a law degree from the University of Colorado (1975). Awards include CU Law Alumni Award for Distinguished Achievement in Education, Distinguished Service Awards from the NACC and ISPCAN, the Commissioner's Award from the US Department of Human Services for Outstanding Leadership and Service in the Prevention of Child Abuse, and the 2011 American Professional Society on the Abuse of Children Ronald C. Laney Distinguished Service Award.

Deborah Daro, Ph.D., is a senior research fellow at Chapin Hall at the University of Chicago. Prior to joining Chapin Hall, Dr. Daro served as the Director of the National Center on Child Abuse Prevention Research, a program of the National Committee to prevent child abuse. With over 30 years of experience in evaluating child abuse treatment and prevention programs, she has directed some of the largest multisite program evaluations completed in the field. Dr. Daro's current research and written work focuses on developing effective early intervention systems to support all new parents and examining the impacts of reforms that embed individualized, targeted home-based interventions within universal efforts to alter normative standards and enhance community context. Dr. Daro has served as president of the American Professional Society on the Abuse of Children and as treasurer and executive council member of the International Society for the Prevention of Child Abuse and Neglect. Dr. Daro holds a Ph.D. in social welfare and a master's degree in City and Regional Planning from the University of California at Berkeley.

Janet Dean, L.C.S.W., is the director of the Community Infant Program, a preventive-intervention service for infants and their parents in Boulder, Colorado. Janet began her research and clinical work in the areas of child abuse and neglect prevention, parent-infant attachment, and home visitation in 1971 with Dr. C. Henry Kempe and colleagues at the University of Colorado Health Sciences Center.

Janet has since concentrated on developing integrated community prevention models, which have the capacity to provide comprehensive home-based infant mental health services in combination with maternal child health nursing to families during pregnancy and the first 5 years.

Janet has authored articles and chapters and produced educational videotapes on the prevention of child abuse and neglect, sexual abuse, and failure to thrive. She provides consultation and training on program development and reflective supervision and working with vulnerable families to multidisciplinary audiences in the United States and abroad.

Jaap E. Doek is emeritus professor of Law (family and juvenile law) at the Vrije Universiteit in Amsterdam (since July 2004). He was dean of the Law Faculty at the Vrije Universiteit (1988–1992). From 1998 to 2003, he was professor of juvenile law at Leiden University. Currently, he is a deputy justice in the Court of Appeal of Amsterdam. He has been a juvenile court judge in the district court of Alkmaar and the Hague (1978–1985). Professor Doek has been a member of the UN Committee on the Rights of the Child (1999–2007) and the chairperson of that committee (2001–2007).

Professor Doek was a founding member of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), board member (1976–1992), president (1982–1984), and vice president for developing countries (1984–1992). He was also involved in the creation of Defence for Children International (DCI; 1979) and established the Dutch Section of this organization (1984). Professor Doek was a member of an ISPCAN/DCI working group on child labor and the board of the International Association of Juvenile and Family Court Magistrates (1982–1986).

Anne Cohn Donnelly is a senior lecturer in social enterprise at the Kellogg School of Management, Northwestern University, in Evanston, Illinois, teaching nonprofit management and board governance. She established the school's Board Fellows Program, and she works with a number of nonprofits on issues of child abuse and child well-being.

Prior to her position at Kellogg, Dr. Donnelly was the executive director of Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse) where she launched the Healthy Families America Initiative.

Born in Evanston, Illinois, Dr. Donnelly received a B.A. degree in sociology from the University of Michigan, an M.A. in Medical Sociology from Tufts University, and both the M.P.H. and D.P.H. degrees in health administration and planning from the University of California (Berkeley) School of Public Health.

Dr. Donnelly designed and directed the first national evaluation study in the United States of child abuse and neglect treatment programs and has lectured and published widely this and subsequent research and policy issues.

Howard Dubowitz, M.D., M.S., is a professor of pediatrics and director of the Center for Families at the University of Maryland School of Medicine, Baltimore. He is President of the Helfer Society, an honorary international group of physicians working in the field of child maltreatment. Dr. Dubowitz serves on the council of the International Society for the Prevention of Child Abuse and Neglect and on the Board of Prevent Child Abuse America. He is a clinician, researcher, and educator, and he is active in the policy arena. His main interests are in child neglect and prevention. Dr. Dubowitz edited *Neglected Children: Research, Practice, and Policy* and coedited the *Handbook for Child Protection Practice* and *International Aspects of Child Abuse and Neglect.* He has over 150 publications.

Michael Durfee, M.D., child psychiatrist, chief consultant for ICAN National Center for Child Fatality Review, has held clinical appointments with USC and UCLA. He provided medical care to several thousand children, infants to adolescents,

at MacLaren Hall in Los Angeles and implemented multiple programs with data systems for accountability. Dr. Durfee initiated the first child death review team in Los Angeles County in 1978 and supported growth to 1,000+ teams in 12 nations. He published on perinatal substance abuse, preschool molested children, and gonorrhea and HIV from child sexual abuse. He helped initiate an annual conference on traumatic child grief. He designed and coordinates a California Network with 100+ hospitals that will automate their child abuse reports. He consults on a perinatal project to serve high-risk pregnancy including incest, developmental disability, women in jail, girls in foster care, and pregnant victims of partner violence.

Sarah Miller Fellows is a current graduate student in anthropology and public health and graduate assistant at the Schubert Center for Child Studies at Case Western Reserve University. Her research interests include models of care during pregnancy and birth, the impact of biomedical birth services, and traditional birth attendants in coastal Kenya.

James Garbarino holds the Maude C. Clarke Chair in Humanistic Psychology and was founding director of the Center for the Human Rights of Children at Loyola University Chicago. Previously, he was Elizabeth Lee Vincent Professor of Human Development and codirector of the Family Life Development Center at Cornell University. Books he has authored or edited include Children and the Dark Side of Human Experience (2008), See Jane Hit (2006), And Words Can Hurt Forever (2002), Lost Boys: Why Our Sons Turn Violent and How We Can Save Them (1999), The Psychologically Battered Child (1986), Understanding Abusive Families (1980; Second Edition, 1997), and Protecting Children From Abuse and Neglect (1980).

The National Conference on Child Abuse and Neglect honored Dr. Garbarino in 1985 with its first C. Henry Kempe Award, in recognition of his efforts on behalf of abused and neglected children. In 1988, he received the American Humane Association's Vincent De Francis Award for nationally significant contributions to child protection. In 1993, he received the Brandt F. Steele Award from the Kempe National Center on Child Abuse and Neglect, and in 1994, the American Psychological Association's Division on Child, Youth, and Family Services' Nicholas Hobbs Award.

Irene V. Intebi, M.D., child psychiatrist and clinical psychologist from Buenos Aires, Argentina, is the president of the International Society for the Prevention of Child Abuse and Neglect. She was the director of the Child Abuse Prevention, Treatment, and Training Programs of the Department of Women's Affairs of the government of the City of Buenos Aires (1993–2006) and the founder and vice president of the Argentinean Society for the Prevention of Child Abuse and Neglect (ASAPMI). She joined ISPCAN in 1988 and has been on its board since 1998, chaired the Education, Training and Consultation Committee (2000–2008) and cochaired the International Training Project by ISPCAN (2000–2008). She has worked both in Latin America (Argentina, Chile, Brazil, Uruguay, and Colombia) and in Europe (mainly in Spain), training both governmental child protection teams and NGO professionals. She has been a professor at the Basque Country

University (UPV) Postgraduate Course on Child Protection (2001–2007) and the director of the treatment program for children with sexual behavior problems in the municipality of Pasaia (Basque Country). With a strong clinical background and expertise in multimodal treatment approaches for abused children and their families, Irene is an international trainer and lecturer on multidisciplinary, intersectoral, and multicultural aspects of child abuse and neglect. She is the author of books, articles, and a screenplay on child abuse and neglect. She speaks fluent Spanish, English, and Portuguese.

David P.H. Jones is a part-time senior lecturer at University of Oxford since retirement from full-time NHS practice in October 2007. His research includes sexual abuse intervention, the impact of court proceedings on children, interviewing children, false accounts of maltreatment, risk management, and treatment outcome. Dr. Jones has written 140 journal articles, chapters, and the books *Interviewing the Sexually Abused Child: Investigation of Suspected Abuse, Child Sexual Abuse: Informing Practice from Research [with P Ramchandani], Communicating with vulnerable children: a guide for practitioners,* and*, The Developing World of the Child [with J Aldgate and W Rose].* He is associate editor of the journal *Child Abuse and Neglect*. He has contributed to several national initiatives and inquiries, including Working Together, The Framework for Assessment (Department of Health), the Victoria Climbié Inquiry, the Cleveland Inquiry, the Memorandum of Good Practice, and Achieving Best Evidence (Home Office). He was previously clinical director and associate professor at the Kempe National Centre in Denver, Colorado, USA, 1982–1986.

Annie Kempe is the second of the late Drs. Ruth and C. Henry Kempe's five daughters. She graduated from Columbia University in New York in 1974, with a degree in occupational therapy. She retired after 30 years as an occupational therapist and made the transition to freelance writing. In addition to writing pamphlets, booklets, and grants, Annie is the author of two books: *A Good Knight For Children: C. Henry Kempe's Quest to Protect the Abused Child* and *From Slap Shots to Flu Shots: The Gordon Meiklejohn Story* (coauthor). Currently, she lives in Newport Beach, working as a fine art consultant in a local art gallery as well as writing on occasion.

Jill E. Korbin Ph.D., is associate dean, professor of anthropology, director of the Schubert Center for Child Studies, and codirector of the Childhood Studies Program in the College of Arts and Sciences at Case Western Reserve University. Korbin earned her Ph.D. in 1978 from the University of California at Los Angeles. Her awards include the Margaret Mead Award (1986) from the American Anthropological Association and the Society for Applied Anthropology, a Congressional Science Fellowship (1985–1986 in the office of Senator Bill Bradley) through the American Association for the Advancement of Science and the Society for Research in Child Development, the Wittke Award for Excellence in Undergraduate Teaching at Case Western Reserve University (1992), and a Fulbright Senior Specialist Award (2005). Korbin served on the National Research Council's Panel on Research on Child Abuse and Neglect and the Institute of Medicine's Panel on Pathophysiology and

Prevention of Adolescent and Adult Suicide. Korbin served for multiple years on the Executive Committee of the International Society for Prevention of Child Abuse and Neglect (ISPCAN) and as an associate editor, book review editor, or editorial board member for *Child Abuse and Neglect: The International Journal*. Korbin has published numerous articles on child maltreatment in relation to culture and context and edited the first volume on culture and child maltreatment, *Child Abuse and Neglect: Cross-Cultural Perspectives* (1981, University of California Press). Korbin's research interests include culture and human development; cultural, medical, and psychological anthropology; neighborhood, community, and contextual influences on children and families; child maltreatment; and child and adolescent well-being.

Richard D. Krugman, M.D., is professor of pediatrics, vice chancellor for health affairs, and dean of the University of Colorado School of Medicine. He served as director of the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect from 1981 to 1992 and has gained international prominence in the field of child abuse. Dr. Krugman is a graduate of Princeton University and earned his medical degree at New York University School of Medicine. A board-certified pediatrician, he did his internship and residency in pediatrics at the University of Colorado School of Medicine. Following a 2-year appointment in the early 1970s with the Public Health Service at the National Institute of Health and the Food and Drug Administration, Dr. Krugman joined the CU faculty in 1973. He went back to the Washington area in 1980 as a Robert Wood Johnson Health Policy Fellow and served for a year as a legislative assistant in the office of US Senator Dave Durenberger of Minnesota. He has earned many honors in the field of child abuse and neglect and headed the US Advisory Board of Child Abuse and neglect from 1988 to 1991. Dr. Krugman is a member of the Institute of Medicine (IOM) and has authored over 100 original papers, chapters, and editorials and four books and stepped down after 15 years as editor-in-chief of *Child Abuse and Neglect: the International Journal* in 2001.

Scott D. Krugman M.D., M.S., is chairman of the Department of Pediatrics at Franklin Square Hospital Center. Dr. Krugman graduated from Dartmouth Medical School and completed his residency at Johns Hopkins Children's Center. After residency, he became a member of the pediatric faculty at Franklin Square Hospital Center and clinical assistant professor of pediatrics at the University of Maryland School of Medicine. In 2002, he became chairman of pediatrics at Franklin Square, and in 2007, added director of the Community Medicine and Wellness Service Line. Dr. Krugman completed a master's degree in epidemiology in 2005. In 2009, he was promoted to Clinical Professor of Pediatrics and Epidemiology and Preventive Medicine at the University of Maryland. He has received numerous awards including the Academic Pediatric Association Health Care Delivery Award and the Minogue Award for Patient Safety Innovation from the Maryland Patient Safety Center. Dr. Krugman is currently the vice president of the Maryland Chapter of the American Academy of Pediatrics. He founded the Franklin Square Hospital Child Protection Team in 2000 and serves as medical director. He is also a member of the Maryland Child Abuse Medical Providers (CHAMP) faculty, the Baltimore County Child

Fatality Review Team, the Baltimore County Child Protection Review Panel, the State Council on Child Abuse and Neglect, and the board of The Family Tree and is past chair of the Child Maltreatment Committee of the Maryland Chapter of the American Academy of Pediatrics.

Margaret A. Lynch, M.D., FRCP, FRCPCH, is emeritus professor of Community Paediatrics at King's College, London, and, until 2004, a clinical and academic social and developmental pediatrician working within the UK National Health Service. Her research and much of her teaching (over 35 years) focused on child protection and children living in difficult circumstances. Margaret attended the first international meeting convened by Henry Kemp in Bellagio in 1975 and is a founding member and past president of ISPCAN (1986–1988). She was a member of the International Working Group on Child Labour set up in 1992 by ISPCAN and Defence for Children International. She has undertaken consultancy work for WHO, UNICEF, Save the Children, and the Oak Foundation. Margaret remains proactively involved internationally and has participated in child protection activities in over 40 countries. This includes long-term involvement with projects in East Africa, the Balkans, countries of the former Soviet Union, and the Middle East. Currently, Margaret is focusing on child protection training and system building activities in the South Caucasus and the Occupied Palestinian Territory.

Ben Mathews is an associate professor in the School of Law at Queensland University of Technology. Ben's primary area of research focuses on the interface between law and children's health, particularly in the context of child abuse and neglect. He has conducted large, multidisciplinary mixed-method studies of professionals' reporting of suspected child abuse, and this research has produced evidence-based recommendations for reform of law, policy, and practice. Dr. Mathews has published widely in national and international journals, with over 40 scholarly refereed publications. Dr. Mathews leads the Health Law Research Program in the QUT Faculty of Law and is co-program leader in the QUT Children and Youth Research Centre.

Gary B. Melton is professor of pediatrics and director of community engagement in the Kempe Center for Prevention and Treatment of Child Abuse and Neglect at the University of Colorado School of Medicine. At the time that this book was written, he was professor of family and community studies, professor of psychology, and director of the Institute on Family and Neighborhood Life at Clemson University, where he remains an adjunct professor. The author of more than 350 publications, Professor Melton has received distinguished contribution awards for research and public service from the American Psychological Association (three times), two of its divisions, the American Psychological Foundation, the American Professional Society on Abuse of Children, Prevent Child Abuse America, and the American Orthopsychiatric Association (Ortho). Coeditor of the *American Journal of Orthopsychiatry,* he has served on 25 editorial boards, and he has been president of Ortho, the American Psychology-Law Society, the Society for Child and Family Policy and Practice, and Childwatch International. He was the principal architect of the neighborhood-based strategy for child protection that was proposed by the US Advisory Board on Child Abuse and Neglect, of which he was vice chair, in the 1990s.

Joav Merrick, M.D., M.Med.Sci., D.M.Sc., is professor of pediatrics, child health, and human development affiliated with Kentucky Children's Hospital, University of Kentucky, Lexington, United States, and the Division of Pediatrics, Hadassah Hebrew University Medical Centers, Mt Scopus Campus, Jerusalem, Israel; the medical director of the Health Services, Division for Intellectual and Developmental Disabilities, Ministry of Social Affairs and Social Services, Jerusalem; and the founder and director of the National Institute of Child Health and Human Development in Israel. He has numerous publications in the field of pediatrics, child health and human development, rehabilitation, intellectual disability, disability, health, welfare, abuse, advocacy, quality of life, and prevention. He received the Peter Sabroe Child Award for outstanding work on behalf of Danish children in 1985 and the International LEGO Prize ("The Children's Nobel Prize") for an extraordinary contribution toward improvement in child welfare and well-being in 1987. e-mail: jmerrick@zahav.net.il; Home-page: http://jmerrick50.googlepages.com/home

Patricia J. Mrazek, M.S.W., Ph.D., is a mental health policy consultant, speaker, and writer specializing in prevention. She began her work with Dr. C. Henry Kempe after obtaining her master's degree in 1971, and she continued to work with him on numerous projects until the time of his death. She participated in the inaugural formative meeting of ISPCAN in Bellagio, Italy, and she was the first assistant director of the National Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado Health Sciences Center. Her pursuit of her Ph.D. and her work on child sexual abuse were possible because of his support. She went on to become the executive director of the Institute for the Advancement of Social Work Research in Washington, D.C. Later she became a senior program officer at the Institute of Medicine of the National Academy of Sciences where she helped coordinate a seminal project on the prevention of mental disorders. Dr. Mrazek has been a consultant to numerous national and international mental health organizations.

R. Kim Oates is a pediatrician who trained in Sydney, London, and Boston. Most of his professional work has been associated with The Children's Hospital at Westmead and the University of Sydney. He was the first holder of the university's Douglas Burrows Chair of Pediatrics and Child Health (1985–1997) and was simultaneously chairman of the Hospital's Division of Medicine. He was the hospital's chief executive from 1997 to 2006. He was the inaugural chair of the New South Wales Child Death Review Team and founding chair of the Federal Government's National Council on the Prevention of Child Abuse. Kim has received a range of national and international awards for his services to and advocacy for children. He has been a president of the International Society for the Prevention of Child Abuse and Neglect and is currently treasurer of that organization. Kim has published widely on child abuse, particularly its longer-term effects and in general pediatrics. He is currently emeritus professor of pediatrics at the University of Sydney.

David L. Olds is professor of pediatrics, psychiatry, public health, and nursing at the University of Colorado Denver, where he directs the Prevention Research Center for Family and Child Health. He has devoted his career to investigating methods of preventing health and developmental problems in children and parents from low-income families. The primary focus of his work has been on developing and testing in a series of randomized controlled trials a program of prenatal and infancy home visiting by nurses known as the Nurse Family Partnership (NFP). Today, the program is operating in over 390 counties, serving 23,000 families per year in the United States. A member of the American Pediatrics Society, the Society for Prevention Research, and the Academy of Experimental Criminology, Professor Olds has received numerous awards for his work, including the Charles A. Dana Award for Pioneering Achievements in Health, the Brooke Visiting Professorship in Epidemiology from the Royal Society of Medicine, and the 2008 Stockholm Prize in Criminology. Professor Olds obtained his B.A. from Johns Hopkins University and his Ph.D. from Cornell.

Philista Onyango, M.A., Ph.D. (Psychology and Sociology), the current director of ANPPCAN, discovered Kempe's work in 1972 when she was a tutorial fellow at the Department of Psychiatry, Faculty of Medicine, University of Nairobi. She later moved to the Department of Sociology, University of Nairobi, where she taught for many years. In 1981, she had the privilege to attend ISPCAN's Congress in Amsterdam where she made a presentation on child labor. The presentations at this conference left a mark on her, and since then, she has attended many of ISPCAN Conferences and learned a lot. She received the Henry Kempe Award in 1988 in Rio, Brazil. Philista has served on many boards, task forces, and working groups dealing with children issues both domestic and international. This ranges from ISPCAN (1992–2004), Global March Against Child Labour (1998–2005), Childwatch International (1993–1995), WHO Adolescent Health (1986–1990), UNICEF Advisory Group (1991–1996), National Council for Children Services (2006 to date) to numerous professional associations. As an advisor and consultant, Philista has lent her expertise to many groups (Rockfeller, WHO, UNICEF, AU, FINIDA, and ILO, among others). Currently, she is leading a team as a member of the NCCS to assist the government of Kenya to come up with a framework of a National Child Protection System. Philista enjoys research and has undertaken many studies and authored or co-authored numerous book chapters and articles, as well as making presentations in many forums. She has been invited by African students in a number of foreign universities to address and mentor them.

Richard Roylance is pediatrician based in Brisbane, Australia. He holds appointments as an Eminent Staff Specialist Paediatrician (Queensland Health), Associate Professor (School of Medicine, Griffith University), Sessional Member of the Queensland Civil and Administrative Tribunal (QCAT), and Presidential Advisor to the International Society for the Prevention of Child Abuse and Neglect (ISPCAN). Professor Roylance's subspeciality interest is in child protection, which constitutes

a significant proportion of his clinical caseload. He has over 20 years experience working at all levels of the Child Protection System: clinical pediatrics; forensic assessment; SCAN Team, multidisciplinary work; court expert; as well as in the broader issues associated with the development and implementation of legislation and policy. Professor Roylance has served as an executive councillor of the ISPCAN Executive Council for 13 years. He is a long-serving past president of *Protect All Children Today* (PACT) – a nongovernment organization with several decades' experience in the provision of support to child witnesses with the criminal justice system.

Desmond K. Runyan is Jack and Viki Professor of Pediatrics and Executive Director of the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado School of Medicine. Runyan was a professor and past chair of the Department of Social Medicine and professor of pediatrics at the University of North Carolina until 2011. He completed his M.D. degree and pediatrics training at the University of Minnesota and a doctorate in public health and the Robert Wood Johnson Clinical Scholars Program at the University of North Carolina. He is board-certified in pediatrics and in preventive medicine. Runyan has researched child abuse for over 30 years while maintaining a clinical practice evaluating possible child abuse victims and as a general pediatrics attending physician. Runyan's research has addressed the identification and consequences of child abuse and neglect. In 1989, he designed and secured funding for the longest multisite prospective study of the consequences of child abuse; LONGSCAN is now 21 years old. This is a prospective study of 1,354 children in five states who either were reported for maltreatment or who were at high risk of maltreatment. With funding from the Centers for Disease Control, the Doris Duke Charitable Foundation, and the Duke Endowment, Runyan is directing a trial of shaken baby prevention with 600,000 families. In addition to this domestic research, Runyan has worked with International Clinical Epidemiology Network medical school faculty in Egypt, India, the Philippines, Brazil, and Chile to increase child abuse knowledge among medical schools internationally. He has worked with ISPCAN, WHO, and UNICEF to study child abuse epidemiology. In collaboration with 120 other scientists from 40 countries, he helped develop a new set of instruments to measure child abuse and neglect.

Gail Ryan, M.A., has worked at the Kempe Center for Prevention and Treatment of Child Abuse and Neglect in Denver since 1975 and retired from the University of Colorado School of Medicine in 2005. She continues part-time as an assistant clinical professor in the Department of Pediatrics and is now focused on dissemination of her work by teaching, writing, and training of trainers. At the Kempe Center, Ms. Ryan has worked with abusive parents and abused children and provided offense-specific treatment for 11–17-year-old males who were molested children for 20 years, with Jeffrey Metzner, M.D. Ms. Ryan's primary interests have been in the correlation between early life experience and dysfunctional behavior, with an emphasis on prevention of the development of abusive behavior in "at-risk" groups of children and adolescents. She is director of the Kempe Perpetration Prevention

Program, facilitator of the National Adolescent Perpetration Network, facilitated the National Task Force on Juvenile Sexual Offending (1987–1993), and is a clinical specialist for the Kempe Center's national resource center. Publications include many journal articles as well as books: *Childhood Sexuality: A guide for parents (1993), Web of Meaning: A developmental-contextual approach in sexual abuse treatment (1998),* and *Juvenile Sexual Offending: Causes Consequences and Correction (1991, 1997, and 2010)*. She is currently training trainers to use the Kempe curriculum: *Primary, Secondary, and Tertiary Perpetration Prevention in Childhood and Adolescence* to train others in their own communities.

Deanne Tilton-Durfee is executive director of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN). She formerly was a regional child welfare administrator. She is director of the National Center on Child Fatality Review (NCFR). Ms. Tilton-Durfee is past chairperson of the US Advisory Board on Child Abuse and Neglect, past board member of PCA-America, and president of PCA-California. She was a commissioner on the US Attorney General's Commission on Pornography, the California Attorney General's Commission on the Enforcement of Child Abuse Laws, and a member of the Child Victim Witness Judicial Advisory Board. She is currently a commissioner on the Los Angeles County Children and Families First Proposition 10 Commission and was recently appointed to the US Attorney General's National Task Force on Children Exposed to Violence.

Michael S. Wald is the Jackson Eli Reynolds Professor of Law Emeritus at Stanford University, where he has taught courses dealing with legal and public policy regarding children and families since 1967. He has published extensively on issues related to child maltreatment. From 1972 to 1975, Wald served as a reporter for the American Bar Association's Juvenile Justice Standards Project, drafting the Standards Related to Child Abuse and Neglect. He was an original member of the board of the National Committee for the Prevention of Child Abuse, was a member of the US Advisory Board on Child Abuse, chaired the California State Advisory Committee on Child Abuse and Neglect, and was a member of the Carnegie Corporation Task Force on Meeting the Needs of Children 0–3. He has helped draft major legislation at the federal and state levels, including the Adoption Assistance and Child Welfare Act of 1980. Wald also served as executive director of the San Francisco Department of Human Services in 1996–1997. From 1993 to 1995, he was deputy general counsel of the US Department of Health and Human Services, with major responsibility in the areas of welfare reform and child welfare.

Natalie K. Worley M.S.S.W., is a first-year doctoral student in the International Family and Community Studies program at Clemson University in Greenville, SC. She has worked in direct practice and community development capacities with diverse groups of children and adults both domestically and abroad. Ms. Worley's master's thesis explored the prevalence of depressive symptoms among older Kurdish refugees, the results of which were later published in the journal *Social Work*. She also has conducted research on the experience of Hispanic immigrant

women who have received a cancer diagnosis and oncology training for social workers on the unique needs of female cancer survivors. In addition to designing health outreach and education programs for immigrant and refugee women, Ms. Worley served on the board of directors for the Nashville International Center for Empowerment in Nashville, TN. Prior to enrolling in her current doctoral program, Ms. Worley worked for several years in the field of immigration law. She currently serves as assistant to the director of Clemson University's Institute on Family and Neighborhood Life.

Chapter 1
Introduction: Opening the Conversation

Jill E. Korbin and Richard D. Krugman

Fifty years ago, pediatrician C. Henry Kempe and his colleagues began a conversation. While not the first to point to the insults and assaults suffered by children at the hands of those responsible for their care and nurturance, the energy, commitment, and single-mindedness with which C. Henry Kempe pursued the needs of maltreated children powerfully shaped, and continues to influence, the field of child maltreatment.

With this book, and the series it initiates, we hope to engage the next steps in this conversation about maltreated children, their families, and their communities. The chapters in this book point us to where we have been with a clear eye to both the positive directions and the challenges emanating from Dr. Kempe's legacy. Subsequent volumes, most notably *The Handbook of Child Maltreatment* (forthcoming, Springer), will address ways the field can move forward.

The impetus for this volume came at the 18th biannual meeting of ISPCAN in Honolulu in 2010. Many of us have come to take for granted the frequent references to Dr. Kempe and his work, particularly at the meetings of ISPCAN, an organization founded by Dr. Kempe. The editor for our new Springer series, *Child Maltreatment: Contemporary Issues in Research and Policy*, Myriam Poort, however, found it striking how many speakers began their talks with a reference to Henry Kempe, and how their work grew from his. At this conference in Honolulu, talks began by noting that someone had met Henry Kempe at a meeting, or in an airport, and it had left a lasting impression.

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We have oriented this book around four of C. Henry Kempe's publications. These publications were chosen to represent his core contributions to the field: "the battered child;" prevention of child maltreatment; child sexual abuse; and international and cultural perspectives. We then invited those who had known, worked with, or worked contemporaneously with Dr. Kempe to contribute chapter commentaries on the legacies of his work emanating from one of these papers. We could not locate everyone we hoped to find, and some of Dr. Kempe's colleagues are deceased. Each of the four parts has a brief introduction to set the stage for the chapters.

To begin the book, we asked one of Dr. Kempe's five daughters, Annie Kempe, to provide a more personal viewpoint of this very private but also very public person. On behalf of her four sisters, Annie Kempe's contribution, based on her book *A Good Knight for Children: C. Henry Kempe's Quest to Protect the Abused Child* (2007) sets the stage for how the personal and professional coalesced. A second chapter in this first part, by Gail Ryan, also exemplifies Dr. Kempe's both personal and professional commitment to providing a safe environment for abused children and their families.

The first of Dr. Kempe's papers we selected for this volume was the obvious choice. Dr. Kempe and colleagues' "The Battered Child Syndrome" (1962) is the classic paper in the field that coined the term and brought public and professional attention to the issue. It is likely the most widely cited paper in the field. A Google Scholar search (December 29, 2011) yielded 2,455 citations since its publication. Fifty years later, it is common to see this paper used as validation that child abuse exists as a significant problem that must be addressed. The chapters in Part II, and the brief introduction preceding them, consider the legacy of this paper, the strides forward it made possible, and the challenges it posed.

Part III begins with Dr. Kempe's Ambulatory Pediatric Association's George Armstrong Lecture published as "Approaches to Preventing Child Abuse: The Health Visitors Concept" (1976). This paper brought together Dr. Kempe's endless energy and commitment to doing something about a problem with his background in infectious disease that led to his interest in preventing maltreatment in addition to treating cases that occurred. The four responding authors in this part include one of the lead researchers from Dr. Kempe's first early identification and prevention project, and three leaders in the field who continue Dr. Kempe's early momentum to prevent maltreatment.

Part IV's lead paper, "Sexual Abuse, Another Hidden Pediatric Problem: The 1977 C. Anderson Aldrich Lecture" (1978) was a vehicle for Dr. Kempe to insist that attention be paid by the medical world to the then emerging issue of child sexual abuse. Dr. Kempe was not the first to write about child sexual abuse, but as the introduction and three chapters in this part demonstrate, he recognized the devastating impact that sexual abuse could have on children and pursued an agenda that included bringing research, treatment, and policy considerations to this issue.

Finally, Part V begins with Dr. Kempe's brief editorial in Pediatrics, "Cross-Cultural Perspectives in Child Abuse" (1982). Twenty years after the publication of the landmark battered child paper, Dr. Kempe took the opportunity to point out to his medical colleagues the importance of cultural and international perspectives in

understanding and responding to child maltreatment. The five chapters in this part illustrate the worldwide impact of child maltreatment work that can be traced to Dr. Kempe, and in particular, his founding of The International Society for Prevention of Child Abuse and Neglect and its flagship journal, *Child Abuse and Neglect: The International Journal*. As this part indicates, the inclusion of "international" in both the society and journal names was fully intentional to broaden the scope of child maltreatment work to encompass the world's children.

The bookends for this volume are a foreword by the current director of the Kempe Center, Dr. Desmond Runyan, and a bibliography of Dr. Kempe's publications on child maltreatment.

This book, then, reflects on the conversation about child abuse that C. Henry Kempe began in 1962. We hope that this volume affords an opportunity for a focused reopening of this conversation. In the intervening 50 years, there has been a virtual explosion of research on child maltreatment, making a multitude of important advances. Yet, the "field" is at a point of needing to step back and reassess, as many of the chapters in this current volume suggest. Forthcoming books in the series will assess not only where we are, but where we need to go to continue this conversation stemming from the legacy of a truly remarkable advocate for the well-being of children.

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Part I
The Personal and Professional Influence of C. Henry Kempe

Chapter 2
Dr. C. Henry Kempe: A Daughter's Perspective

Annie Kempe

Dr. C. Henry Kempe seemed destined to take "the road less traveled," and his life story reflects that phrase.

Karl Heinz Kempe was born in Breslau, Germany on April 6, 1922, to parents Mary and Richard and older sister, Paula. The Kempes lived simply in a modest rented apartment, typical of German Jews of that period. They had a large extended family, with Heinz's grandmother serving as matriarch and hosting weekly Sabbath dinners.

Heinz became very ill at the age of 5 and was hospitalized for several months with an undiagnosed illness, (presumably tuberculosis). Formerly an active child and soccer player, he never fully recovered from the weakness and decreased endurance resulting from prolonged bed rest. Thereafter, he was less athletic, more quiet, and introspective. He read avidly, played violin (accompanying Paula's piano playing), and often walked to the local park, especially to hear live band concerts in the gazebo. He frequently accompanied his father to cafes to drink cocoa and read comics while Mary and Paula prepared lunch. Richard was a "schmoozer," and Heinz partly learned that skill from observing his father's talent for socializing.

For his Bar Mitzvah, Heinz was given a used bicycle, which allowed him unprecedented freedom to cycle wherever he wished and to see the sights of Breslau. Despite the unsettled political climate in Germany, Heinz attended cultural offerings of his hometown, especially opera, and participated in philosophical discussions with his intellectual friends.

In 1934, when Heinz was 12, he and his family were required to register as Jews and given identification cards at the police station in Breslau. Amidst the ever-increasing menace of the rising Nazi Party and pervasive German anti-Semitism,

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the Kempe children's school was suddenly locked one morning, and they were required to study in informal small groups. Richard's watch repair business was gradually required to close through formal sanctioned boycotting. The family sold most of their belongings, including their beloved piano. On the day that Hitler came to power, Heinz's grandmother became agitated and said, "This is the end of us." Later that day, she passed away in her favorite chair, an ominous sign to the family.

It became inevitable that the Kempe family would have to leave Germany to escape imminent threats and persecution. Paula was sent to England to serve as a maid and governess, Richard and Mary fled to Bolivia, and Heinz finalized plans to accompany his youth group to Israel. During the interim, he stayed with a family friend, Dr. Landsberger. However, Heinz's X-ray during his final physical exam before departing revealed a spot on his lung, and he was summarily rejected as a passenger with his traveling group. Soon after, Nazi officers stopped Heinz and Dr. Landsberger as they walked together on the street. After they both presented their identification papers, the doctor was immediately arrested and taken by train to a concentration camp, where he died a week later. Heinz was saved from arrest because he was 15 years old, and the cutoff age for detention at that time was 16.

With the sponsorship and help of a Quaker group in England, Heinz was sent via Kinder Transport (Children's Train) to London. There he was housed in Oxford before traveling by boat to Boston, then by train to Los Angeles. His new temporary home was an orphanage for Jewish immigrant refugees. The kindly director, Mr. Bonaparte, encouraged Heinz to get an education and a profession. Heinz, who had always been bright but not scholarly, became a serious student. After a stint in junior college, where he improved his English language skills, he was accepted to the University of California at Berkeley. He legally changed his name to Charles Henry Kempe (using "C. Henry Kempe"), but because of his nationality and accent, he was often viewed with suspicion. He distinguished himself in college, graduating in 1942, determined to live up to the Jewish ideal of "Mitzvoth" (giving back).

He was therefore very pleased to matriculate as a medical student at the University of California in San Francisco. The curfew required by his "Enemy Alien" status frustrated him, as he was unable to study in the library after 9:00 p.m. Finally, he sought the assistance of the University's Chancellor, who helped him enlist in the army as a Private First Class assigned to "Medical Training," which freed him to fully participate in his medical school work. Henry graduated in 1945; the same year, he became a US citizen, and was determined to make a contribution to his new country. With his typical intensity, he threw himself into medical research. Henry became interested in virology, serving in the Army as a Chief Virologist at the Presidio in San Francisco and at Walter Reed Army Hospital. He was offered a position as an Assistant in Pediatrics at Yale University in 1948. It was there that he met fellow pediatric resident, Ruth Irene Svibergson.

Ruth was raised on a farm in Norwood, Massachusetts, within a closely knit Swedish Lutheran community. Her parents and siblings had emigrated from the island of Aaland, Sweden, and moved to rural Massachusetts before Ruth's birth in 1921. They owned three cows, and grew much of their own food in their garden and on orchard fruit trees. Ruth's father, Emil, was a carpenter and helped to build several of the neighbors' homes. In contrast to the challenges of Henry's early years,

Ruth's childhood was secure, serene, and included the freedom to wander alone through nearby fields, swim in the local pond, and sled in Boston Commons in winter. Aiming for stardom, she entertained neighbor children with her vocal performances, while one of them held a flashlight's spotlight on her. A bright student, she studied at Girl's Latin School and later attended Radcliffe College, the women's branch of Harvard University. While most professional women of her day chose teaching or nursing as careers, Ruth preferred medicine. Harvard didn't admit women to its medical school in the 1940s; Ruth was accepted at Yale University as one of only three women in her medical school class. She chose to specialize in pediatrics, where she crossed paths with classmate Henry Kempe, a new pediatric resident at Yale, specializing in virology. Within a month of their meeting, they were holding hands on daily medical rounds. Three months after their first date, they married. After residency, they moved to San Francisco, where Henry was hired as an assistant professor of medicine at UCSF. Their first four daughters, Karin, Annie, Miriam, and Allison, were born during those years. The youngest, Jenny, was born later in Colorado, and "The Girls" finally numbered five. The family joke was that Henry wanted at least one son, so "kept trying."

The Girls were very fortunate in our choice of parents. Their close relationship showed us the importance of romantic partnership as they exemplified the cliché of "soul mates." Ruth and Henry were determined that we experience cultural events and performances when very young and included us en masse in outings to opera, theater, and museums. As a special treat, Dad would tell Dr. Kempe Stories, original impromptu tales that included having his daughters actively participate. He would describe an adventure and we would act it out, as he often singled out a heroine for the night.

Mom was a very loving, concerned mother who always listened and offered quiet, sage advice. She often softened Da's strictness as the self-described, "Benevolent Dictator." They were both very affectionate and demonstrative. The European custom of kissing on both cheeks was the norm chez Kempe. As Ruth and Henry would say, "That way you are balanced!" After a hard day at the hospital, Dad often pretended to whine, "Please help Your-Poor-Broken-Down-Old-Father!"

Henry's work in virology included an interest in smallpox; there were smallpox epidemics in several places around the world at that time, most notably in India. As a 30-year-old, Henry ventured to India to research and treat smallpox among the populations in Madras, Delhi, and more rural regions.

Henry was offered and accepted the position of Chairman of the Department of Pediatrics at the University of Colorado in 1956, and the family relocated to Denver. He continued his work in virology, especially in smallpox research and treatment, with extended trips to India. Over the years, he would be instrumental in researching and helping to eradicate smallpox. Henry also initiated and promoted national polio vaccine programs.

He loved teaching medical students and residents, although his often stern, intense demeanor laced with quiet humor yielded a contradictory sense of intimidation and affectionate loyalty from his students. He was an astute clinician and especially enjoyed Grand Rounds, wherein he was presented with a set of symptoms from a mystery illness and challenged to determine the diagnosis. His success rate was

high, but one busy week, he simply wandered into the medical school library, established which diagnosis-related books had been checked out recently, and impishly attended Grand Rounds with afore-knowledge. Henry often referred to this funny story about his impressive investigative talents, which he relished even over his medical acumen.

Perhaps in part due to his own prolonged childhood illness, Henry had a profound sensitivity to the needs of sick children, and often handed out so much candy on rounds that one patient in India said, "Here comes the candy doctor!" He once reportedly gave a very sick child a stuffed animal, although the patient was not his.

The Kempes enjoyed a sabbatical year abroad in 1962, where Henry worked at the Pasteur Institute in Paris, continuing his research in smallpox. The family lived in a small town, Limeil-Brevannes, in a large house with extensive gardens and orchards. It was there we encountered an unmistakable case of child abuse. The groundskeeper, who lived with his family on the grounds, drank heavily, and was violent and ill-tempered. His young son Danny was underfed, always hungry, unwashed, and often covered with bruises and welts. As his playmates, The Girls were protective of him. We felt relief and admiration when Dad confronted the larger, stronger man, telling him in no uncertain terms that the violence against Danny must stop. At least for the time we remained, it did.

In his position at the University of Colorado, Dr. Kempe had the added responsibility of overseeing four pediatric sites: University of Colorado Hospital, The Children's Hospital, Denver General Hospital, and National Jewish Hospital. In that capacity, he was provided a global perspective about emergency room admissions, specifically the diagnoses of children being seen. Henry began to notice a disturbing trend in the types of injuries and related diagnoses of the young patients. Parents and caretakers of the children treated in emergency rooms frequently explained apparently "nonaccidental injuries" in ways that were incongruous to the types of injuries with which children presented.

Henry recalled, "I got into the problem of the battered child for no reason of altruism but rather, at first, out of rage at the intellectual blocks I encountered when I went on ward service in 1957–58. I saw child after child, both at Denver General Hospital and at Colorado General Hospital, who came in to the emergency room only to receive diagnoses that were patently absurd. They included:

- Spontaneous subdural hematoma
- Osteogenesis imperfecta tarda
- Spontaneous multiple bruising due to unexplained bleeding disorders
- Failure to thrive of unknown etiology

You could fairly say I hate illogical diagnoses and that I felt strongly that these cases represented denial on the parts of interns, residents, attending physicians, and specialists about an obviously traumatic or neglectful situation. This was not good for our intellectual honesty, nor did it do any good for the abused child, his siblings, and his suffering parents, most of whom we could help. The medical staffs were trying to make sense of what didn't make sense; the assumption was that parents were telling you what really happened."

While some medical professionals recognized and acknowledged the issue of violence against children, Henry and colleagues felt it was time to make a dramatic statement, especially within the medical community, to begin to confront the pervasive, often hidden issue of child maltreatment. Henry Kempe, Brandt Steele, Fred Silverman, William Droegemueller, and Henry Silver cowrote the landmark paper entitled, "The Battered Child Syndrome," a document whose title was tailored to make the most impact. Henry chose "A jazzy title, designed to get physicians' attention."

As one of the planners of the American Academy of Pediatrics meeting in 1961, Henry was in a position to feature "The Battered Child" paper on the program, with a view toward reaching a wide, specific, and captive audience of pediatricians. Henry felt that it was urgent and essential, as pediatricians are often a child's first, and sometimes last, line of defense in emergency rooms and private offices. With some trepidation, Dr. Kempe gave what was to become a landmark speech. The physicians in the audience reacted to his direct and blunt appraisal of the prevalence of child maltreatment with the mixed responses of gratitude, incredulity, and outright hostility. After his presentation, one of the pediatricians told Henry that he had never seen a single case of child abuse. Henry replied, "Yes you have. You just didn't know what you've been seeing."

It is perhaps difficult to appreciate nowadays that confronting child abuse resulted in potential danger to clinicians. In the early days of his efforts, Dad warned our family to let him know if we saw anyone suspicious around our home, as an angry father had threatened to kill him for identifying his injured child as an abused child. Dad felt it necessary to obtain a restraining order.

In 1960, due to the efforts of Henry Kempe and others, the Colorado Reporting Law passed, protecting from prosecution those who reported suspected cases of child abuse. Henry continued to push through legislative bills related to child protection, both locally and nationally, as well as testifying in court to protect children in crisis. He recognized that preventing and treating child abuse could not be limited to the domain of medicine, but must also incorporate legislative, judicial, societal, cultural, and philosophical realms, the implementation of which reflected a huge step outside his comfort zone.

On one occasion, Henry told a judge in court, "If you send this child home to the same dangerous situation, the next time we see him in the emergency room, he may well be dead." When the child died a few months later of a fractured skull and brain damage, Henry said, "These are the times that I hate being right."

Meanwhile, Ruth had enhanced her medical education by specializing in the field of child psychiatry. She was indispensable in Henry's work, a coworker instrumental in every aspect of his efforts. Ruth provided him and others with a valuable perspective about child development, as well as expertise concerning the emotional and psychological issues abused children face. As coauthors of books and articles on child abuse, Henry always acknowledged the importance of Ruth's input, countering her self-effacing way of minimizing her own contribution. Henry Kempe once referred to his own contributions as "Tilting at Windmills," like Don Quixote. It reflects his own tenacity and idealism in his work.

Along with Henry Kempe, several professionals interested in the field participated as members of the Child Protection Team, which reviewed child abuse cases and made plans for children in the system. As he recalled, "We started in 1957, with just myself, one social worker, and the head nurse on the ward. We met weekly to review all of the X-rays of children under 4 years of age taken in the emergency rooms, outpatient departments, and wards. That turned out to be another effective, though late, diagnostic tool; eventually, the radiology staff were on the look-out for this serious syndrome."

In 1972, the National Center for the Prevention and Treatment of Child Abuse and Neglect opened its doors in a residential house on 12th and Oneida in Denver, Colorado. There, children and families received treatment, therapies, and attended the therapeutic preschool. Its dedicated staff provided (and still does), a safe, welcoming, and homey atmosphere, enhanced by daily freshly baked cookies.

Henry and his colleagues acknowledged that the problem of child maltreatment was not localized to Colorado or to the United States; it was a worldwide issue. To that end, they created ISPCAN, the International Society for the Prevention of Child Abuse and Neglect in Geneva, Switzerland in 1976. ISPCAN gathered together professionals from several countries working in child maltreatment fields to discuss issues, problems, and research findings, to share the common goal of preventing and treating child abuse. ISPCAN established an international journal wherein specialists working worldwide in child abuse contribute their research to the global knowledge base, providing information and support for professionals working with abused children. Furthermore, members of ISPCAN have held international meetings every 2 years since the inception of the organization, and continue to promote international education and research in the field.

Twice nominated for the Nobel Peace Prize, Henry appreciated Representative Pat Schroeder's words: "Peace has been defined as a state of mutual harmony between people or groups, especially in personal relationships. In this regard, Dr. Kempe, one of the outstanding physicians of the 1900s, is most deserving of the 1984 Nobel Peace Prize for his noteworthy and numerous contributions to the children of the world." He was most pleased that the nomination would heighten awareness of the issue of child abuse, albeit briefly.

Dr. C. Henry Kempe died in Hawaii in 1984, and Dr. Ruth Kempe passed away in Denver in 2009. When asked about his legacy, Henry Kempe had said, "You might have a building named after you and yet it could be torn down one day. But having children and grandchildren, and perhaps changing the way people think – that's immortality."

It may be apropos to end with a favorite Dad sign-off:
Love from Your-ever-loving-understanding-type-candy-feeding-father.

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Chapter 3
Henry

Gail Ryan

People often say that Henry Kempe was a man of vision. He was also a man of insight. He had the capacity to see inside others' qualities and capacities untapped and to motivate with little more than a word. The relationship of history to the priorities and pursuits of people is often lost when the minutia is overshadowed by their greatness. And the role of common sense is also often overlooked.

When I wrote the paper: "Extreme Food Behaviors in Abusive Families" in 1978, I was an ancillary staff person working with Henry Kempe (Ryan 1978). My curiosity about what seemed to me to be quite different about the food behaviors of the families living at our center led Henry to encourage me to write about it. In doing a literature search, I found little reference to the extremes of hoarding, gorging, withholding, and manipulation I had observed. There was not much of an "eating disorder" literature until the 1980s and the thing I found that was most relevant was a little book from the 1940s about behaviors observed among war refugees (Selling and Ferraro 1945). It was many years later when it occurred to me that Henry's appreciation of the role of food might have begun in his own experiences fleeing the Nazis as a teenager and finding himself in a foster home in California.

My earliest memories of Henry Kempe were perceived as a lay person baking cookies and making meals for families and staff at the Kempe Center. I had been hired to supervise the food for clients in several programs at the center, including "Circle House," where families lived with their children. Henry's instructions were clear and concise: (1) Make the center feel like home and (2) Don't be perfect! His deep belief was that troubled children and families would do much better if their first perception of the center was of a safe and nurturing place. The welcoming smell of cookies baking accomplished this nicely, so the first stories that come to

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mind when I think of Henry are the "food stories" of the Kempe Center. The first was Henry's own observation.

> As a pediatrician caring for young children before there was widespread awareness of child abuse and neglect, he said, one of the things he noticed was this: Most of his little patients who came into his office would notice the candy jar that was on the shelf, and they would ask right away if they could have one. He would answer, "Yes, you may, as soon as we finish." And so, when they were ready to leave, he would take the jar down and they would take one and be on their way.
>
> The abused children, though, would notice the jar right away, but didn't ask. So he felt things might be a bit better when they would ask, but then, when he took the jar down, they would take a big handful…and perhaps try to stuff it in their pocket so they could hold some more. So he figured things must be getting better as the handfuls got smaller,…and he said that he was sure things were much better when they offered him one!

Over the years, we observed a parallel process in many of the parents and children we treated, who were initially reticent to ask (for food or for help), then seeming to scoop it all up and try to take more than they needed, but gradually becoming able to ask for what they needed and show concern for others' needs as well.

It was this "trickle down" theory, which guided our earliest work, nurturing parents so they would be better able to nurture their children. So the fresh cookies I baked every morning for the next 16 years became tangible currency in this nurturance. Over the years, Henry continued to enjoy sharing lunch with the children in our preschool, sitting on the tiny wood chairs with them, and telling them that he was the real cookie monster.

Of course, chocolate chip cookies were always a favorite, and I learned that for some, adding nuts made them special, while nuts spoiled them for others, and still others really preferred to nibble the dough uncooked…but the ease of accommodating the unique needs of each individual became both apparent and gratifying. I later came to appreciate that it is the validation of each individual's uniqueness that most genuinely informs our relationships. Just remembering which person liked ketchup could begin the bond that healed.

Of course, the smell of fresh baked cookies is great, but would be hard to resist with it wafting through the building every morning at work. One morning in 1976, Pat Beezley (now Mrazek), who was the center's co-director with Henry at that time, came to me to ask if it would be too much work for me to make enough cookies for the staff to have one too, and I had to smile as I said that it wouldn't be any problem at all, since she and Henry's wife, Ruth, were the only two in the building who didn't already eat them!

So the next food story was about the staff: Henry said he found that the cookie jar was a good barometer of how things were going. Knowing that it was full each morning, he said if he came in late in the day and it was still half full, either there weren't many people working, or they weren't working very hard. If he came in at noon and it was already empty, then he figured people were really stressed out. But if there were just a few left at the end of the day, he figured things were going good.

That same old glass cookie jar is still full everyday, and although the cookies aren't homemade any more, it is still a good barometer of stress and productivity… and abused and neglected children still find candy in a jar nearby.

Henry Kempe said that you couldn't expect people to keep on nurturing others if they never got a refill of nurturance for themselves. Henry's appreciation of the role of food in nurturance, and of the powerful effects of the deprivation of consistent nurturance, was quite practical and matter of fact. Yet I think his own concern about responding to peoples' basic needs resonated with his appreciation of Brandt Steele's observation that the abusive and neglectful parents seemed to be repeating their own lack of nurturance…that they had not had anyone pay attention to and respond to their own most basic needs for care and nurturance, and then seemed unable to provide it for their own babies. (Steele and Pollock 1968; Steele 1980a, b)

What Brandt referred to as "empathic care," researchers have subsequently defined as "sensitive parenting;" providing care in response to the cues of the infant (Landry and Peters 1992). Such care validates the internal cues of the infant and provides meaning, developing confidence in interpersonal communication and a foundation for basic trust. It is also the experience of empathic recognition and responses which models emotional awareness and expression, the ability to accurately interpret and express one's needs.

When Dick Krugman came to the Kempe Center, someone mentioned "spoiling" a baby. Dick said "Meat spoils. Babies don't spoil!" And indeed, we find that the more "care" babies receive, the more responsive and caring they become! Research shows that infants who receive "sensitive" care begin to respond to the cues of others around 18 months of age: Toddlers who see someone crying and go to comfort them, because they recognize the cues of sadness and know how to respond (Landry and Peters 1992). So we continue to be in awe of the power of a nurturing relationship, and through the years, we have continued to nurture and be nurtured.

When we first began treating the boys who had molested other children, we knew that many had been abused themselves, but we did not expect that nurturance would have much to do with either the causes or correction of their abusive behavior (Ryan et al. 1987; Ryan and Lane 1991). Yet we found parallels in both etiology and needs, and also saw the power of nurturance in the corrective habilitation, of both victims and abusers (Ryan 1989; Ryan and Lane 1997).

One boy, many years ago, was telling the other boys in a group about being beaten in one of the homes he had lived in as a young child. When his peers asked what he would get a beatin' for, he first made a joke, but then stated "They beat me for things you shouldn't beat a child for…" He paused for a minute before continuing: "… like eating the apples off the tree in the yard!" Without comment, we began bringing a basket of apples for snack in the group. At first, this boy would eat several apples during the group, and take a couple with him after. Over time, we saw that he would eat one and take only one with him. And ultimately, he became able to offer them to others. The parallel to Dr. Kempe's "candy jar" was striking (Ryan 1998a).

Food is an imperative for survival, and in the hierarchy of needs, it is second only to physical safety. Yet it is not just the "nutrition" of food which keeps us well; which nurtures life and growth in us. We depend on food, not just to meet our physical needs, but also for the nurturance which connects us to others, for the social and emotional attachments that characterize human interactions. We know that infants can be well fed, yet still wither and die, if the nutrition is not

accompanied by care and interaction (Spitz 1945). The social nature of humans requires that we communicate and respond to each other.

In the 1970s, when no one knew much about child abuse, hiring criteria were not based on academic credentials or job experience. Henry looked for people who had had a good experience of being parented, and had good experiences parenting. Intending to "reparent" the parents in treatment, the search for "grandmotherly" types was a given. However, we discovered that nurturance is not about age, or the gray in one's hair, or the size of one's lap. It is the product of understanding and being responsive to the unique needs of individual human beings. It is the validation of one's needs that allows for attachment to the caregiver (Bowlby 1977; Steele 1980a, b; Ainsworth 1985; Bowlby 1985; Main et al. 1985; Steele 1987). Differentiation of the needs of each individual parent and child was not unlike the role of parents with multiple children, who recognize and validate the specialness of each.

Henry's insight was apparent in the diversity of his multidisciplinary team: that he appreciated both expertise and simple common sense. His foresight drove the evolution of many Kempe Center programs over time: He would see a problem, put words to it, define it, and dispatch his colleagues with simply: "see what you can do," then on to the next problem. And in all the work, the medical model of "see one, do one, teach one" demanded a clinical base to inform all we did, while the urgency to prevent and protect children drove rapid dissemination. When criticized for advocating "interventions without scientific proof" of their effectiveness, Henry used to say: "If I wait for random controlled trials to prove what experience and common sense have taught me, there will be another generation of dead babies. No child dies as a result of a protection investigation." As a doctor well trained in public health, Henry did not discount science but did act in good faith when the indicated intervention would "do no harm."

Current models for treatment continue to require the same "individualized, differential diagnosis and treatment planning." Research now informs evidence-based interventions which have proven effective in treating some of the common denominators associated with the victimization and perpetration of child abuse, but can only succeed when applied to the individual needs of the patient. Similarly, we still find the need to foster growth and development for those who "missed" childhood stages of development, so creating the safety in a therapeutic relationship that allows for regression, relaxation, and play can be critical elements in the process of change (Helfer 1984; Ryan 1995; Ryan and Blum 1994; Ryan et al. 2002).

And research now informs our understanding of the etiology and correction of abusive behaviors, identifying not only the risks but also the protective factors that differentiate those who abuse from those who do not (Ryan 1995, 1998a, 1999, 2005). Yet the balance of risks and assets continues to defy explanation in that the resilience of human beings is so uniquely driven by individual differences, and we find that it is the perceptual experiences of people that are much more relevant to outcomes than the facts of their history (Hindman 1989; Ryan 1998b).

Henry and Brandt's appreciation of the role of attachment in parent–child relationships preceded much of the work on attachment (Steele and Pollock 1968). Yet along with other international pioneers in child protection, their attention to

the child's earliest interactions with their caregivers informed their evaluation of the nature of child abuse and neglect. In discovering the ability to foresee the risk of serious physical abuse within the first hours and days of an infant's interaction with the caregiver, the protective properties of secure attachment became evident (Grey et al. 1979). In time, the understanding that abuse is, at its core, a disorder of attachment emerged. And again, one might hypothesize that the role of secure attachment may have been a protective factor for Henry when he was separated from his family during the war, yet emerged from the trauma, and losses, and uncertainties to become who he was.

The Kempe Center has been a professional family to many…for better and worse! Like most families, there have been good times and tough times and a few times when all felt discouraged, neglected, and undernourished. So when we come together for business, pleasure, education, or philanthropy, we first offer food and drink. And it is not the "joy of cooking," but the "joy of feeding" that is most gratifying. At meetings, conferences, and around coffee pots, we gather and share food, thoughts, and camaraderie. We show our caring for each other, as well as our concern for the needs of others to be nurtured as we are. And we honor the memory of Dr. Kempe, along with the work and workers which continue to adapt the recipe of compassion and concern and action which Henry envisioned.

As abhorrent as abusive behavior is, it is neither "natural" nor "deviant." It is the predictable outcome of babies not being well cared for, and children not being protected, and the deprivation of nurturance and humanity which define "child abuse and neglect." We are all changed by the knowledge of child abuse and neglect, but the change need not be negative. The way we are changed by our vicarious exposure to the horrors of abuse may be to make us more grateful for our own nurturing relationships, or to be more nurturing in our own lives. It may be to make us stronger in our resolve to do better, and even hopeful, because we do know how to help parents do better, and we have research that defines what children need to be successful.

We now know that child protection today can reduce the risk of children growing up to be abusive: Working to be sure babies are well cared for, working to help children be protected, working to help children be successful. And we can be encouraged and hopeful that as we are each changed by the knowledge of abuse, the future of abuse is also being changed. As Henry is often quoted saying, change occurs "one child at a time."

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Part II
The Battered Child

Chapter 4
Introduction and Commentary: The Battered Child

Richard D. Krugman

Jules Amer, MD, is a recently retired pediatrician living in Denver, Colorado who remembers when C. Henry Kempe came to Denver to be Chairman of the Department of Pediatrics at the University of Colorado School of Medicine in 1958. He was the general pediatrician who referred children with unexplained injuries to the Pediatric Service at Colorado General Hospital, and he was at the American Academy of Pediatrics Annual Meeting held at the Palmer House in Chicago in November, 1961 when Henry chaired an all morning plenary symposium entitled "The Battered Child Syndrome." Jules remembers the hush in the hall at the conclusion of the session and the silence as the pediatricians filed out. I had a similar experience 20 years later when I gave a talk on physical and sexual abuse of children to a group of physicians in Aberdeen, Scotland. There was silence when I finished, and no questions. Such is the response when confronted with information that one either does not believe or does not want to hear.

Henry had invited a reporter from the Chicago Tribune to his Symposium in Chicago. The next day the silence of the pediatricians in the hall was overcome by the explosion of national public discussion of the findings of this work. By the time the paper was published in *the Journal of the American Medical Association* 7 months later, the professional gaze aversion was lifting and the public and professional interest in the issue began to grow. While not the first paper in the literature to describe the abuse of children, The Battered Child Syndrome clearly ignited a long simmering and dormant interest in the issue and led to what is now five decades of experience in trying to deal with it.

This part reprints what *JAMA* has republished as one of its "Landmark Papers" in its first 50 years of publishing. It is interesting to reread it now to get a glimpse of what was clearly "just the tip of the iceberg" Henry and his colleagues were describing (e.g., the estimate that there were 749 cases in the USA). Since the initial

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approach to identifying and treating cases of abuse was housed in the child welfare system, and since there had to be a legal framework for what many thought was "intrusion" into the privacy of family life, we asked Don Bross and Ben Matthews, two of our distinguished legal scholar colleagues, to review the changes in the law and advocacy that have occurred as a result of the paper.

"The Battered Child," which is at its core a description of physical abuse, led to a broader definition of child maltreatment to include all forms of abuse and also child neglect. Howard Dubowitz, MD, traces the evolution of that field in his chapter on child neglect, a problem that is now recognized to be greater in incidence than physical abuse. And just as neglect has surpassed physical abuse in scope of cases reported to authorities, emotional maltreatment is probably even more prevalent. Jim Garbarino, PhD, reviews this area which also grew out of the 1962 paper.

The next chapter in this part is contributed by Abraham Bergman, MD, a pediatrician from the state of Washington who has been a longtime advocate for children and an acerbic observer of the child protection system in his state and the rest of the USA. It is the first of several somewhat critical assessments in this part of what we call the child protection system in the USA – which, broadly defined, includes the child protective services agencies in child welfare (or human development services departments as they are now known), law enforcement, juvenile courts, the mental health system, and the rest of the health care and community agencies that have been charged with responding to reports of child maltreatment in the USA.

When the Battered Child Symposium was presented in Chicago, Henry and his colleagues in Denver already had 5 years of experience reviewing cases of suspected abuse and neglect at Colorado General Hospital in Denver and were convinced that the recognition, intervention (and later the prevention) of physical abuse *required* a multidisciplinary approach. Scott Krugman, MD, reviews the various iterations of multidisciplinary teams, and Michael Durfee, MD, and Deane Tilton Durfee focus on the evolution of specialized approaches to address the most serious outcome for battered children – fatal abuse.

The last two chapters in this part – one by Michael Wald and another by Natalie Worley and Gary Melton – take a thoughtful look at what has been not so successful in our national responses to the problem that was identified by Kempe and his colleagues in 1962. They suggest strongly that there is still a lot left for us to do if we are to attain the goal of protecting abused and neglected children from harm and, in doing so, treating their families.

Chapter 5
The Battered-Child Syndrome

C. Henry Kempe, Frederic N. Silverman, Brandt F. Steele, William Droegemueller, and Henry K. Silver

The battered-child syndrome, a clinical condition in young children who have received serious physical abuse, is a frequent cause of permanent injury or death. The syndrome should be considered in any child exhibiting evidence of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma. Psychiatric factors are probably of prime importance in the pathogenesis of the disorder, but knowledge of these factors is limited. Physicians have a duty and responsibility to the child to require a full evaluation of the problem and to guarantee that no expected repetition of trauma will be permitted to occur.

THE BATTERED-CHILD SYNDROME is a term used by us to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent. The condition has also been described as "unrecognized trauma" by radiologists, orthopedists, pediatricians, and social service workers. It is a significant cause of childhood disability and death. Unfortunately, it is frequently not recognized or, if diagnosed, is inadequately handled by the physician because of hesitation to bring the case to the attention of the proper authorities.

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Incidence

In an attempt to collect data on the incidence of this problem, we undertook a nation-wide survey of hospitals which were asked to indicate the incidence of this syndrome in a one-year period. Among 71 hospitals replying, 302 such cases were reported to have occurred; 33 of the children died; and 85 suffered permanent brain injury. In one-third of the cases proper medical diagnosis was followed by some type of legal action. We also surveyed 77 District Attorneys who reported that they had knowledge of 447 cases in a similar one-year period. Of these, 45 died, and 29 suffered permanent brain damage; court action was initiated in 46% of this group. This condition has been a particularly common problem in our hospitals; on a single day, in November, 1961, the Pediatric Service of the Colorado General Hospital was caring for 4 infants suffering from the parent-inflicted battered-child syndrome. Two of the 4 died of their central nervous system trauma; 1 subsequently died suddenly in an unexplained manner 4 weeks after discharge from the hospital while under the care of its parents, while the fourth is still enjoying good health.

Clinical Manifestations

The clinical manifestations of the battered-child syndrome vary widely from those cases in which the trauma is very mild and is often unsuspected and unrecognized, to those who exhibit the most florid evidence of injury to the soft tissues and skeleton. In the former group, the patients' signs and symptoms may be considered to have resulted from failure to thrive from some other cause or to have been produced by a metabolic disorder, an infectious process, or some other disturbance. In these patients specific findings of trauma such as bruises or characteristic roentgenographic changes as described below may be misinterpreted and their significance not recognized.

The battered-child syndrome may occur at any age, but, in general, the affected children are younger than 3 years. In some instances the clinical manifestations are limited to those resulting from a single episode of trauma, but more often the child's general health is below par, and he shows evidence of neglect including poor skin hygiene, multiple soft tissue injuries, and malnutrition. One often obtains a history of previous episodes suggestive of parental neglect or trauma. A marked discrepancy between clinical findings and historical data as supplied by the parents is a major diagnostic feature of the battered-child syndrome. The fact that no new lesions, either of the soft tissue or of the bone, occur while the child is in the hospital or in a protected environment lends added weight to the diagnosis and tends to exclude many diseases of the skeletal or hemopoietic systems in which lesions may occur spontaneously or after minor trauma. Subdural hematoma, with or without fracture of the skull, is, in our experience, an extremely frequent finding even in the absence of fractures of the long bones. In an occasional case the parent or parent-substitute may also have assaulted the child by administering an overdose of a drug or by exposing the child to natural gas or other toxic substances. The characteristic

distribution of these multiple fractures and the observation that the lesions are in different stages of healing are of additional value in making the diagnosis.

In most instances, the diagnostic bone lesions are observed incidental to examination for purposes other than evaluation for possible abuse. Occasionally, examination following known injury discloses signs of other, unsuspected, skeletal involvement. When parental assault is under consideration, radiologic examination of the entire skeleton may provide objective confirmation. Following diagnosis, radiologic examination can document the healing of lesions and reveal the appearance of new lesions if additional trauma has been inflicted.

The radiologic manifestations of trauma to growing skeletal structures are the same whether or not there is a history of injury. Yet there is reluctance on the part of many physicians to accept the radiologic signs as indications of repetitive trauma and possible abuse. This reluctance stems from the emotional unwillingness of the physician to consider abuse as the cause of the child's difficulty and also because of unfamiliarity with certain aspects of fracture healing so that he is unsure of the significance of the lesions that are present. To the informed physician, the bones tell a story the child is too young or too frightened to tell.

Psychiatric Aspects

Psychiatric knowledge pertaining to the problem of the battered child is meager, and the literature on the subject is almost nonexistent. The type and degree of physical attack varies greatly. At one extreme, there is direct murder of children. This is usually done by a parent or other close relative, and, in these individuals, a frank psychosis is usually readily apparent. At the other extreme are those cases where no overt harm has occurred, and one parent, more often the mother, comes to the psychiatrist for help, filled with anxiety and guilt related to fantasies of hurting the child. Occasionally the disorder has gone beyond the point of fantasy and has resulted in severe slapping or spanking. In such cases the adult is usually responsive to treatment; it is not known whether or not the disturbance in these adults would progress to the point where they would inflict significant trauma on the child.

Between these 2 extremes are a large number of battered children with mild to severe injury which may clear completely or result in permanent damage or even death after repeated attack. Descriptions of such children have been published by numerous investigators including radiologists, orthopedists, and social workers. The latter have reported on their studies of investigations of families in which children have been beaten and of their work in effecting satisfactory placement for the protection of the child. In some of these published reports the parents, or at least the parent who inflicted the abuse, have been found to be of low intelligence. Often, they are described as psychopathic or sociopathic characters. Alcoholism, sexual promiscuity, unstable marriages, and minor criminal activities are reportedly common amongst them. They are immature, impulsive, self-centered, hypersensitive, and quick to react with poorly controlled aggression. Data in some cases indicate

that such attacking parents had themselves been subject to some degree of attack from their parents in their own childhood.

Beating of children, however, is not confined to people with a psychopathic personality or of borderline socioeconomic status. It also occurs among people with good education and stable financial and social background. However, from the scant data that are available, it would appear that in these cases, too, there is a defect in character structure which allows aggressive impulses to be expressed too freely. There is also some suggestion that the attacking parent was subjected to similar abuse in childhood. It would appear that one of the most important factors to be found in families where parental assault occurs is "to do unto others as you have been done by." This is not surprising; it has long been recognized by psychologists and social anthropologists that patterns of child rearing, both good and bad, are passed from one generation to the next in relatively unchanged form. Psychologically, one could describe this phenomenon as an identification with the aggressive parent, this identification occurring despite strong wishes of the person to be different. Not infrequently the beaten infant is a product of an unwanted pregnancy, a pregnancy which began before marriage, too soon after marriage, or at some other time felt to be extremely inconvenient. Sometimes several children in one family have been beaten; at other times one child is singled out for attack while others are treated quite lovingly. We have also seen instances in which the sex of the child who is severely attacked is related to very specific factors in the context of the abusive parent's neurosis.

It is often difficult to obtain the information that a child has been attacked by its parent. To be sure, some of the extremely sociopathic characters will say, "Yeah, Johnny would not stop crying so I hit him. So what? He cried harder so I hit him harder." Sometimes one spouse will indicate that the other was the attacking person, but more often there is complete denial of any knowledge of injury to the child and the maintenance of an attitude of complete innocence on the part of both parents. Such attitudes are maintained despite the fact that evidence of physical attack is obvious and that the trauma could not have happened in any other way. Denial by the parents of any involvement in the abusive episode may, at times, be a conscious, protective device, but in other instances it may be a denial based upon psychological repression. Thus, one mother who seemed to have been the one who injured her baby had complete amnesia for the episodes in which her aggression burst forth so strikingly.

In addition to the reluctance of the parents to give information regarding the attacks on their children, there is another factor which is of great importance and extreme interest as it relates to the difficulty in delving into the problem of parental neglect and abuse. This is the fact that physicians have great difficulty both in believing that parents could have attacked their children and in undertaking the essential questioning of parents on this subject. Many physicians find it hard to believe that such an attack could have occurred and they attempt to obliterate such suspicions from their minds, even in the face of obvious circumstantial evidence. The reason for this is not clearly understood. One possibility is that the arousal of the physician's antipathy in response to such situations is so great that it is easier for the physician to deny the possibility of such attack than to have to deal with the exces-

sive anger which surges up in him when he realizes the truth of the situation. Furthermore, the physician's training and personality usually makes it quite difficult for him to assume the role of policeman or district attorney and start questioning patients as if he were investigating a crime. The humanitarian-minded physician finds it most difficult to proceed when he is met with protestations of innocence from the aggressive parent, especially when the battered child was brought to him voluntarily.

Although the technique wherein the physician obtains the necessary information in cases of child beating is not adequately solved, certain routes of questioning have been particularly fruitful in some cases. One spouse may be asked about the other spouse in relation to unusual or curious behavior or for direct description of dealings with the baby. Clues to the parents' character and pattern of response may be obtained by asking questions about sources of worry and tension. Revealing answers may be brought out by questions concerning the baby such as, "Does he cry a lot? Is he stubborn? Does he obey well? Does he eat well? Do you have problems in controlling him?" A few general questions concerning the parents' own ideas of how they themselves were brought up may bring forth illuminating answers; interviews with grandparents or other relatives may elicit additional suggestive data. In some cases, psychological tests may disclose strong aggressive tendencies, impulsive behavior, and lack of adequate mechanisms of controlling impulsive behavior. In other cases only prolonged contact in a psychotherapeutic milieu will lead to a complete understanding of the background and circumstances surrounding the parental attack. Observation by nurses or other ancillary personnel of the behavior of the parents in relation to the hospitalized infant is often extremely valuable.

The following 2 condensed case histories depict some of the problems encountered in dealing with the battered-child syndrome.

Report of Cases

Case 1

The patient was brought to the hospital at the age of 3 months because of enlargement of the head, convulsions, and spells of unconsciousness. Examination revealed bilateral subdural hematomas, which were later operated upon with great improvement in physical status. There had been a hospital admission at the age of one month because of a fracture of the right femur, sustained "when the baby turned over in the crib and caught its leg in the slats." There was no history of any head trauma except "when the baby was in the other hospital a child threw a little toy at her and hit her in the head." The father had never been alone with the baby, and the symptoms of difficulty appeared to have begun when the mother had been caring for the baby. Both parents showed concern and requested the best possible care for their infant.

The father, a graduate engineer, related instances of impulsive behavior, but these did not appear to be particularly abnormal, and he showed appropriate emotional concern over the baby's appearance and impending operation. The mother, aged 21, a high school graduate, was very warm, friendly, and gave all the appearance of having endeavored to be a good mother. However, it was noted by both nurses and physicians that she did not react as appropriately or seem as upset about the baby's appearance as did her husband. From interviews with the father and later with the mother, it became apparent that she had occasionally shown very impulsive, angry behavior, sometimes acting rather strangely and doing bizarre things which she could not explain nor remember. This was their first child and had resulted from an unwanted pregnancy which had occurred almost immediately after marriage and before the parents were ready for it. Early in pregnancy the mother had made statements about giving the baby away, but by the time of delivery she was apparently delighted with the baby and seemed to be quite fond of it. After many interviews, it became apparent that the mother had identified herself with her own mother who had also been unhappy with her first pregnancy and had frequently beaten her children. Despite very strong conscious wishes to be a kind, good mother, the mother of our patient was evidently repeating the behavior of her own mother toward herself. Although an admission of guilt was not obtained, it seemed likely that the mother was the one responsible for attacking the child; only after several months of treatment did the amnesia for the aggressive outbursts begin to lift. She responded well to treatment, but for a prolonged period after the infant left the hospital the mother was not allowed alone with her.

Case 2

This patient was admitted to the hospital at the age of 13 months with signs of central nervous system damage and was found to have a fractured skull. The parents were questioned closely, but no history of trauma could be elicited. After one week in the hospital no further treatment was deemed necessary, so the infant was discharged home in the care of her mother, only to return a few hours later with hemiparesis, a defect in vision, and a new depressed skull fracture on the other side of the head. There was no satisfactory explanation for the new skull fracture, but the mother denied having been involved in causing the injury, even though the history revealed that the child had changed markedly during the hour when the mother had been alone with her. The parents of this child were a young, middle-class couple who, in less than 2 years of marriage, had been separated, divorced, and remarried. Both felt that the infant had been unwanted and had come too soon in the marriage. The mother gave a history of having had a "nervous breakdown" during her teens. She had received psychiatric assistance because she had been markedly upset early in the pregnancy. Following an uneventful delivery, she had been depressed and had received further psychiatric aid and 4 electroshock treatments. The mother tended to gloss over the unhappiness during the pregnancy and stated that she was

quite delighted when the baby was born. It is interesting to note that the baby's first symptoms of difficulty began the first day after its first birthday, suggesting an "anniversary reaction." On psychological and neurological examination, this mother showed definite signs of organic brain damage probably of lifelong duration and possibly related to her own prematurity. Apparently her significant intellectual defects had been camouflaged by an attitude of coy, naïve, cooperative sweetness which distracted attention from her deficits. It was noteworthy that she had managed to complete a year of college work despite a borderline I.Q. It appeared that the impairment in mental functioning was probably the prime factor associated with poor control of aggressive impulses. It is known that some individuals may react with aggressive attack or psychosis when faced with demands beyond their intellectual capacity. This mother was not allowed to have unsupervised care of her child.

Up to the present time, therapeutic experience with the parents of battered children is minimal. Counseling carried on in social agencies has been far from successful or rewarding. We know of no reports of successful psychotherapy in such cases. In general, psychiatrists feel that treatment of the so-called psychopath or sociopath is rarely successful. Further psychological investigation of the character structure of attacking parents is sorely needed. Hopefully, better understanding of the mechanisms involved in the control and release of aggressive impulses will aid in the earlier diagnosis, prevention of attack, and treatment of parents, as well as give us better ability to predict the likelihood of further attack in the future. At present, there is no safe remedy in the situation except the separation of battered children from their insufficiently protective parents.

Techniques of Evaluation

A physician needs to have a high initial level of suspicion of the diagnosis of the battered-child syndrome in instances of subdural hematoma, multiple unexplained fractures at different stages of healing, failure to thrive, when soft tissue swellings or skin bruising are present, or in any other situation where the degree and type of injury is at variance with the history given regarding its occurrence or in any child who dies suddenly. Where the problem of parental abuse comes up for consideration, the physician should tell the parents that it is his opinion that the injury should not occur if the child were adequately protected, and he should indicate that he would welcome the parents giving him the full story so that he might be able to give greater assistance to them to prevent similar occurrences from taking place in the future. The idea that they can now help the child by giving a very complete history of circumstances surrounding the injury sometimes helps the parents feel that they are atoning for the wrong that they have done. But in many instances, regardless of the approach used in attempting to elicit a full story of the abusive incident(s), the parents will continue to deny that they were guilty of any wrongdoing. In talking with the parents, the physician may sometimes obtain added information by showing that he understands their problem and that he wishes to be of aid to them as well

as to the child. He may help them reveal the circumstances of the injuries by pointing out reasons that they may use to explain their action. If it is suggested that "new parents sometimes lose their tempers and are a little too forceful in their actions," the parents may grasp such a statement as the excuse for their actions. Interrogation should not be angry or hostile but should be sympathetic and quiet with the physician indicating his assurance that the diagnosis is well established on the basis of objective findings and that all parties, including the parents, have an obligation to avoid a repetition of the circumstances leading to the trauma. The doctor should recognize that bringing the child for medical attention in itself does not necessarily indicate that the parents were innocent of wrongdoing and are showing proper concern; trauma may have been inflicted during times of uncontrollable temporary rage. Regardless of the physician's personal reluctance to become involved, complete investigation is necessary for the child's protection so that a decision can be made as to the necessity of placing the child away from the parents until matters are fully clarified.

Often, the guilty parent is the one who gives the impression of being the more normal. In 2 recent instances young physicians have assumed that the mother was at fault because she was unkempt and depressed while the father, in each case a military man with good grooming and polite manners, turned out to be the psychopathic member of the family. In these instances it became apparent that the mother had good reason to be depressed.

Radiologic Features

Radiologic examination plays 2 main roles in the problem of child-abuse. Initially, it is a tool for case finding, and, subsequently, it is useful as a guide in management.

The diagnostic signs result from a combination of circumstances: age of the patient, nature of the injury, the time that has elapsed before the examination is carried out, and whether the traumatic episode was repeated or occurred only once.

Age

As a general rule, the children are under 3 years of age; most, in fact are infants. In this age group the relative amount of radiolucent cartilage is great; therefore, anatomical disruptions of cartilage without gross deformity are radiologically invisible or difficult to demonstrate (Fig. la). Since the periosteum of infants is less securely attached to the underlying bone than in older children and adults, it is more easily and extensively stripped from the shaft by hemorrhage than in older patients. In infancy massive subperiosteal hematomas may follow injury and elevate the active periosteum so that new bone formation can take place around and remote from the parent shaft (Figs. lc and 2).

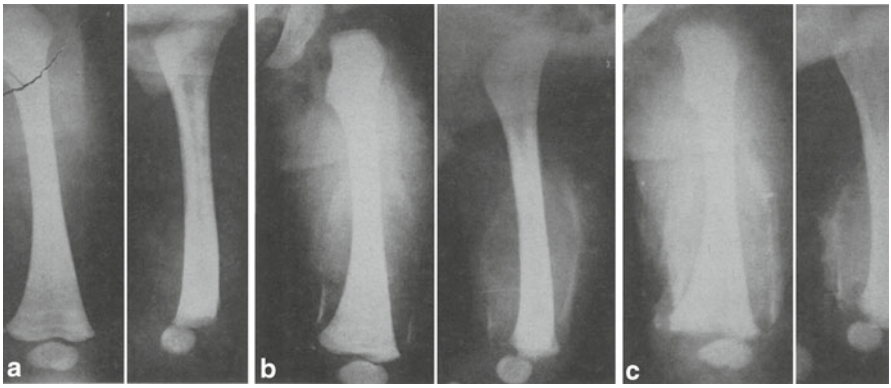

Fig. 1 —Male, 5 months: *a,* Initial films taken 3 to 4 days after onset of knee swelling. Epiphyseal separation shown in lateral projection with small metaphyseal chip shown in frontal projection; *b,* Five days later, there was beginning reparative change; c, Twelve days later (16 days after onset), there was extensive reparative change, history of injury unknown, but parents were attempting to teach child to walk at 5 months.

Nature of Injury

The ease and frequency with which a child is seized by his arms or legs make injuries to the appendicular skeleton the most common in this syndrome. Even when bony injuries are present elsewhere, e.g., skull, spine, or ribs, signs of injuries to the extremities are usually present. The extremities are the "handles" for rough handling, whether the arm is pulled to bring a reluctant child to his feet or to speed his ascent upstairs or whether the legs are held while swinging the tiny body in a punitive way or in an attempt to enforce corrective measures. The forces applied by an adult hand in grasping and seizing usually involve traction and torsion; these are the forces most likely to produce epiphyseal separations and periosteal shearing (Figs. 1 and 3). Shaft fractures result from direct blows or from bending and compression forces.

Time After Injury That the X-Ray Examination Is Made

This is important in evaluating known or suspected cases of child-abuse. Unless gross fractures, dislocations, or epiphyseal separations were produced, no signs of bone injury are found during the first week after a specific injury. Reparative changes may first become manifest about 12 to 14 days after the injury and can increase over the subsequent weeks depending on the extent of initial injury and the degree of repetition (Fig. 4). Reparative changes are more active in the growing bones of children than in adults and are reflected radiologically in the excessive new bone reaction. Histologically, the reaction has been confused with neoplastic change by those unfamiliar with the vigorous reactions of young growing tissue.

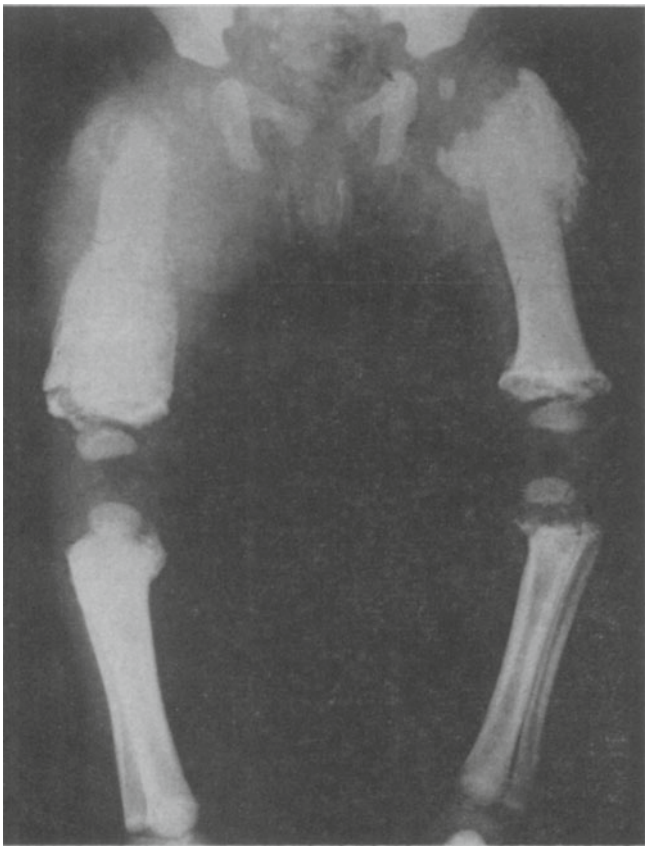

Fig. 2 —Female, 7 1/2 months with a history of recurring abuse, including being shaken while held by legs 4-6 weeks prior to film. Note recent (2-3 weeks) metaphyseal fragmentation, older (4-6 weeks) periosteal reaction, and remote (2-4 months) external cortical thickening. Note also normal osseous structure of uninjured pelvic bones. (By permission of *Amer J Roentgenol*.)

Repetition of Injury

This is probably the most important factor in producing diagnostic radiologic signs of the syndrome. The findings may depend on diminished immobilization of an injured bone leading to recurring macro- and microtrauma in the area of injury and healing, with accompanying excessive local reaction and hemorrhage, and ultimately, exaggerated repair. Secondly, repetitive injury may produce bone lesions in one area at one time, and in another area at another, producing lesions in several areas and in different stages of healing (Fig. 3).

Thus, the classical radiologic features of the battered-child syndrome are usually found in the appendicular skeleton in very young children. There may be

Fig. 3 —Male, 5 months, pulled by legs from collapsing bathinette 6 weeks earlier. Epiphyseal separation, right hip, shown by position of capital ossification center. Healing subperiosteal hematoma adjacent to it. Healing metaphyseal lesions in left knee, healing periosteal reactions (mild) in left tibia. No signs of systemic disease. (By permission of *Amer J Roentgenol*.)

irregularities of mineralization in the metaphyses of some of the major tubular bones with slight malalignment of the adjacent epiphyseal ossification center. An overt fracture may be present in another bone. Elsewhere, there may be abundant and active but well-calcified subperiosteal reaction with widening from the shaft toward one end of the bone. One or more bones may demonstrate distinctly thickened cortices, residuals of previously healed periosteal reactions. In addition, the radiographic features of a subdural hematoma with or without obvious skull fracture may be present.

Differential Diagnosis

The radiologic features are so distinct that other diseases generally are considered only because of the reluctance to accept the implications of the bony lesions.

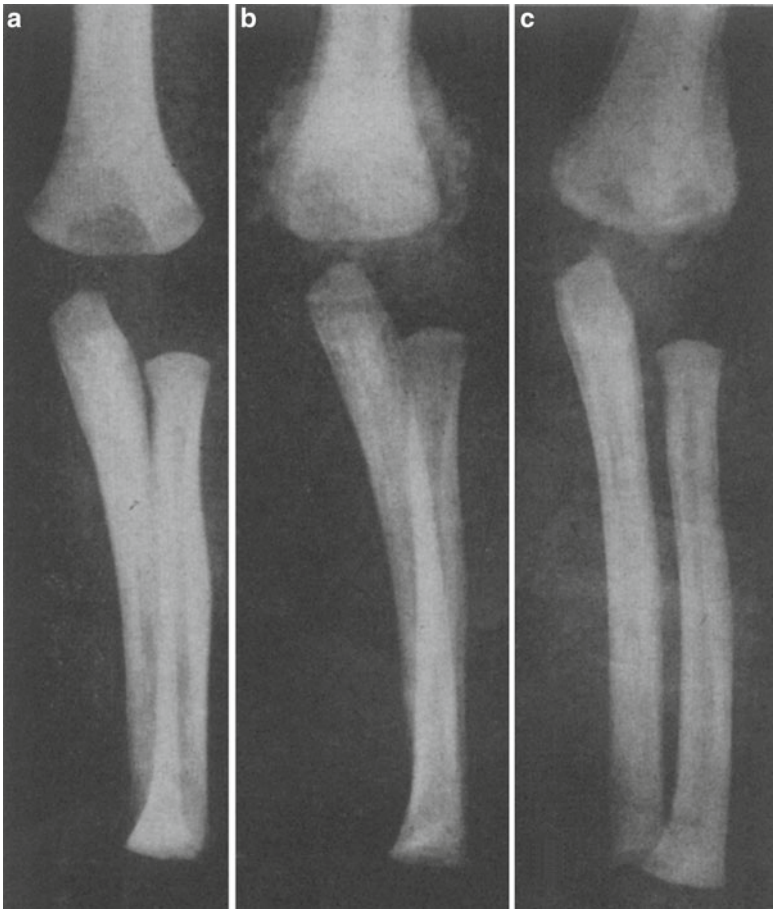

Fig. 4 —Female 7 1/2 months: *a,* Elbow injured 30 hours before, except for thickened cortex from previous healed reactions, no radiologic signs of injury; *b,* Fifteen days after injury, irregular productive reaction, clinically normal joint; c, Three weeks after *b,* organization and healing progressing nicely. (By permission of *Amer J Roentgenol*.)

Unless certain aspects of bone healing are considered, the pertinent findings may be missed. In many cases roentgenographs examination is only undertaken soon after known injury; if a fracture is found, reexamination is done after reduction and immobilization; and, if satisfactory positioning has been obtained, the next examination is usually not carried out for a period of 6 weeks when the cast is removed. Any interval films that may have been taken prior to this time probably would have been unsatisfactory since the fine details of the bony lesions would have been obscured by the cast. If fragmentation and bone production are seen, they are considered to be evidence of repair rather than manifestations of multiple or repetitive trauma. If obvious fracture or the knowledge of injury is absent, the bony changes may be considered to be the result of scurvy, syphilis, infantile cortical

hyperostoses, or other conditions. The distribution of lesions in the abused child is unrelated to rates of growth; moreover, an extensive lesion may be present at the slow-growing end of a bone which otherwise is normally mineralized and shows no evidence of metabolic disorder at its rapidly growing end.

Scurvy is commonly suggested as an alternative diagnosis, since it also produces large calcifying subperiosteal hemorrhages due to trauma and local exaggerations most marked in areas of rapid growth. However, scurvy is a systemic disease in which all of the bones show the generalized osteoporosis associated with the disease. The dietary histories of most children with recognized trauma have not been grossly abnormal, and whenever the vitamin C content of the blood has been determined, it has been normal.

In the first months of life *syphilis* can result in metaphyseal and periosteal lesions similar to those under discussion. However, the bone lesions of syphilis tend to be symmetrical and are usually accompanied by other stigmata of the disease. Serological tests should be obtained in questionable cases.

Osteogenesis imperfecta also has bony changes which may be confused with those due to trauma, but it too is a generalized disease, and evidence of the disorder should be present in the bones which are not involved in the disruptive-productive reaction. Even when skull fractures are present, the mosaic ossification pattern of the cranial vault, characteristic of osteogenesis imperfecta, is not seen in the battered-child syndrome. Fractures in osteogenesis imperfecta are commonly of the shafts; they usually occur in the metaphyseal regions in the battered-child syndrome. Blue sclerae, skeletal deformities, and a family history of similar abnormalities were absent in reported instances of children with unrecognized trauma.

Productive diaphyseal lesions may occur in *infantile cortical hyperostosis*, but the metaphyseal lesions of unrecognized trauma easily serve to differentiate the 2 conditions. The characteristic mandibular involvement of infantile cortical hyperostosis does not occur following trauma although obvious mandibular fracture may be produced.

Evidence that repetitive unrecognized trauma is the cause of the bony changes found in the battered-child syndrome is, in part, derived from the finding that similar roentgenographic findings are present in *paraplegic patients with sensory deficit* and in patients with *congenital indifference to pain;* in both of whom similar pathogenic mechanisms operate. In paraplegic children unappreciated injuries have resulted in radiologic pictures with irregular metaphyseal rarefactions, exaggerated subperiosteal new bone formation, and ultimate healing with residual external cortical thickening comparable to those in the battered-child syndrome. In paraplegic adults, excessive callus may form as a consequence of the lack of immobilization, and the lesion may be erroneously diagnosed as osteogenic sarcoma. In children with congenital indifference (or insensitivity) to pain, identical radiologic manifestations may be found.

To summarize, the radiologic manifestations of trauma are specific, and the metaphyseal lesions in particular occur in no other disease of which we are aware. The findings permit a radiologic diagnosis even when the clinical history seems to refute the possibility of trauma. Under such circumstances, the history must be reviewed, and the child's environment, carefully investigated.

Management

The principal concern of the physician should be to make the correct diagnosis so that he can institute proper therapy and make certain that a similar event will not occur again. He should report possible willful trauma to the police department or any special children's protective service that operates in his community. The report that he makes should be restricted to the objective findings which can be verified and, where possible, should be supported by photographs and roentgenograms. For hospitalized patients, the hospital director and the social service department should be notified. In many states the hospital is also required to report any case of possible unexplained injury to the proper authorities. The physician should acquaint himself with the facilities available in private and public agencies that provide protective services for children. These include children's humane societies, divisions of welfare departments, and societies for the prevention of cruelty to children. These, as well as the police department, maintain a close association with the juvenile court. Any of these agencies may be of assistance in bringing the case before the court which alone has the legal power to sustain a dependency petition for temporary or permanent separation of the child from the parents' custody. In addition to the legal investigation, it is usually helpful to have an evaluation of the psychological and social factors in the case; this should be started while the child is still in the hospital. If necessary, a court order should be obtained so that such investigation may be performed.

In many instances the prompt return of the child to the home is contraindicated because of the threat that additional trauma offers to the child's health and life. Temporary placement with relatives or in a well-supervised foster home is often indicated in order to prevent further tragic injury or death to a child who is returned too soon to the original dangerous environment. All too often, despite the apparent cooperativeness of the parents and their apparent desire to have the child with them, the child returns to his home only to be assaulted again and suffer permanent brain damage or death. Therefore, the bias should be in favor of the child's safety; everything should be done to prevent repeated trauma, and the physician should not be satisfied to return the child to an environment where even a moderate risk of repetition exists.

Summary

The battered-child syndrome, a clinical condition in young children who have received serious physical abuse, is a frequent cause of permanent injury or death. Although the findings are quite variable, the syndrome should be considered in any child exhibiting evidence of possible trauma or neglect (fracture of any bone, subdural hematoma, multiple soft tissue injuries, poor skin hygiene, or malnutrition) or where there is a marked discrepancy between the clinical findings and the historical data as supplied by the parents. In cases where a history of specific injury is not available, or in any child who dies suddenly, roentgenograms of the entire skeleton

should still be obtained in order to ascertain the presence of characteristic multiple bony lesions in various stages of healing.

Psychiatric factors are probably of prime importance in the pathogenesis of the disorder, but our knowledge of these factors is limited. Parents who inflict abuse on their children do not necessarily have psychopathic or sociopathic personalities or come from borderline socioeconomic groups, although most published cases have been in these categories. In most cases some defect in character structure is probably present; often parents may be repeating the type of child care practiced on them in their childhood.

Physicians, because of their own feelings and their difficulty in playing a role that they find hard to assume, may have great reluctance in believing that parents were guilty of abuse. They may also find it difficult to initiate proper investigation so as to assure adequate management of the case. Above all, the physician's duty and responsibility to the child requires a full evaluation of the problem and a guarantee that the expected repetition of trauma will not be permitted to occur.

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Chapter 6
The Battered-Child Syndrome: Changes in the Law and Child Advocacy

Donald C. Bross and Ben Mathews

Introduction

Dr. C. Henry Kempe was the driving force behind a definitive social change in recognizing the phenomenon of severe physical abuse of children. Yet, it is salutary to remember that he also had to be remarkably persistent to overcome a fundamental cultural resistance to the reality of child abuse and the need to do something about it (Silver 1980). Dr. Kempe's achievements in this regard were threefold. First, Kempe established irrefutably the medical evidence of severe child abuse, identifying the "Battered-Child Syndrome" as "a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent," with an emphasis on severe injury such as fractures and subdural hematoma, and acknowledging that "in general, the affected children are younger than 3 years" (Kempe et al. 1962, p. 17). Second, Dr. Kempe drew attention to the medical profession's obliviousness and resistance to the condition. He observed that there was a major problem even in the subset of cases that presented clinically because "Unfortunately, it is frequently not recognized or, if diagnosed, is inadequately handled by the physician because of hesitation to bring the case to the attention of the proper authorities" (Kempe et al. 1962, p. 17). Dr. Kempe's third achievement was his landmark success in creating a broad awareness in American culture of severe physical abuse of children and in characterizing it as a form of violence that could not be tolerated. This was achieved in several ways that would make it harder to ignore child abuse in the

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future, including by catalyzing the introduction of legal reporting requirements as part of a therapeutic intervention system. Hence, Dr. Kempe was integral in identifying severe physical violence against children, characterizing it as an unacceptable form of abuse that required recognition and response, and in setting a new cultural and legal standard in how society treats children.

Eventually, Dr. Kempe's work would resonate widely and be replicated internationally. By revisiting the events that led to the first mandatory reporting laws, it might be possible to discern which policies are essential for maintaining an awareness of and an adequate response to severe child maltreatment. Certain themes and questions arise, which are partially addressed here. Recognition and reporting of child abuse involves more than one discovery about us as human beings. For example, why does a parent injure or kill his or her own child? Is this something new in human behavior, perhaps a result of new conditions for human life created by rapid change and today's complex world? If child abuse is not new, then why did it take so long for most of us to recognize and respond to child abuse and neglect? Do we not care about the children of others, does the depth and persistence of the problem perhaps make us feel not competent to act, or are there other explanations? If these questions are not answered and necessary actions taken, is it not likely that child maltreatment will remain or become an orphaned issue in the future?

Recognition, the *Sine Qua Non* (The Essential Condition)

An essential step in the modern recognition of severe child physical abuse was to develop a body of evidence that no reasonable person could ignore. Dr. Kempe was at the heart of the research and advocacy that generated this evidence, and which led to the recognition of the "Battered-Child Syndrome." Due to years spent at the Kempe Center, the first author of this chapter heard numerous stories constituting an "oral tradition" from Kempe's colleagues – including Drs. Henry Silver, Ruth Kempe, Brandt Steele, Ray Helfer, Don Cook, and many others – about not only the work done in recognizing the syndrome, but also the cultural obstacles to a broader acceptance of its existence. Some events confirming this oral tradition can be gleaned from the original "Battered-Child Syndrome" paper, and there is an abundance of literature for anyone interested in these developments. A prime example is that Kempe's colleague Dr. Henry Silver knew personally how difficult it was to convince other physicians that child abuse was a real and large problem. Moreover, in 1959, 3 years before the publication of the "Battered-Child Syndrome" paper, he and Kempe had written a letter about the topic for the *American Journal of Diseases of Children*, which was essentially ignored (Silver and Kempe 1959).[1]

The body of evidence developed about child abuse occurred through a process of team building, an important hint of what is necessary for long-term, successful child

[1] Dr Kempe's wife, Ruth Kempe, reported that he even received a death threat, and was criticized by other pediatricians for dramatizing the issue (Chadwick 2011; Silver and Kempe 1959).

advocacy. Dr. Kempe had arrived in Denver at age 34 in 1956 to be Chairman of the Department of Pediatrics, University of Colorado School of Medicine, already having an international reputation for work preventing and treating smallpox. He would need his considerable reputation as a physician and all of his credentials as a scientist and medical innovator to address child maltreatment. While the Department at the time was small, with colleague Dr. Henry Silver (Silver et al. 2009),[2] Dr. Kempe formed a partnership that developed into a team doing clinical work and research. Many who worked with Dr. Kempe in the late 1950s spoke about his earliest attention to child abuse beginning in 1958 (Schmitt 1978).[3] A first attempt to draw attention to child abuse is found in the letter by Kempe and Silver to the American Journal of Diseases of Children in 1959, a letter having little impact. A separate effort to expand interest and understanding involved Dr. Kempe's "recruitment" of colleague Dr. Brandt Steele, an adult psychiatrist whose work focused on trying to understand why parents would abuse their children. Dr. Steele reported that the first time the joint research on the diagnosis and prevalence of severe child physical abuse was submitted for presentation to the 1960 meeting of the American Academy of Pediatrics (AAP), the paper was rejected as being unscientific. This story echoes Dr. Silver's reports about the difficulty of convincing many different groups of the reality of child abuse. According to Steele, Dr. Kempe's solution was to gain appointment as Chairman of the AAP Scientific Committee for the next meeting in 1961. In due course, this occurred and "The Battered-Child Syndrome" was first presented at a national scientific meeting in 1961, and followed by publication in the Journal of the American Medical Association on July 7, 1962. Recognition of the Battered-Child Syndrome, at least among physicians, had crystallized. Over time, the validity of the diagnosis would be accepted by other societal institutions; for example, in 1991, the U.S. Supreme Court recognized the diagnosis as a scientifically recognized condition.[4]

Why the Initial Recognition Endured: Cultural and Legal Change

This scientific naming of a condition and the research that established its validity provides one essential reason why the diagnosis of severe child physical abuse has not "gone away." However, Dr. Kempe's publication was not the first about the

[2] Dr. Henry Silver's son describes the friendship and environment of colleagues in which the "Battered-Child" was described (Silver et al. 2009).

[3] Dr. Kempe wrote that the first hospital-based child protection teams "came into being 25 years ago through the efforts of Betty Elmer, M.S.W. of the Pittsburgh Children's Hospital; Helen Boardman, M.S.W., Children's Hospital in Los Angeles; and C. Henry Kempe, M.D., of the Department of Pediatrics at the University of Colorado Medical Center in Denver" (Kempe 1978, p. xiii).

[4] From the legal perspective, "the Battered-Child Syndrome" provides evidence that is res ipsa loquitur, which is to say it provides information that "speaks for itself" (*Estelle v. McGuire*, 112 S. Ct. 475 (1991)).

topic; others including Tardieu in the nineteenth century (Labbé 2005)[5] and Caffey (1946) had made similar observations. So, it is necessary to ask why Dr. Kempe's recognition of the "Battered-Child Syndrome" did not simply go away. Perhaps it would have gone away without a "moral entrepreneur," scientist, and child advocate who felt that the simple act of diagnostic recognition was not enough. Here is where Dr. Kempe's associated actions after recognition became so critical. These actions facilitated powerful and enduring changes to law, culture, and attitudes.

Two vital steps accompanied the recognition of BCS as a phenomenon. First, Dr. Kempe identified the clinical resistance to it, which arguably was a reflection of society's gaze aversion. Second, Dr. Kempe laid the foundation for a new cultural norm by stating that the "Battered-Child Syndrome" could not be tolerated: the treating doctor had to "make certain that a similar event will not happen again [by reporting] possible willful trauma to the police department or any special children's protective services" (BCS p 23). This insistence that the injury already inflicted required official intervention in itself (not only because it implied a risk of recurrence) was the focus for Dr. Kempe's commitment to promoting practical actions which would overcome this aversion and facilitate a system to identify abused children to protect them from further abuse.

Major initiatives led by Dr. Kempe included the creation of multidisciplinary child protection teams (Kempe 1978; Bross et al. 1988), an approach which would be widely adopted, and the commencement of a new body of research on identification, treatment, and prevention of abuse. Child protection teams anticipated the recognition of secondary trauma, the nature of "emotional work" (Mastracci et al. 2011), and the role of team practice in supporting child professionals (Chiesa and Bross, in press). He also "institutionalized change" through the creation of a National Center for the Prevention and Treatment of Child Abuse and Neglect (now known as the Kempe Center), and establishing *Child Abuse & Neglect, The International Journal*, and the International Society for the Prevention of Child Abuse and Neglect. In addition, although detailed further in another chapter of this volume,[6] Dr. Kempe facilitated a key socio-legal development that merits attention here: the enactment of mandatory reporting laws regarding suspected severe child physical abuse in all 50 American states.

Legal Change: Responding to Violence as a "Vector of Harm"

Before turning his attention to child abuse, Dr. Kempe was a virologist who made important contributions to the smallpox eradication campaign (Bray 2004). The reporting of communicable diseases became a common legal duty for physicians as

[5] Chapter 2 of Hobbes et al. 2004 covers many aspects of the history of child maltreatment to which there was no long-term response.

[6] See Chap. 13, Gary Melton's chapter in this volume.

early as 1917, when 38 communicable diseases were officially reportable in the USA (Gordon 1965). Identification and reporting of infectious diseases had been proved to be essential in reducing and treating infection in the absence of antibiotics that would be developed decades later. Even today, identification of disease outbreaks, and efforts to discover and limit contact with sources of disease, are crucial elements of public health. The notion of a "contagion" or a "vector of harm" was at the heart of many advances in infectious disease control, and this history helps us understand the importance and power of the legislative mandatory reporting innovation instigated by Dr. Kempe after publication of the "Battered-Child Syndrome."

Whether consciously intended or not, the science of communicable disease identification, systematic documentation of the condition and transmission (epidemiology) of disease, followed by specification of three different stages (primary, secondary, and tertiary) of prevention, provided a useful analytical structure for responding to the person-to-person transmission of "this enemy within us."[7] This analytical scientific framework for dealing with human violence as a contagious process is reflected also in Dr. Steele's suggestion that, to some extent, child abuse within families was communicated from generation to generation (Kempe et al. 1962). The notion that a human psychological condition, perhaps a "disorder of empathy," could be transmitted through human interactions, also offers intellectual scaffolding that permits the psychologically traumatic work of responding to child maltreatment to be discussed more objectively, as if it were "outside of us."[8] Whatever the true explanation for eons of disregard of severe child abuse and generally ignoring and leaving it untreated, mandatory reporting laws "cut through" all of the barriers, and required protective attention and resources to be brought to bear on the plight of severely assaulted children.

The perceived need to enshrine in legislation this mechanism of response to overcome resistance and apathy stemmed from the perhaps inevitable failure of existing socio-legal systems. While in theory, the common law and equity enabled responses to the needs of vulnerable individuals, in reality, protection for children and funding for child maltreatment intervention only increased nationwide as reporting laws made the importance of child abuse more evident, and insisted on actions by medical professionals who encountered cases of severe physical abuse. This essential concern of the reporting laws embodied Kempe's insistence that "Above all, the physician's duty and responsibility to the child requires a full evaluation of the problem and a guarantee that the expected repetition of trauma will not be permitted to occur" (Kempe et al. 1962, p. 24). Critically, the laws enabled light to be shed on severe assaults inflicted on children in the privacy of their homes,

[7] Brandt F. Steele, a psychiatrist and coauthor of the "Battered-Child Syndrome" remarked on a number of occasions that people seem more able to recognize and respond to an external enemy, than to the "enemy within us."

[8] In observing this possibility, rather than diminish in any way the absolutely critical psychiatric and psychological work with human emotions, thought processes, hormonal, and in general, neurobiological aspects of human-to-human violence, this framework suggests that "behavioral transmission" of an important health condition is also possible.

without which the child's situation was far less likely to be addressed. This was a paradigm case of the sanctified private sphere, so cherished by liberal society as deserving freedom from intervention, facilitating the perpetration of cruelty on vulnerable individuals who could not protect themselves. The laws' public setting and mechanism enabled therapeutic intervention into private situations of familial violence which would otherwise have remained shrouded. They also embodied a cultural and attitudinal change, treating children not as chattels of parents but as individuals with rights to safety and security.

In this way, in Dr. Kempe's terms, children were guaranteed a "right of access to society."[9] The scale of Dr. Kempe's success in advocating for reform is evident in the fact that following his lobbying efforts in 1963, in only 4½ years (by 1968), all 50 US states adopted reporting laws, requiring physicians to report reasonably suspected non-accidental serious physical injury inflicted by a parent or caregiver (Paulsen 1967). Reporters of suspected abuse were granted immunity from liability provided their reports were in good faith. The first specific US Federal legislation focused on child abuse, Public Law 93–247 (The Child Abuse and Prevention and Treatment Act), became law in 1974. Since the states had acted independently, the Federal law created standards for reporting laws across the 50 states, thus creating national consistency, at least initially. Dr. Kempe advocated strongly for the new Federal law.[10]

Along with funding for pilot projects, and funding for states that adopted consistent laws, states wishing to receive the special funds under the Act had to have *Guardians ad Litem* for children. The first attorney hired by Dr. Kempe, a Canadian citizen by the name of Brian G. Fraser, testified in support of the law and wrote a seminal paper (1976) that laid the foundation for modern attorney representation in the USA, as well as the creation of Court Appointed Special Advocates. The attorney hired by Dr. Kempe to succeed Brian Fraser established the National Association of Counsel for Children (Bross 1980).[11] Today, in over half of the states in the USA, lawyers can be examined to become "Child Welfare Law Specialists" (Duquette and Haralambie 2010).

After reporting established that child maltreatment was a major and perhaps growing health problem for children, other legal changes were encouraged by Dr. Kempe. Dr. Kempe's experience with child protection teams convinced him that there had to be an interdisciplinary approach to child abuse and by 1975 he began lobbying for legislation that authorized or mandated child protection teams for local child protection agencies (Fraser 1976). Through his legislation advocacy, hiring of people with specific skills, and institution building, Dr. Kempe revealed a strategic

[9] This paraphrases Dr. Kempe's frequent declaration that "all children should have access to society."

[10] The law was also referred to as the Schroeder-Mondale Act. Senator Mondale at that time was the senior U.S. Senator from Minnesota. Pat Schroeder was the Congresswoman from Denver, Colorado, and thus C. Henry Kempe was her "constituent."

[11] The organization today has nearly 2,000 members, accredits child welfare law specialists under the aegis of the American Bar Association, and files amicus curiae briefs to the state courts of last resort and the U.S. Supreme Court.

understanding of the inherent difficulties in sustaining improvements in the lives of children. Following more than three decades of innovation, child protection teams under various names are now common practice throughout the USA in children's hospitals and a large percentage of American states and individual counties (Kolbo and Strong 1997). In fact, as documented by the National District Attorneys Association, child protection teams are legislatively recognized or even mandated in virtually every one of the American states (NCPCA and NDAA 2010). Positive effects have been documented for the provision of treatment services for children whose cases are heard by a multidisciplinary team (Hochstadt and Harwicke 1985). At least one state supreme court has expressed a preference for child protection team participation in complex matters of child maltreatment.[12] A number of studies have reported positive effects for child protection professionals who participate in child protection team meetings, including fewer indications that the individual is planning to leave child protection work, fewer delays in seeing clients, and better working relationships with medical and legal colleagues (Fryer et al. 1988).

Another issue raised by C. Henry Kempe in the 1970s was the problem of permanency of placement for maltreated children. Patterned on the Triangle, a Dutch program, the Circle House program provided continuous (24 hour) residential treatment at the Kempe Center for the entire family (defined as the parents and all minor children) for up to 6 months duration. Families referred to the Circle House were considered the most difficult to treat in terms of the experience of child protection services. Virtually all of the parents had some degree of severe mental health, substance abuse, or childhood trauma experiences. While some of the families succeeded in providing safety and a degree of normal parenting, others were not treatable in time for a child to grow up either safely or minimally well (Bross 1978). Protective services personnel and juvenile courts across the USA were beginning to recognize the extreme nature of some parenting problems and termination of the parent–child legal relationship legislation was enacted first in individual states with eventual encouragement by the US Congress.[13]

Some Effects in the USA and Internationally

The existence, nature, and extent of the reporting laws still generate some debate, with much of this centered around the nature and efficacy of reporting and response systems and their application to different maltreatment types.[14] While these matters may remain debated, there can be little doubt that the objective of identifying cases

[12] *In the Interest of Carlota B.*, 408 S. E. 2d 365 (W. Va. 1991).

[13] The Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. §§621 U.S.C. et seq; 42 U.S.C. §§670 et seq.

Adoption and Safe Families Act, Public Law No. 105–89, as codified in scattered sections of 42 United States Code.

[14] See, for example, the debate between those who favor the laws (e.g., Mathews and Bross 2008; Drake and Jonson-Reid 2007; Finkelhor 2005; Mathews 2012; Besharov 1985, 2005) and those who do not (e.g., Melton 2005).

of severe physical maltreatment through the legalized reporting duties was attained, and this continues today. In the USA, for example, in the year 2008, there were 121,137 substantiated cases of child victims of physical abuse, with a substantial majority of these cases being the result of reports by mandated reporters (USDHHS 2010, p. 47; USDHHS 2009, p. 45). Furthermore, just as Kempe observed, there remains a clear developmental vulnerability. Kempe had noted that most cases involved children aged under 3; the data from the USA show that the younger the child, the more vulnerable she or he is, and that one-third of all victims of severe physical abuse are aged under 4 (USDHHS 2010, p. 47).

Importantly, as well as assisting in the identification of cases of severe physical abuse in the USA, it is likely that the laws and their associated child protection systems and social agencies, together with other factors, have contributed to the documented decline in physical abuse. Based on annual national data of substantiated cases, and consistent with other indications of declines, David Finkelhor has charted a 55% decline in physical abuse from 1990 to 2009 (Finkelhor 2008; Finkelhor et al. 2009). As well as this decline, and consistent with children's developmental vulnerability to severe physical abuse, the reporting laws and associated support systems have substantially reduced annual child fatalities in the USA (Sedlak 1989; Besharov 2005). After the publication of the "Battered-Child Syndrome" and the resulting attention, national, local, public and private funding was invested in protecting children in a targeted way, and among the results have been profound changes in understanding of parent–child relationships, trauma, and child well-being.

International Jurisdictions

The introduction of mandatory reporting laws and their associated child protection systems in the USA influenced other jurisdictions to gradually adopt similar laws and systems as a major social policy aimed at reducing child abuse and assisting families in need of services. The case identification results in the USA referred to above have been found in other nations which have broadly adopted mandatory reporting laws, such as Canada (Public Health Agency of Canada 2010; Trocmé et al. 2005),[15] and Australia (Australian Institute of Health and Welfare 2010).

Jurisdictions in numerous countries have enacted mandatory reporting laws, but have done so at different times, and in different ways (Mathews and Kenny 2008). These different approaches reflect debates about the prudence of the reporting laws, the fact that jurisdictions within a nation have their own legislative and practical responsibility for child protection (which impede unified national approaches), and, just as if not more importantly, specific cultural factors and the need for

[15] In 2003 in Canada, reports from professionals accounted for 79% of the 25,257 substantiated cases of physical abuse (Trocmé et al. 2005, p. 86).

well-resourced child protection systems to receive, act on, and respond to reports. So, for example, even within a comparatively wealthy nation such as Australia, its States have enacted reporting duties at different times, applying to different types of abuse and different professions. Regarding physical abuse, in 1972, South Australia became the first Australian State to introduce a legislative reporting duty for doctors. In 1977, New South Wales, the most populous Australian State, first required medical practitioners to report a reasonable suspicion of a child being "assaulted, ill-treated, or exposed." Queensland, the third most populous State, introduced a similar legislative duty for doctors in 1980. In contrast, Victoria, the second most populous State, which adjoins NSW, only introduced a similar duty in 1993. In an even starker contrast, Western Australia still does not have legislation requiring any professional, including medical practitioners, to report severe physical abuse.

Other nations, including the United Kingdom and New Zealand, have chosen not to enact mandatory reporting laws. However, perhaps almost as importantly, in dozens of jurisdictions, industry groups such as medical and educational professions have created policy-based duties to report suspected abuse. There are complex questions about whether such duties (and associated systems) are as effective as legislative duties in creating a harmonized and well-informed professional culture of child protection best able to identify cases of severe child abuse. While rigorous research into this question is required, there is evidence that policy-based duties are not as effective in these respects as legislative duties. Doctors in the United Kingdom, for example, have a policy-based reporting duty that does not provide the normal protections given to reporters by legislative duties regarding confidentiality and immunity from proceedings. This less robust and coherent approach is known to have exposed doctors making good faith reports to harassment by parents and to professional disciplinary proceedings; these consequences have influenced a reduction in doctors' willingness to make child protection reports and to occupy child protection roles (Mathews et al. 2009). Furthermore, this distinction between duties based on policy and legislation has influenced some significant recent developments. Ireland has to date preferred policy-based duties, but in July 2011 indicated that it will introduce mandatory reporting legislation. According to Frances Fitzgerald, Ireland's Minister for Children and Youth Affairs, this decision was at least partly influenced by the fact that policy-based reporting duties have previously been ignored.[16]

Dr. Kempe's insistence that a legislative duty for doctors to report physical abuse was required to overcome a cultural resistance to reporting, combined with training to enable practitioners to recognize abuse, thus continues to be a crucial theme for children's health and social welfare. Globally, these matters remain pertinent to many nations which are already sensitized to child abuse; there is evidence of medical practitioners' failure to report suspected severe physical abuse even in the presence of a legislative reporting duty and a relatively well-developed

[16] This failure to comply with policy-based reporting duties seemed particularly prominent in cases of sexual abuse, but the Minister appeared to indicate it had broader application (Fitzgerald 2011).

culture of child protection (Flaherty et al. 2006; Gunn et al. 2005). For other nations, which, for numerous cultural, historical, social, and economic reasons, do not yet have such a general sensitization to preventing and responding to child abuse, Kempe's impulse toward enhanced child protection from severe physical abuse arguably remains an aspiration which will hopefully see progress in future decades. Such nations may presently have attitudes toward children's rights to health and "access to society" which are different from other societies, or at least afford them less priority among perhaps even more dire concerns. Yet, the ratification by these and indeed almost all nations of the *United Nations Convention on the Rights of the Child* indicates at least a rhetorical commitment to protecting children from abuse, since article 19(1) requires States parties to "take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s), or any other person who has the care of the child." This international legal instrument's echoing of Kempe's mandatory reporting laws in the USA reflects what historic changes his work catalyzed. Coming decades will witness whether, in all nations, such rhetorical commitments translate into practical reality.

Summary

The reporting laws laid a foundation for legal accountability on behalf of maltreated children throughout the USA, enabling child-caring individuals to act for an abused child with less fear of retribution. Subsequently, the legislative duty for physicians to report severe physical abuse would be extended to other professionals dealing with children, and to other forms of child maltreatment; these duties remain today (Kalichman 1999; Mathews and Kenny 2008).

What can be shown historically is that in only 4½ years, that is by 1968, all 50 US states adopted mandatory reporting laws advocated by C. Henry Kempe. In 1973, specific US Federal Legislation focused on child abuse (Public Law 93–247), to create standards for the reporting laws across the USA, along with funding for pilot projects, money for states appointing *guardians ad litem* for maltreated children in court, and protections for reporters of suspected child abuse. The reporting laws laid a foundation for legal accountability on behalf of maltreated children throughout the USA. The result was to create a duty of protection sanctioned nationwide. As a direct outcome of the "Battered-Child Syndrome" and Dr. Kempe's continuing advocacy, maltreated children were guaranteed both a "right of access to society" and courtroom advocacy. Other legal innovations related to the catalyzing effects of Kempe's work were the dissemination of child protection teams and legislation to assure permanent safe homes for maltreated children.

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Chapter 7
The Battered Child Syndrome Paper: Influence on the Field of Child Neglect

Howard Dubowitz

A Landmark Paper

The 1962 paper on the "battered child" by Kempe and colleagues in a prestigious medical journal triggered a crucial turning point in US awareness of how children may be maltreated (Kempe et al. 1962). Child abuse had been previously noted in the medical literature, particularly by radiologists speculating about unexplained injuries (Caffey 1946). It was the paper by Kempe et al., however, that evoked a strong response by both clinicians and legislators. Within a few years, all 50 US states passed laws aimed at protecting children from abuse.

The battered child paper was important in another respect. Given how little was known about child maltreatment at that time, the paper is remarkable for its rich insights into the problem. The authors accurately identified important barriers, such as physicians' reluctance to become involved in these cases. While notable progress has been achieved, these issues remain relevant 50 years later (Lane and Dubowitz 2009). Similarly, Kempe and colleagues quickly recognized the need for an "evaluation of psychological and social factors." There is no doubt that this seminal paper has influenced the field of child maltreatment over the years. This chapter will focus on its role with regard to child neglect, now known to be by far the most prevalent form of identified child maltreatment (USDHHS 2011).

With regard to how the paper directly addresses neglect, it is naturally necessary to recognize the thinking and limited knowledge base at the time. In this historical context, it is interesting to have a peek into how neglect was then viewed. In terms of its subsequent influence, there are inevitably many factors that shape a developing

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field, making attributions to any one paper somewhat speculative. With these caveats, let us consider how the battered child paper may have influenced our thinking and practice regarding child neglect over the past five decades.

A Dramatic Title

Kempe later described their need for a dramatic title. He had been talking about child abuse for years, but there was little interest. The "battered child" certainly conjures up repugnant images of a severely physically abused child. Those who previously may have remained indifferent could no longer easily turn away. The title demanded a response. But, beyond the title, the authors were careful to describe a spectrum of severity; not all children were horrifically abused. This spectrum included child neglect.

It is hardly surprising that neglect was viewed as less serious. This perspective is likely true today, despite ample evidence demonstrating that the short- and long-term harm of neglect appears to be as severe as that of abuse. Indeed, almost three quarters of the annual deaths attributed to child maltreatment involve neglect (USDHHS 2011). There were probably several reasons why physical abuse was construed as more severe than neglect. The different nature of the experiences – a child being violently struck compared to needs insidiously not being met – understandably evokes very different responses. It is also possible that Kempe et al.'s paper focusing on the most severe manifestations of physical abuse created a lasting image of what child maltreatment represented and influenced future priorities.

At the same time, the paper should be credited for drawing some attention to the problem of neglect. This was probably one of the first times the term appeared in the medical literature, and so physicians were introduced to this form of maltreatment related to abuse. Other disciplines, particularly social work, however, had long been working with neglected children and their families (Gehlert 2006).

The View of Neglect in 1962

Kempe and colleagues focused on physical manifestations of neglect, mostly failure to thrive (FTT, i.e., poor growth) and poor skin hygiene. This is not surprising given that they are relatively overt and observable. Fifty years later, the focus on easily identified physical problems including household sanitation remains paramount when child protective services (CPS) investigate reports of maltreatment. While the importance of clean clothing or a tidy home have likely been given too much weight, they do probably serve as at least crude markers of how families are functioning, and their ability to adequately meet children's basic needs and provide a safe and nurturing home environment. In addition, the authors were likely mindful of how physicians could reasonably identify neglect, poor hygiene serving as a useful marker.

FTT, usually diagnosed in infancy and early childhood, was a prevalent problem at the time. Up to 5% of pediatric hospital admissions were for this reason. Reflecting the thinking then, the authors considered this a form of neglect. Again, with physicians routinely tracking children's growth, FTT would have been another useful marker of underlying neglect. And, here too, similar thinking remains commonplace today (Block et al. 2005). Some state laws and many professionals still view FTT simply as a sign of neglect, despite it later becoming evident that omissions in parental care and feeding were not always responsible and hardly the whole story. Perhaps the battered child paper had an enduring impact on thinking about neglect?

It is interesting that the paper makes no mention of emotional deprivation as a form of neglect. The work of Bowlby and others had prominently drawn attention to the devastating impact of emotional deprivation, such as that suffered by children raised in institutions (Bowlby 1951). In the early 1960s, orphanages were quite common in the USA, and there may have been concern about the wellbeing of their residents (Frank et al. 1996). It is striking once again that emotional or psychological neglect remains relatively neglected by the child welfare system, unless accompanied by other forms of neglect or abuse. Several reasons are plausible. The definition of emotional neglect is a challenge, with no clear discrete act and no clear threshold at which such parenting is deemed neglectful. Thus, aside from the most egregious of circumstances, physicians and other professionals are often uncertain about when emotional neglect should be labeled as such, and, few reports are made to CPS. Kempe et al.'s paper probably reflected the prevailing inattention to this problem at the time, at least within medicine. It may also have contributed, together with other factors, to the ongoing relative lack of consideration of children's unmet emotional needs within the US child welfare system.

Maltreating Parents

The paper probes the context of abuse, primarily parental psychological functioning and "defects in character structure." The focus on parental psychopathology likely reflected and influenced the thinking of what could be underpinning battering. With little research at the time on the etiology of abuse, it was difficult to comprehend how a parent may grotesquely harm their helpless infant. Accordingly, serious psychopathology offered a plausible and perhaps convenient explanation. Convenient, because this created and distanced a small deviant "other" while protecting the sane, "normal" majority. Nevertheless, the paper likely helped shift thinking from simplistic notions of "evil" parents to a more sympathetic view of their problems, while trying to understand the roots of abuse.

There may have been other unintended consequences of the authors' view of "batterers." The word evokes a terrible image of the guilty party and may have inadvertently contributed to the enduring stereotype of abusive parents. The focus on individual parental psychopathology likely steered thinking in this direction,

while diverting attention from sociocultural influences. Yet again, 50 years later, there remains a strong and narrow focus on "culpable" individuals with rather little regard to underlying systemic problems that we have long learned contribute to child maltreatment. In addition, the paper's focus on parental psychopathology mostly concerned severe physical abuse and not neglect. Here too, however, there may have been an unintended contribution to stereotyping maltreating parents, and apportioning blame.

Closely aligned with their focus on psychopathology, the paper drew attention to the intergenerational transmission of maltreating behavior. While clearly a real phenomenon, its role was later exaggerated with potentially positive and negative consequences (Kaufman and Zigler 1987). A positive outcome may have been an empathic stance toward maltreating parents, recognizing that they too may have once been victims. This may have drawn attention to childhood experiences and parenting and the need for supportive policies and programs. A negative consequence may be the inappropriate blaming of some grandparents who had not abused their children (e.g., "if she abused her kid like this, I wonder how she was raised!"). For some, emphasizing the intergenerational link may have fostered anxiety in expectant parents (e.g., "if abuse leads to abuse, and I was abused, then....").

It is noteworthy, however, that the paper also includes nuanced insights into the varying circumstances associated with maltreatment. For example, the authors acknowledged the varied and sometimes "good" backgrounds of abusive parents. This may have encouraged careful consideration of the specific circumstances in which maltreatment can occur – an important issue for both abuse and neglect.

Maltreatment Is the Symptom

Kempe et al.'s paper made a valuable contribution in drawing attention to the broader context of child maltreatment and the need to understand its etiology. Kempe, a noted virologist, was applying the established medical model – after identifying the problem or disease, elucidating its cause would be the road to the cure. The authors recognized that psychopathology was hardly the full story and called for also investigating and addressing the social circumstances – another call that remains equally relevant 50 years later. Subsequent research and clinical experience has supported the ecological theory of child maltreatment – multiple and interacting factors contribute to the problem (Belsky 1980, 1993).

The paper suggests that it is not enough to simply diagnose or substantiate maltreatment. If we are to intervene effectively, a good understanding of the underlying factors is key to tailoring a response to meet the needs of the individual child and family. It should also be the guide to develop necessary policies and programs to address child maltreatment.

A Message to Physicians

The paper strongly points to physicians who were unwilling or unable to respond appropriately to clear evidence of maltreatment. With regard to severely physically abused children, the authors would be pleased that most physicians do respond appropriately. With regard to neglected children, however, their point still resonates today (Dubowitz 1994). For at least 50 years, we have been made aware of this problem. We have learned a good deal about neglect's seriousness, and about how to intervene. And, we might learn from Kempe et al. that physicians can play a valuable role, helping ensure children's health, development, and safety.

Kempe and colleagues made a profound contribution in drawing professional and public attention to the plight of abused and neglected children and their families. It is gratifying to witness the immense progress that has been made. It is also sobering to recognize how many of the challenges remain 50 years later.

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Chapter 8
The Emotionally Battered Child

James Garbarino

In 1962, when he was 40 years old, Henry Kempe and his colleagues Fred Silverman, Brandt Steele, William Drogemueller, and Henry Silver published their iconic article "The battered child syndrome" in the *Journal of the American Medical Association*. I was 15 at the time. My own first professional publication in the field of child maltreatment came in 1976 (on community factors associated with higher and lower rates of child abuse and neglect). My first publication on the topic of emotional abuse was in 1978 (in the journal *Child Abuse and Neglect*), and in 1986, my colleagues Edna Guttmann and Janet Sebes, and I published our book *The Psychologically Battered Child*. Henry had died 2 years earlier, a young man (aged 61—3 years younger than I am as I write this chapter).

Like other contributors to this volume, I had first-hand, personal contact with Henry during the mid-1970. Henry and I met up in the New Orleans airport after a meeting of the Society for Research in Child Development in 1977. I was with my then infant son Josh, and Henry requested a picture of him after he observed us together and declared that my son exemplified a "well-bonded" baby. Parent-infant "bonding" was a hot topic that year (after Marshall Klaus and John Kennel published their book *Parent-Infant Bonding* in 1976). I mention all this to convey how young "our field" is, and how historically near we still are to its pioneers. Henry Kempe is a vivid part of our professional (and personal) heritage, our "intellectual lineage" if you will, and he will continue to be such as my generation passes from the scene and our students take our place.

It was no coincidence that we titled our 1986 book *The Psychologically Battered Child*, of course. It was a homage to Henry's pioneering work. However, it was also an attempt to reach beyond the limits of what Kempe et al. offered as the focal point for child abuse studies in their 1962 article. That article focused on physical abuse

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resulting from parental assault (with only a passing reference to neglect and no explicit reference to emotional maltreatment). It saw the phenomenon as primarily one affecting very young children. (Kempe and colleagues wrote, "As a general rule, the children are under 3 years of age; most, in fact are infants" (p. 21).) And, it laid the principal "blame" (in the sense of causation) on psychiatric issues ("Psychiatric factors are probably of prime importance in the pathogenesis of the disorder…" p. 24). Indeed, the analysis cites "psychopathic and sociopathic characters" as a common factor and suggests that "a frank psychosis is usually readily apparent" in cases where the child is actually killed.

It is not the purpose of this chapter to comment on how the field of child maltreatment in general has evolved since 1962: toward an appreciation for the social and cultural conditions that support child abuse and neglect (taking the field well beyond psychopaths and sociopaths), toward a recognition of neglect (which in most empirical analyses accounts for more cases than abuse), and toward an understanding that maltreatment affects kids across the age span (particularly as the scope of definitions broadens beyond bone-breaking physical assault). My purpose here is to comment on how our understanding of psychological maltreatment (emotional abuse and neglect) has come to be seen as a core issue in child protection, even though Kempe and his colleagues did not address this issue specifically in their 1962 report.

Interestingly, when it comes to "emotional abuse" (or "psychological maltreatment," the term I actually prefer), there is a "pre-Kempe" history worth noting. Consider this statement published in the journal *Child Welfare* in 1958, by Robert Mulford, 4 years before Kempe and his colleagues published their article: Mulford wrote, "It is significant that at this stage of the development of child protective services attention is being focused nationally on emotional neglect of children" (1958).

I first cited Mulford's comment 20 years after it was published—more than 30 years ago—and commented that his observation proved to be unfounded, in the sense that very little national attention really had been focused on the emotional neglect of children. By the late 1970s, it *did* seem that the topic of psychological maltreatment was beginning to take hold in the field of child protection and research on child abuse and neglect. Thirty-five years ago, there *were* many conferences and workshops being devoted to the topic of psychological maltreatment, and the Advisory Committee for the American Humane Association's National Study of Child Abuse and Neglect Reporting had recommended "emotional maltreatment" as one of four principal reporting categories. In 1978, two prominent researcher/clinicians wrote that, "Mental health professionals have avoided the topic of emotional abuse" (Lourie and Stefano 1978). All that was supposed to change. To some degree it has. In the last three decades, research and practice have proliferated. Nonetheless, psychological maltreatment remains a kind of intellectual and policy step-child of the child protection field. I think an exploration of the particular dynamics of this topic will help us see why this has been the case.

First, there was a kind of absolute moral and political purity to what Kempe and his colleagues exposed in 1962: very young children (mostly infants) whose bones and brains were broken by crazy and/or evil people. What's not to hate about that!

In the decades that followed, however, this pure clarity was compromised by casting an increasingly wider net. Abused teenagers (like abused wives) were often seen as complicit somehow in their abuse (e.g., through their provocative behavior) in a way that infants were not (could not, from most perspectives). What is more, less severe maltreatment was much closer to the "normal" behavior of "normal" people—who routinely did assault their children under the rubric of "corporal punishment," and often it appeared difficult to distinguish excessive "normal" physical punishment from abuse. Furthermore, large numbers of poor and socially marginal people did not meet their obligations to educate, socialize, feed, clothe, and house their children according to society's minimum standards, and thus could be said to neglect their children.

Finally (and to the point of this discussion), the process of setting minimum standards of care against which to judge whether or not parental behavior constituted psychological maltreatment (emotional abuse and/or neglect) proved very difficult. This process was (and still is) much more difficult than identifying the source of the grievous physical injuries presented by the children Kempe and his colleagues reported on in 1962. Let me tackle this last issue, since it is at the heart of the "problem" in moving from the physically battered child to the psychologically battered child.

A child whose leg is broken playing football is not an abuse victim; a child whose leg is broken because of a parental beating is. It is not the injury but the context in which it occurs, more specifically the message it conveys, the meaning of the injury that matters. Psychological maltreatment is about that meaning, and this is why it is a core issue in the larger domain of child maltreatment. Defining it is an ongoing dialogue about how to raise the standards of care for how children are treated, standards of care that are tied to the basic human rights of children.

Rarely in child development does the process of cause and effect work universally. Rather, cause/effect operates in the context established by family, as family itself operates within the context of neighborhoods and community, which in turn reflects the socioeconomic systems, of culture, of gender and ethnicity, of prior experience, and of historical circumstance. This is the fundamental lesson we learn from scientific research on human development from an ecological perspective. When we look at the development of children and ask, "does x cause y?" The best scientific answer is almost always "it depends." That is one of the most important messages from modern developmental science, and it provides the foundation for an ecological perspective as laid out by developmental psychologist Urie Bronfenbrenner (beginning at roughly the same time Kempe and his colleagues were identifying the battered child syndrome).

This perspective guides us through the complicated realities of child maltreatment. It helps us make sense of the finding that only about half of the kids who experience child maltreatment show long-term damage. As Michael Rutter (2007) concludes after reviewing the evidence on the consequences of child maltreatment, "a substantial proportion (about half) of all individuals suffering physical or sexual abuse in childhood nevertheless shows unremarkable positive psychosocial functioning afterwards." An ecological perspective anticipates this finding. "Does child maltreatment cause long-term developmental damage?" As always and

everywhere, the answer is "of course, it depends." This highlights the fact that child maltreatment cannot be defined by its effects: rather it must be defined in reference to standards of child care.

This ecological approach lodges child maltreatment solidly within a human rights framework. It recognizes that protecting children is an ongoing effort to raise the standards for how children are treated, as knowledge and awareness of what children are entitled to experience at the hands of their parents advance and how that entitlement influences positive and negative development increases. This process occurs in the "macro-systems" of culture and politics, but also in the "micro-systems" of families and schools, and the "exo-systems" (institutional settings in which children do not participate directly but in which actions take place that affect the lives lived by children). Thus, at any particular time and in any particular place, to label something as "child maltreatment" is to recognize that the institutions of a community have come to understand that the minimal standards of child care are being violated in ways that put the child at risk (*not* "that harm the child").

It is a kind of negotiated settlement between science and professional expertise, on the one hand, and culture and community values, on the other. In a sense, the UN Convention on the Rights of the Child is at its heart a manifestation of this process in that it represents a global consensus of what it should mean to be a child, and what the adult world should feel compelled to do about it when this social contract is violated.

Because I think that the ecological perspective is vital in understanding the developmental impact of psychological maltreatment, I also believe that framing the issue in terms of the basic human rights of children is essential. While no one-to-one correspondence between experiencing abuse and maladaptive human development is evident, it clearly does increase the probabilities that such negative patterns will emerge. What is more, when maltreatment occurs in the context of heightened vulnerability as a result of organismic risk factors, the probabilities of harm increase dramatically.

This is evident in the research of Caspi, Moffet, and their colleagues (2002) on the developmental impact of child abuse among children who are genetically vulnerable because they have an MAOA gene turned "off" (in the sense that it appears in the recessive form in which monoamine oxidase neurotransmitter leads to diminished capacity to process arousal productively). In such cases, some 85% of abused children develop a chronic pattern of aggression, bad behavior, acting out, and violating the rights of others (diagnosed as "Conduct Disorder")—double the rate for abused children without this vulnerability, and eight times the rate for non-abused children. Thus, I think it is fair to say that the consequences of violating the child's basic human right to live free of abuse are often dreadful, for the child and for the larger community, particularly among especially vulnerable children, and, of course, among children exposed to the most severe abuse such as those reported upon by Kempe and his colleagues in 1962.

Because it is the mental and spiritual development of children that is most central to their overall human development, anything that inhibits or distorts these dimensions of development is a core concern of those who care for children and their

human rights to thrive. Where minimal standards can be set for the psychological treatment of children, a domain of psychological maltreatment can be identified. We know that terrorizing, ignoring, isolating, corrupting, and rejecting children can undermine their mental functioning, their personality development, their moral reasoning, and their ability and motivation to behave pro-socially (Garbarino et al. 1986). These then are the core components of psychological maltreatment.

Furthermore, we can recognize that in most cases even when the immediate violation of the child is in the form of physical or sexual abuse, the most pervasive consequences are psychological. Children develop as their minds and spirits develop. As personalities, they can survive (and even thrive) if they confront physical injury, so long as that injury does not have psychological implications of rejection and shame (*and* does not dramatically damage their brains). Decades of research by Ronald Rohner and his colleagues (2005) have demonstrated that parental rejection is associated with problematic development (accounting for about 25% of the variance across cultures and societies). Research by James Gilligan (1997) pinpoints shame as a primary mental health toxin, linked to violent behavior by those who experience it.

Fifty years after Henry Kempe and his colleagues identified the battered child syndrome, we are still struggling to implement a comprehensive vision of child protection. Decades after I "signed up" for the child protection movement that Henry and the other pioneers launched, I remain convinced that our ultimate success in this endeavor will depend in large part upon our progress in establishing a human rights perspective for professionals, policy makers, community leaders, and parents, in which the right to be safe *emotionally* is affirmed and implemented. We cannot limit our efforts to preventing the physical battering of children but must always strive to protect them from psychological battering as well. Child protection must be about the child's right to live in a world free from rejecting, terrorizing, isolating, ignoring, and corrupting.

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Chapter 9
A Pediatrician's Perspective on Child Protection

Abraham B. Bergman

The memory remains vivid in my mind. I was an intern at Boston Children's Hospital in 1959; our ward team had gathered for x-ray rounds. On display was a radiograph of an infant with multiple fractures of different ages. Among the senior clinicians, the discussion was not about whether the findings were typical of a metabolic disease, but rather which particular metabolic disease. The radiologist, Martin Wittenborg, said quietly, "this is trauma." He was ignored.

That was not surprising. The definitive study on subdural hematomas in infants—98 patients over a 6-year period—emanated from the same hospital (Ingraham and Matson 1944). Looking at the case descriptions, it is likely that most of those infants sustained intentional trauma. But that possibility was never raised by the authors. It was not that intentional trauma to children was unknown. Child and infant homicide were known about. But a great number of instances of traumatic injury not resulting in death were simply not recognized.

Henry Kempe, of course, was not the first to write about abuse. His brilliance was figuring out the steps needed to bring the magnitude of the problem to the attention of physicians and the public. Using the term "battered child" was a stroke of genius (Kempe et al. 1962). The term, coupled with the concept of "child protection" paved the way for dramatic changes in how the problem was dealt with. By the time I took up my first job as director of outpatient services at Seattle Children's Hospital in 1964, a policy of admitting all children with suspected abuse for evaluation was already established. In those days, the practices of individual physicians were inviolate; hospital authorities had little to say. Many physicians found it hard to believe that parents in their practices who they knew, were capable of injuring their children. However, the attention about abuse within the medical community and the public publicity breached the previously impenetrable wall of physician sovereignty.

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My hospital was typical. As a "specialist" in community pediatrics, I was charged with organizing a child abuse team with the power to evaluate all instances of suspected abuse. The team consisted of a pediatrician, me, responsible for establishing the diagnosis, a social worker responsible for making the disposition recommendation, and a child psychiatrist to assess the capacity of the parents to care for their child at home. I saw all children admitted to the hospital where the suspicion of abuse was raised. And in consultation with other physicians, confirmed or refuted the diagnosis of intentional trauma. I also informed the parents that (a) the injuries were inflicted, (b) the case would be reported to "the authorities", and (c) that a social worker would shortly be speaking with them in more detail.

The majority of children with inflicted injuries are easy to identify. The most decisive factor is when the signs of injury do not match the history related by the caretakers. In a relatively small proportion of children, the picture is more complicated. On such occasions, I did not feel the need to rush, but rather to gather as much expert opinion as needed.

I also did not find confronting parents with the diagnosis to be difficult. Not as difficult as bearing grim news to the parents of a child in an automobile crash, or a child who has drowned. I try to be direct; i.e., "your child's injuries were not an accident but caused by 'someone' hitting him." I use the term "someone" advisedly. The most frequent reaction to this news is resignation and sadness. Occasionally belligerence. "I have the right to spank my kid when he does something wrong." I respond, "but it is against the law to leave marks." I then say that I am obliged to report the case to "the authorities," and that "they and others would be talking with them soon." That was usually the end of my involvement in the case, unless medical testimony was required. The social worker then took responsibility for continuing contact with the family, and making a recommendation on disposition. Except for "unexpected deaths" that had to be reported to the coroner, it was not always clear what to do in cases with less serious injuries. Given the national publicity about "battered children," and the fact that we were a teaching hospital, which means that questions are asked, most cases of inflicted trauma were identified and reported to the Seattle Police Department. Within the department, it was "the women's division" that was responsible for dealing with crimes against children. The unit was staffed by two experienced officers with knowledge of abuse. They would refer substantiated cases of suspected assault to the prosecuting attorney.

Origins of Children's Protective Services

As mentioned above, the diagnosis of physical abuse was usually straightforward. Management after the diagnosis was confirmed was quite another matter. Few police personnel were capable of investigating a hitherto unknown entity, and social workers did not possess the power to ask questions of persons who did not want to speak to them. Hence, the appearance of a new breed of professionals with the legal power to investigate combined with the skills to provide support for the child and family.

The far-reaching impact of the "battered child" article is illustrated by the fact that it took only 3 years from the time of publication to the adoption of reporting laws in all 50 states. In Washington, the first law enacted in 1965 permitted "practitioners" to report suspected abuse. Mandatory language (i.e., "shall" as opposed to "may") did not appear in the statute until 1971. Because there were no public funds to train and hire CPS workers, private agencies were asked to help. In Seattle, a prominent social service agency, Medina Children's Services, undertook a pilot program to field and act upon reports of abuse. The federal government did not enter the child protection arena until more than a decade later with the enactment of the Child Abuse Prevention and Treatment Act of 1974. It was then that federal funds became available for state child welfare agencies to hire CPS workers.

When the concept of CPS workers was initially conceived, their role in supporting families was deemed important because it was assumed that the majority of children involved with CPS would either remain in or return to their homes. As Paulsen said:

> Protective services aim at effecting constructive change within the family in which there has been child neglect or abuse so that the child's environment may be improved (1974).

An idealistic concept to be sure. But reality trumped idealism as large numbers of CPS workers were hired who had little training and support, and were inundated with large caseloads and inadequate supervision (Melton 2005).

More importantly, simultaneous changes in American society greatly affected the lives of children. Among them: (a) more women joining the workforce, (b) single mothers keeping babies instead of giving them up for adoption, and (c) the vulnerability of these infants in the face of poverty, substance abuse, and lack of affordable childcare. The upshot was a whole lot of infants being born to couples who had no business being parents.

Consequences of Publicity

The public response to the battered child paper was electric. The marked decrease in rates of physical and sexual abuse can be ascribed in part to the fact that the intentional maltreatment of children came to be viewed as an abhorrent act in American society. A high proportion of long-term abusers have been identified and separated from their child victims. But while the number of reported cases of physical and sexual abuse has fallen, the number of neglect cases has remained relatively level and now constitutes almost three-quarters of cases reported to CPS (USDHHS 2009).

A less admirable effect of enlisting the public's help in "the fight against child abuse" has been a failure to distinguish the different forms and dynamics of abuse. A pervasive belief that exists to this day is the existence of a "child abuser," akin to a rabid dog who seeks out children upon which to inflict injury. Hence the rush to remove all other children from the home when a case of physical abuse is identified. And a common response from suspected perpetrators is, "but I'm not a child abuser." However, in the case of sexual abuse, the perpetrator is apt to be a predator who reoffends if not stopped.

The Rush to Report

In 1983, I moved from Children's Hospital to Harborview Medical Center, a facility owned by the county, but operated by the University of Washington. Harborview is a major trauma and burn center serving a large four-state area of the Pacific Northwest, as well as carrying out the traditional mission of a county hospital, caring for vulnerable adults and children.

By that time, it was clear that the spectrum of child maltreatment had changed. Our Seattle group published a paper showing that between the decades 1971–1973 and 1981–1983, though there was little change in the number of child homicide cases, or number of children hospitalized with intentional trauma, the severity of those injuries was greater, and the known perpetrators were more likely to be men (Bergman et al. 1986). Cases of the "battered child," i.e., chronic abuse, became rare. The dynamic of severe physical abuse that sticks in my mind is that of a baby being cared for by a man who is not the father. A sudden impulsive act of violence is unleashed in response to an infant who will not stop crying, or a small child who will not eat, or who "poops" in his pants.

When suspected cases of child abuse came to the emergency room, there was frequently a rush by nurses or social workers to report the case to CPS. At times, even the paramedics would radio a report to CPS in the course of transporting a child to the hospital. All-too-many of these reports were for a questionable home environment, or poor parenting practices, i.e., "the house was filthy; there was dog poop all over the floor," or that a child in a car crash was not wearing a seat belt. The social workers hated it when I pointed out that they would never dare apply the same standards of reporting to middle-class families, and that a public health nurse (PHN) referral would be more appropriate.

Sometimes, time is needed to sort out the injuries, especially scald burns, and to obtain consultation from radiologists, burn and orthopedic surgeons, and ophthalmologists. My stance was to admit all children with suspected abuse, compile accurate medical information, provide this information to the family, and have an evaluation by an experienced social worker before submitting a report to CPS. The exception was children with serious injuries who were promptly reported to the police.

But our emergency room social workers were not deterred. Their stated reasons: "we are required by the law as individuals to report," and "I know it's not abuse, but reporting to CPS is a way this family can get needed services." The myth that CPS provides social services is widespread, and persists to this day (Campbell et al. 2010).

When I came to Harborview, we had four full-time pediatricians who were all capable of dealing with abuse. We did not need child abuse specialists on a routine basis. As mentioned before, the medical aspects of abuse are usually straightforward, well within the capabilities of general pediatricians. Occasionally, the cases are puzzling. In those instances, we called on our esteemed colleague, Kenneth Feldman, to consult.

Following the Colorado model, a "child abuse medical consultation network" was establishing in Washington in 1986 to serve physicians, police, prosecutors,

and CPS workers. Six pediatricians located in different areas of the state were available to provide consultation through a 24-hour-a-day hotline, and to provide medical testimony in court. Interestingly, the program was funded by federal Baby Doe money, intended to investigate instances of medical neglect. As physicians and law enforcement personnel became more adept at dealing with maltreatment, virtually all the calls came from CPS workers. These calls tended to come from experienced workers wanting to talk over puzzling cases. The less experienced, insecure workers—the ones who most needed help—rarely called.

More Harm Than Good

The job of a CPS worker is as difficult as any I can imagine. The pay is low, the paperwork is prodigious, and second-guessing is rampant. In medicine, we can always ask colleagues to help with difficult decisions. CPS workers often must make crucial decisions alone with little data, i.e., "are the children safe in this house?" And worst: how can one's spirits be maintained when most client visits are met with hostility? My quibble is not with the individual workers, it is with the no-win system in which they were forced to operate.

In 1984, I was invited by my friend, Dick Krugman, to speak at the annual conference on child abuse and neglect at Keystone Colorado. My topic: "Does CPS Do More Harm than Good?" The thesis: that lacking the skills and/or job description to provide support, CPS workers are viewed as enemies by the families they serve. Never have I faced a more angry audience. The furor was such that Krugman, the editor of *Child Abuse and Neglect*, would not publish the talk in his journal.

Another clash with social workers took place over drug testing of newborns at the University of Washington Hospital. They were in the habit of routinely requesting toxicology screening of urines of infants whose mothers had a history of substance abuse. The reason given was that judges would not grant orders for temporary foster placement unless the screening test was positive. I objected on the grounds that the result of a single screening test is not a good criterion for judging parenting ability. Therefore, whenever I was the attending physician in the newborn nursery, I refused to allow routine screening on my patients. Instead I insisted that the hospital's recommendation on where an infant goes after discharge be made on the basis of a traditional social service evaluation. My reputation as an "obstructionist doctor" in the CPS community was confirmed.

What Now?

What now? Idealistic as its mission was when first spawned, CPS has long since outlived its usefulness (Bergman 2010). Especially when cases of child neglect now constitute almost three-quarters of reported cases. Yet the child protective system

has remained virtually unchanged over the past 40 years. I fear that significant change might not occur over the next 40 years—because the public and politicians continue to believe there are no alternatives to "fighting" child abuse. Also there are now about 25,000 CPS investigators and 4,000 intake staff employed by child welfare agencies in the USA (U.S. General Accounting Office 2003). No group of government employees backed by a strong constituency is going to pack their tents and fade away.

In the early days, police and prosecutors knew little about abuse. Now most of them do. Therefore, the investigative role of CPS in cases of suspected physical or sexual abuse is duplicative, and should cease. Since these acts are crimes, investigation should be conducted by law enforcement personnel.

When concerns of child neglect are raised, public health nurses should be the first-line responders. They possess the skills to assess child and family functioning, and are more apt to be accepted in homes than CPS workers. The flaw in this argument, alas, is that PHNs are a vanishing breed in the USA.

Prevention

What about prevention? The landmark studies of Olds and colleagues (2010) and Kitzman and colleagues (2010) have demonstrated how nurse home visits to families at risk result in improved family functioning and cost savings. On an individual level in the newborn nursery, it is possible to approximate the risk of poor parenting by how the mother holds the baby, how she speaks about the baby, and whether a support system is present.

The dilemma is that the resources necessary to prevent child maltreatment do not exist. Why not? Because there is no constituency attempting to bring about reforms. As mentioned above, CPS is entrenched in the child welfare system, and the work of public health nurses is not even promoted within the nursing profession. Also, the pediatricians in the newly created specialty of child abuse appear to be more involved in the forensic aspects, i.e., searching out abuse cases that are missed, than in developing and promoting prevention programs. Prevention is a hard concept to sell. But just as Henry Kempe brought about changes in how American society viewed child maltreatment, leadership must inevitably rise to help us take the next big step.

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Chapter 10
Multidisciplinary Teams

Scott D. Krugman

Readers of the case reports of the "Battered Child Syndrome" may be left to wonder how exactly the diagnosis was made. Clearly, there was a role for the pediatrician in the evaluation. But additionally, the mother in case 2 had a "psychological and neurological evaluation" (Kempe et al. 1962). In case 1, "both doctors and nurses" made observations about the mother's behavior (Kempe et al. 1962). What is unspoken in the JAMA article is the multidisciplinary team behind the scenes. Years prior to the publication, C. Henry Kempe formed a dedicated team of doctors, psychologists, nurses, social workers – with the sole purpose of evaluating children suspected of being physically abused. The work of this team not only led to the publication of the seminal JAMA article but led to a proliferation of teams across the nation and the world.

Historical Child Protection Teams

Three forward-thinking institutions with influential leaders created the first Child Protection Teams (CPT) in the 1950s. Two social workers at opposite ends of the country, Elizabeth Elmer at the Children's Hospital of Pittsburgh and Helen Boardman at the Children's Hospital Los Angeles began to systematically evaluate abused children in their institutions (Bross et al. 1988). The individual pediatrician who receives credit for the creation of a team is C. Henry Kempe, who founded the original CPT at University of Colorado in the late 1950s. These original teams typically consisted of a pediatrician, a social worker, and a nurse. At the time, child abuse was believed to be a relatively infrequent phenomenon. Kempe "found"

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749 cases of the Battered Child Syndrome in a 1 year time period from hospital and district attorney sources (Kempe et al. 1962).

After publication of the Battered Child Syndrome article and passage of federal reporting laws, the next 20 years saw a dramatic increase in the number and types of CPTs. Dr. Barton Schmitt published the first edition of the *Child Protection Team Handbook* in 1978, describing the approach used by the University of Colorado CPT in evaluating all types of abuse, how to form and organize a team, how to create reports, and how to work together in a multidisciplinary setting (Schmitt 1978). Teams at this time had expanded membership to include professionals from psychology, law, education, and psychiatry and often had child protection workers from local agencies on the team. The variety of teams included hospital-based, community-based, rural, and regional. Despite the proliferation, estimates in the late 1970s about the incidence of abuse remained quite low. As noted in the handbook: "The incidence of child abuse is approximately 500 new cases per million population per year," leading to the estimate of needing one CPT per 300,000–400,000 population in a city (Schmitt 1978).

By the publication of the second edition of the *Child Protection Team Handbook* 10 years later, the number of CPT teams was estimated to be over 1,000 (Bross et al. 1988). The CPT expansion included new professionals (criminal prosecution, dentists) and new locations (mental health centers, departments of social services, military installations, and tribal jurisdictions). The significant expansion of multidisciplinary teams at this time reflected the increasing awareness and incidence of child maltreatment. From the original low estimates of abuse a decade prior, by 1980, the first National Incidence Study (NIS) reported over one million individual children were reported to social services nationally and 470,600 substantiated cases leading to an incidence of 7.6/1,000 children (U.S. Department of Health and Human Services 1981).

Current Child Protection Teams

Academic/Children's Hospitals

The first CPTs were formed in academic medical centers and children's hospitals. As referral centers for the most critically ill and injured children in a community or state, these hospitals would have a concentration of child abuse cases that lead to expertise and the need to develop a multidisciplinary team to help in the evaluation. National Association of Children's Hospitals and Related Institutions (NACHRI) studies have demonstrated that between 60% and 72% of their member hospitals had either a Child Abuse Program or child abuse team (Tien et al. 2002; National Association of Children's Hospitals and Related Institutions 2009). In 2008, only 8% of hospitals offered no child abuse services. Given that these hospitals serve as training sites for 35% of all pediatricians, the quality of child abuse training has long-lasting impacts on future provider comfort with diagnosing child abuse.

The members of most academic teams include a medical director, a CPT coordinator, physicians, social workers, and allied health professionals. A smaller number of teams include fellows, forensic interviewers, psychologists, case managers, medical assistants, educators, child life specialists, and lawyers (Tien et al. 2002). Many academic teams maintain a fourfold mission: child abuse evaluation, treatment, research, and education/training (Bross et al. 1988; National Association of Children's Hospitals and Related Institutions 2009). Academic CPTs and structured child abuse programs evaluate an average of 1,061 children annually, 21 times more than children's hospitals that only provide child abuse services through a single physician or emergency department (National Association of Children's Hospitals and Related Institutions 2009). Unfortunately, the services provided by these teams are not financially valued. The median deficit of a children's hospital child abuse program is $186,000, with a range up to $1,293,000 (National Association of Children's Hospitals and Related Institutions 2009).

Community Hospital

While children's hospitals are a focus of treatment for large numbers of children with severe illness and injury, the vast majority of children who seek acute medical care do so at a community hospital. In 1997, 75% of the 6.4 million pediatric admissions were not to children's hospitals (Sigrest et al. 2003). Children under 15 years old with an injury accounted for 8,568,000 emergency department visits in 2005 (Nawar et al. 2007). Unfortunately, fewer than 10% of emergency departments nationally have a pediatric-specific unit (American Academy of Pediatrics 2001) and only 6% have the recommended pediatric supplies (American Academy of Pediatrics 2009). Since most community hospitals primarily care for adults, it is not surprising that there are inadequate resources for the care of children.

As child abuse evaluations are an even more specialized pediatric evaluation, despite the lack of literature, it is likely that very few community hospitals have any resources or expertise in the evaluation of abused or neglected children. The American Academy of Pediatrics (AAP) Section on Child Abuse and Neglect (SOCAN) lists available child abuse programs by state. Of the 248 listed programs, only 8% could be considered based at a community hospital (American Academy of Pediatrics 2011). While these are not likely all of the community hospital-based CPTs in the country, if you apply the 8% rate to the total number of hospitals in the United States (4,919 in 2004), that would leave 4,522 community hospitals without one.

The examples of community hospital-based CPTs exist primarily at larger, regional community centers like MeritCare in North Dakota and St. Luke's Regional Medical Center in Idaho. The state of California has seven community hospital-based programs, the most of any other state in the AAP dataset. Very few articles have been published describing the structure, function, or impact of community hospital-based CPTs.

In Maryland, soon after Kempe's seminal article, Dr. Robert Chabon published an article on the development of a CPT at Sinai Hospital in Baltimore (Chabon et al. 1973). This was presumably the first community hospital team in the state. Unfortunately, the team did not last past a decade and it appears that it was the only community hospital CPT in the state until 2000 (teams at the two medical schools continued to exist). In 2005, I published outcomes of the first 4 years of the Franklin Square Hospital CPT (Krugman 2005). The community hospital team provides physical abuse, neglect, and forensic sexual abuse evaluations to 350 children annually at the hospital and has served 2,000 children in 10 years. Staffed by a CPT coordinator, 24/7 social work coverage, and four pediatricians with child abuse experience, it can serve as a model for how to deliver services in other community hospitals.

Regional (City, County, State)

Since the inception of the CPT, creating a regional approach to child abuse evaluations has made sense. One of the first teams created was the Denver Child Protection Team, founded in 1974. This team linked the Denver city authorities to the Denver General Hospital (now Denver Health). As documented in the second edition of the *Child Protection Handbook*, "all cases involving suspected or known abuse in Denver County" were presented to the team (Bross et al. 1988). The goal of this team has been to provide oversight for the child protection process.

Currently, regional teams function in 12 states per the SOCAN resource list. No state has a more developed network than Florida. Under the guidance of director Dr. Jay Whitworth, the state of Florida has been divided into 15 districts and 8 sub-districts (total of 23 teams). Each region has a CPT led by a physician and supported by a core staff that includes a team coordinator, case coordinators, an attorney, a psychologist, and support staff. The prosecutor, law enforcement officer, protective services worker, and guardian ad litem for each case are considered members of the team as well. The teams provide standardized core services which include medical assessment and consultation, psychosocial and psychological evaluation, multidisciplinary staffing, treatment linkages, expert testimony, and training (Socolar et al. 2001). The statewide system includes quality assurance and peer review for individual cases as well as annual reviews for each team.

Other states such as New York, Pennsylvania, and North Carolina have developed state-wide physician training programs but do not have such an extensive network of multidisciplinary teams as Florida. Many other states have networks of Child Advocacy Centers (CAC) which can be seen as an extension of the traditional CPT and a "one-stop shop" for collaboration between physicians, law enforcement, and protective services (Reece 1992). One limitation of the CAC model has been the focus primarily on sexual abuse evaluation rather than all forms of abuse.

Rural

As expected, the majority of the rural CPT experience in the nation comes from Colorado, in which teams formed in 1974 and 44 community-based teams serve 54 rural counties. Providing child protection services in rural communities create unique challenges for professionals in the child abuse field. First, the likelihood of a given community having significant child abuse expertise is unlikely. Second, the ability to provide complete membership from every agency can be challenging, since the number of workers in each agency can be very low. Burn out can be more prevalent if the same people have to do all the difficult work all the time. Despite these challenges, rural teams can enhance service delivery to abused children and can offer support to social services agencies (Bross et al. 1988).

International

CPT development has progressed around the world. Academic-based teams and rural teams provide coverage throughout Canada. With the help of the University of Iowa, Turkey has developed an intricate university-based team that supports the country (Agiritan et al. 2009). The International Society for the Prevention of Child Abuse and Neglect (ISPCAN), founded by Kempe in 1977, provides training for the creation of multidisciplinary teams around the world. The International Training Program of ISPCAN has worked in Pakistan, South East Asia, Africa, and India.

Benefits/Evidence

The multidisciplinary approach to child maltreatment evaluations makes logical sense, but how effective are they? Theoretical benefits include missing fewer cases of actual abuse, reducing the number of unnecessarily reported cases, improving coordination with investigative authorities, and increasing efficiency of staff that would otherwise have to spend time reporting abuse and going to court. Most CPTs would anecdotally report that they provide these benefits to their institutions and communities. Unfortunately, few studies exist that corroborate these benefits.

Most reports about CPTs detail their own experience. A few studies have demonstrated that recommendations by CPTs have high concurrence with dispositions by courts. In 1989, Paluszny et al. noted that the Medical College of Ohio CPT recommended state custody of an abused child more often than their children's services board, but the courts were more likely to remove children, even when not recommended by the children's services board (Paluszny et al. 1989). A follow-up study on CPT cases by Hochstadt and Harwicke demonstrated 100% of the placement

decisions made by the multidisciplinary team were followed by local social services (Hochstadt and Harwicke 1985).

The first NACHRI study demonstrated that hospitals with CPTs provided more comprehensive documentation and follow-up of children suspected of having been abused than institutions without CPTs (Tien et al. 2002). Two modified Delphi studies have evaluated CPTs. One described the factors which make CPTs effective and concluded that interdisciplinary collaboration, provision of resources, and team collegiality were the most critical factors that lead to effective functioning (Kristin et al. 2010). A second study from New Zealand rated nine domains of effective and quality child abuse programs. The highest ranked domains were: policies and procedures that outline the assessment and treatment processes, safety and security for the child at risk, collaboration within a hospital and between external stakeholders, cultural environment in which the institution believes recognition of child abuse and neglect is an important issue, and training of providers to recognize and respond to abuse (Wilson et al. 2010).

Given the fact that a majority of CPTs are not profitable, further research will need to better delineate the benefits of CPTs in more tangible terms. One area which has not been well studied is the reduction of the liability that can occur if cases are missed. If a hospital with a CPT is more likely to recognize abuse which leads to the protection of the child and less abuse, then that child would be much less likely to be re-abused. Cases of missed child abuse, especially abusive head trauma (AHT), in which medical providers have failed to recognize the signs or symptoms of abuse have lead to successful malpractice lawsuits against those providers. The prevention of one lawsuit would fund a typical CPT for at least a few years.

Conclusion

For the past 60 years, the multidisciplinary CPT remained faithful to the initial tenets set out by one of its founders, C. Henry Kempe. CPTs provide an invaluable service around the world in the evaluation of injured and abused children by streamlining communication, coordination, and evaluation of abuse victims. While more research should be done to provide better evidence of their effectiveness, at 60 years post initiation, it remains the most effective tool to date.

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Chapter 11
Fatal Child Abuse and Neglect

Michael Durfee and Deanne Tilton-Durfee

Dr. Henry Kempe noted fatal child abuse in his 1962 publication, "The Battered Child Syndrome." In the past 50 years, the challenge of responding to child deaths from abuse has brought new research, new policies, programs, and multiagency teams. This chapter will address the history, current practice, and the future hope for preventing deaths of children at the hands of those entrusted with their care.

Precursors

French Physician Ambrose Tardieu described fatal child abuse in 1860, with painful graphic detail (Roche et al. 2005). There were social movements in response to child abuse in the 1870s (The New York Society for the Prevention of Cruelty to Children 1875), but the world of medical literature did not respond. Decades later, in 1946, Radiologist John Caffey, MD, wrote on fractures and chronic subdural hematoma (Caffey 1946; Kleinman 2006). His work was followed by others who subsequently wrote about unexplained injuries and the possibility of child abuse.

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The Battered Child

Henry Kempe noted the work of Caffey and others in "The Battered Child," with 16 of the 18 articles in his bibliography describing fractures and serious physical injury, including severe head trauma and death (Kempe et al. 1962). Two articles referenced social work, including one by Helen Boardman, an outspoken social worker from Children's Hospital Los Angeles, who involved herself in cases from the emergency room to the courtroom. Kempe's article was readable, with multiple topics including data, individual case histories, and physician resistance to acknowledging child abuse. "Many physicians find it hard to believe that parents could have attacked their children and they attempt to obliterate such suspicion from their mind" (Kempe et al. 1962).

Kempe's 1962 article was easy to miss in the precomputer paper version of Index Medicus. "The Battered Child" appeared in a list of articles addressing various children's issues. Child abuse was not specifically listed in Index Medicus until 1965 (Durfee et al. 2009).

Dr. Kempe included two surveys to obtain national numbers on child abuse, with 302 cases from 71 hospitals and 442 from district attorneys. Both of these surveys found many children with fractures and both had more than 10% fatality. This national fatality data was sadly unique. Dr. Kempe spoke of four severely abused children in his hospital at the same time. Two died. One went home and was abused again and died. These three child deaths and the failure to protect them could have been hidden to preserve the hospital's image, but they were shared to help us learn.

Literature Can Reflect the Limitations of Writers and Readers

Missing topics – child abuse was added to the paper index of the 1965 edition of Index Medicus, 102 years after Ambrose Tardieu's vivid descriptions of children's injuries and 3 years after Henry Kempe's "Battered Child Syndrome." The 1960s brought laws on child abuse. Incest was indexed in 1968 and was followed by child sexual abuse programs in the late 1970s. Infanticide, the killing of a child, was indexed in 1970 (Durfee et al. 2009) and was followed years later by child death review teams.

News media covered the topic of fatal child abuse in 1987 with the death of Lisa Steinberg. Lisa died from beating by a caretaker attorney who also battered his female partner. Joel Steinberg took custody of Lisa when asked to find her a home. The case included substance abuse and domestic violence and received massive press.

An informal ICAN study using Google Internet news alerts notes a growth of fatal child abuse newspaper articles in the 1990s. Almost all deaths were covered by female reporters. Several were Pulitzer finalists and one was awarded the prize. By the turn of the century, male reporters began to write of fatal abuse. Television news joined print media. Fatal family violence was officially of interest. News stories in

this century began a focus on failures by child protective services agencies. Line staff and department heads were blamed for inadequate case management resulting in a child's death.

A National Report Moved the Process

In 1995, the US Advisory Board on Child Abuse and Neglect, then chaired by Deanne Tilton Durfee, issued a report after 21/2 years of hearings in 10 states. *A Nation's Shame: Fatal Child Abuse and Neglect in the United States* noted that more children die from child abuse than from auto accidents or drowning, falls, or poisoning, and that 90% of the victims were under 4 years of age (USDHHS 1996). In addition, the number of such deaths was seriously underreported. The Board concluded that at least 2,000 children die each year, or some 5 each day.

The Advisory Board reported on incomplete data collection, inconsistent tracking of cases, and inadequate accountability among the law enforcement, medical, and child protection agencies responsible for investigating and managing child deaths. The Board also pointed to unresolved differences in terminology used to describe manner and cause of death, outmoded investigation and reporting practices, and the failure of any powerful leader to take on this "crisis." The Board issued 26 recommendations, including calling for a national commitment at the highest levels to understand the scope and nature of fatal child abuse and neglect. The Board recommended the establishment of local and regional teams for states as well as teams for Indian Nations and the Military (USDHHS 1996). The release of *A Nation's Shame* was covered by scores of local and national media, and demand for the report soon exhausted the supply printed by the Department of Health and Human Services.

The call for a national commitment at the highest levels fell on unresponsive ears. The Administration issued no formal response and, in fact, disbanded the US Advisory Board soon after the release of *A Nation's Shame*.

The Advisory Board's call for child death review teams in every state did seem to inspire a response. By 2001, all 50 states had formed child death review teams, primarily through the efforts of individuals and groups volunteering their efforts (Durfee and Tilton-Durfee 1995; Durfee et al. 2002).

History of Child Death Review Team Formation

The first child death review team structure was created by Michael Durfee, MD, in 1978, after several years of gathering case information from hospital and coroner records. The initial motivation came from several failures to gather follow-up on children seen in medical school who faced possible death for medical or surgical reasons. It became clear that this was not work to pursue alone. A public health nurse joined

the initial process. This was painful but compelling work. Most of the original structure continues today in 1,000 teams in at least 10 nations (Durfee et al. 2009).

The first meeting involved the Los Angeles County Interagency Council on Child Abuse and Neglect, ICAN. Agencies were resistant to meet on child death, but representatives came in response to a request by ICAN Director Deanne Tilton. After the first meeting, many of them stayed until they retired. San Diego County formed the second team in 1982. Other California counties were followed by Oregon, Boone County Missouri, and South Carolina. A requirement to participate in such review was for each agency to share what they knew about scheduled cases. Local teams may have begun with agencies gathering for a notorious case, but with time, teams shifted their focus to prevention of intentional and non-intentional injuries.

Child Death Review Has Expanded Our Perspectives

Often, the perpetrator of fatal abuse is not whom we would expect. A baby was taken out of his playpen by a 7-year-old sibling and holding hands they spun around until the sibling lost his grip and the infant's head hit the wall. The boy was not a suspect until he confessed to a mental health professional.

The importance of expert medical examiner involvement in the investigation of fatal child abuse was illustrated in a case where timing of a toddler's death changed the suspect away from either parent to the babysitter who was caring for him at the time of death.

The lack of teamwork and interagency communication can result in needless tragedy. Had the police officer and social worker separately investigating a neighbor's reports communicated, they would have realized that neither had asked to see the 4-year-old who was bound and gagged in a cubbyhole near the door. His last words were "me no breath."

One of the most compelling lessons from the review of child abuse fatalities has come from realizing the trauma and grief that surviving children experience. In one case, five siblings watched abuse of a 5-year-old brother and 2-year-old sister, and then were forced to help the father bury them in shallow graves. The traumatized survivors received counseling, but struggled a decade later.

Domestic violence is often accompanied by severe and fatal child abuse and neglect of children caught in the crossfire. One abusive father asphyxiated his five children after videotaping their goodbyes to their mother, who had threatened to leave him.

Mission

The child death review team process was designed to share information and resources among agencies, disciplines and jurisdictions to improve prevention of fatal child injury, and to improve intervention and case management following child deaths.

Process

The central process is driven by the distress that professionals feel with the death of a child. A common practice is to review cases one at a time, connecting separate fragments of case data into the story of a child's life and death. Senior staff may be added, but the work involves observations and actions from individuals on or near the line in multiple professions. Victims of fatal abuse tend to be young. The National Child Abuse and Neglect Data System survey of social service data systems found 80% of fatal cases were under age 3 (USDHHS 2009). Agencies learn to work together with young children and intervene before death with future cases. The review of these cases provides tools for prevention with a focus on infants, toddlers, and a potential focus on high-risk pregnancies. The team experience can provide material and direction for future training, policy, and programs. The process can promote more effective case management, assure accountability, and address intentional and non-intentional child injuries.

Teams may disagree on their primary task. Some would address management of the death. Others would only want prevention of future deaths. Another split may be between professionals who work in offices and those who "knock on doors." The latter group includes law enforcement, CPS, PHN, coroner investigators, and home visitors. With time and experience, the degree of separation can decrease. Criminal justice professionals have been valuable in the creation of prevention programs. Public health, social services, and mental health can assist with investigation (Durfee et al. 2009).

Membership

Most teams seem to have similar membership with a core from law enforcement, CPS, health, public health, civil and criminal attorneys. Some teams add schools, mental health, clergy, child advocates, and domestic violence program advocates. Case review is one case at a time to hear the story of the child as a person. Some add 911 audiotapes and photographs. Teams from other counties or states may share cases that cross jurisdictions.

Multiple agencies may have a different motivation to attend death reviews, knowing that a child on their caseload could die. Case managers, who are close to a child, may have particular distress. This may be particularly true for line staff from multiple agencies may have a different motivation who have touched a child and physically and socially interacted with them (Durfee et al. 2009).

Case Data

Data systems have been part of the process since creation of the first teams. San Diego in 1984 used age data to compare their homicide cases with Los Angeles and changed their focus to infants who may have been missed. Data systems are

complicated by the use of different terms: Coroners and law enforcement use the word *homicide* with similar definition. CPS uses *child abuse/neglect fatalities*. Courts add *manslaughter* and *murder*. Coroners and public health add the terms: *undetermined, intentional, unintentional, accidental*, and *pending*. It is important for team members to use all of them in the appropriate context (Alexander and Case 2009; Leeb et al. 2008).

Records for one child death may exist in different counties or states. For example, a child from Maryland with a history of neglect is injured while visiting in Virginia. The child could be transferred to Washington DC for medical care where the child dies. Maryland may have CPS records. Law enforcement files their investigation in Virginia. Medical records and Coroner Medical Examiner files are in Washington DC. Other records may be of value, particularly health records for birth, well-child care, injury, and lab studies, including x-rays. Records of medical treatment for injuries to siblings and parents may be indicative of previous abuse or domestic violence.

Complex Cases

Fatal child abuse can include multiple types of family violence and cross professions and jurisdictions. Connecting agencies for these cases creates relationships of value for other issues. An infant death following 35+ agency contacts motivated the LA County Child Death Review Team to create a multiagency Family and Children's Index (FCI) to help connect multiple agency records (ICAN 2004a, "Family and children's index").

Investigation

Some child abuse investigators want the benefit of the team review as part of investigation. Charleston, South Carolina, tries to review child deaths within a week, with multiagency line staff from the death scene. Other teams may delay review for up to a year to separate review from investigation.

Multiagency/Multijurisdictional Working Relationships

New England states have joined to share resources and cases. The Southern states created a large group with multiple states. Both networks exist today. Rural counties gather in regions (e.g., the Texas Panhandle) with different jurisdictions meeting and learning to work together. Texas gathered all teams in an annual meeting that helped new counties join the process.

Protocols

There is a growing literature on fatal and severe child abuse, but few protocols on investigation of child death with criminal justice literature focused on adult victims. Exceptions include a few texts that address multiple themes (Alexander and Case 2009). One exception is Sudden Unexpected Infant Death Investigation Protocols created by the CDC and the National Association of Medical Examiners, NAME (CDC 2011). These protocols include training for agencies working together on these cases.

Other Forms of Death Review

Domestic Violence Fatality Review, DVFR, began with support from the criminal justice system. DVFR has spread to multiple states and Canada (NDVFRI 2011). Elder Abuse Fatality Review teams (Steigel 2005) may also address Dependent Adult Fatalities Review. Fetal Infant Mortality Review, FIMR, is a public health concept that uses data and history of natural deaths to improve fetal/infant health (Koontz et al. 2004). These programs also spread in the past few decades.

The Future

Data systems will integrate child and family data with data on criminal justice, domestic violence, birth, and well-child records, including records from separate jurisdictions. The ICAN California Hospital Network will connect hospitals to local Child Death Review teams.

Domestic Violence Fatality Review, Nonfatal Severe Child Injury Review, and Child Fatality Review will be connected. These practices are underway today in separate teams that can share models. Regions including New England and South Eastern States will connect child death review teams with each other. Teams learn from each other.

Grief support is growing. We are learning to identify and serve survivors. Specialized programs can serve children who survive fatal family violence but suffer from traumatic loss and grief. The effects of managing these tragic cases can also lead to professional stress. We will expand our management of professional trauma (ICAN 2004b, “Issues”).

Prevention

The review of infant and toddler victims provides an opportunity for multiple agencies to work together with young victims. These relationships can be used for early

intervention and prevention programs, including Safe Surrender, Safe Sleeping, Don't Shake Your Baby, Back to Sleep, and education on healthy pregnancy and parenting skills. Child Death Review Teams have helped with laws and programs for pool safety, fire safety, and grief counseling for child survivors.

Nonfatal severe child injury programs, including the ICAN California hospital network, are connecting to Child Fatality Review and programs for intervention and prevention. Children shouldn't need to die before we recognize their vulnerability and act on the insights and information we have learned from child death review. We will expand our focus on friends, family, and neighbors who provide the first defense for children long before agency intervention.

Summary

"The Battered Child Syndrome" brought us a study that was ahead of its time with medical findings, a broad spectrum of key issues, and candor in describing resistance to reporting child abuse and neglect. Henry Kempe provided important lessons for our current efforts to identify and review child abuse fatalities.

In the 50 years since publication of Dr. Kempe's landmark study, we have learned about the importance of data systems to measure our response and effectiveness, the nexus of domestic violence and child abuse, and the importance of health-care systems in the identification, tracking, and reporting of suspected child abuse and neglect. We have identified the need for grief support for children who survive fatal family violence, and the need to extend team review to nonfatal severe injuries. Most importantly, we have learned the importance of involving multiple agencies, individuals, and professions working together.

We are honored to be a part of this tribute.

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Chapter 12
Taking the Wrong Message: The Legacy of the Identification of the Battered Child Syndrome

Michael S. Wald

Perhaps the largest legacy of The Battered Child Syndrome (BCS) was to draw national[1] attention to the problem of child abuse. It led directly to the passage of child abuse reporting laws in almost all states, which resulted in a dramatic increase in cases reported to child welfare agencies and the transformation of the child welfare system. In 1967, approximately 10,000 cases of child abuse or neglect were reported to child welfare agencies. By 1975, nearly 300,000 cases were reported (Waldfogel 1998).[2] Today more than six million children are reported to a child protection agency each year, over 8% of all children in the United States (USDHHS 2010). Over the past 50 years, the reach of the child protection system has been greatly expanded to address situations far removed by those identified in the BCS.

While publication of the BCS brought a new focus on a critical problem—severe and repeated abuse of children—I believe that the net impact of expanding the scope of the child protection system has not been beneficial to most children who experience inadequate parental care that significantly effects their development. First, as discussed below, there is little reason to believe that the majority of children reported

[1] My discussion focuses on child protection in the United States. The BCS also influenced policy and programs in many other countries. Many of these countries are experiencing problems similar to the ones I describe with respect to the US system (Lonne et al. 2008).

[2] While reporting increased, the number of children under state supervision did not change dramatically at this time. In the 1960s, there already were several hundred thousand children in foster care. They came to state attention in a variety of ways, especially the actions of social workers supervising families receiving Aid to Families with Dependent Children and requests from parents who could not care for their children, often due to poverty. The large numbers of children placed in foster care, often for lengthy periods, constituted a situation of great concern to many commentators (Wald 1975, 1976).

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to CPS benefit as a result of CPS intervention. Moreover, in terms of public policy related to parents and children, parenting has been divided into two categories—acceptable and maltreatment. While the child protection system (CPS) is responsible for responding to inadequate parenting that is considered maltreatment, no system has *responsibility* for dealing with inadequate parenting that does not constitute maltreatment. While it is recognized that children may need more from their parents than is provided by many "acceptable" parents, federal and state policies try to promote the well-being of most children through programs that are voluntary in terms of whether parents choose to use them, for example, Head Start. These programs promote the development of many children. However, these services do not reach a significant proportion of the children and families that need them the most and they generally are not well designed to help children living in very poor, disorganized families. As a result, many children in these families receive few needed services and evidence significant developmental deficits as children and into adulthood.

This dichotomy does not make sense in terms of protecting and facilitating children's basic development. It has led to inappropriate and inefficient use of resources and poor program design. As a result, while children now receive somewhat more protection from severe physical abuse, the great majority of children who experience seriously inadequate parenting fail to receive needed support. In this commentary, I will discuss why the CPS system should be focused on the types of harms to children identified by Dr. Kempe and his coauthors in the BCS and Dr. Kempe's later publication "Sexual abuse, another hidden pediatric problem," and outline why a new approach is needed to meet the needs of other children whose futures are seriously compromised because they receive highly inadequate parenting.

The BCS Message

In the BCS, Dr. Kempe and his coauthors were concerned about two things:

- Situations that could result in death or severe injuries to children.
- A pattern of parental behavior that made it highly likely that the harm would be repeated. That was the essence of identifying it as a syndrome, that is, a repeated series of injuries caused by parental actions toward the child.[3]

Kempe argued that parents who inflicted such injuries had serious psychological problems that generally were not amenable to treatment, at least given the knowledge base for treatment at that time, and therefore that most interventions should

[3] The situations identified in the BCS largely involved children less than 12 years of age; most cases involved infants and toddlers and my analysis of the current situation focuses largely on younger children.

lead to removal of the child.[4] These factors made the need for protective intervention essential, undebatable, and reasonably focused. The parental behavior clearly deserved the label abuse or maltreatment and using the term helped focus public policy in an appropriate direction with respect to these type situations.

The Response

The publication of the BCS helped spawn a variety of responses that transformed the child welfare system. The central response was to greatly expand the reach of the system through the passage of reporting laws. Initially, the focus was primarily on physical abuse. Prior to the BCS, physicians had generally assumed that virtually all injuries to children, even repeated ones, were caused by accident and rarely alerted police or child welfare agencies about the situation. To deal with this situation, nearly all states passed laws requiring physicians to report suspected cases of physical abuse to child welfare agencies.

The BCS also generated enormous growth in the number of people and organizations focused on threats to children. The interests of this expanded constituency extended beyond physical abuse; there was concern for any situations thought to involve potential harm to children. As a result of the efforts of multiple groups, in 1974, the US Congress enacted the Child Abuse Prevention and Treatment Act (CAPTA). CAPTA offered states funds to deal with child abuse, conditioned upon changes in state policies. A critical provision was that to receive federal support for its child protection system, the state must establish a system for investigating reports of neglect and serious harm to a child's *emotional or academic* well-being caused by parents or primary caregivers, as well as physical abuse.[5] All states complied with these standards; they also, over time, significantly expanded the categories of professionals required to report cases of suspected abuse or neglect. In addition, CAPTA created the National Center on Child Abuse and Neglect (NCCAN), which gave added impetus to expanding the reach of the child protection system.

[4] While knowledge regarding treatment has expanded greatly, there still is not much evidence on how to successfully work with parents who severely abuse young children.

[5] Other factors also contributed to the increased focus on maltreatment, including the emergence of a children's rights movement in the 1960s and the increased legalization of the juvenile justice and child welfare systems as a result of several US Supreme Court decisions. However, there were, even at that time, substantial debates about the definition of abuse and the role of the child protection system. These were reflected in the work of a major project established in 1972 by the American Bar Association and the Institute for Judicial Administration, the Juvenile Justice Standards Project. I was the reporter for a volume of that project that focused on Standards Related to Child Abuse and Neglect. Due to the debate over the appropriate scope of intervention, the proposed Standards Related to Abuse and Neglect were the only standards not adopted by the ABA. These debates are discussed in two law review articles that I wrote at that time (Wald 1975, 1976).

Second, many states and counties reorganized social welfare services in response to the new laws. Prior to the late 1960s, most states and local jurisdictions had a single child welfare department or agency. The focus of these agencies, at least theoretically, was on children's overall well-being, not just protection from injuries. Staffed by social workers, the agencies provided support to low-income families, including Aid to Families with Dependent Children, and voluntary services, including foster care, to families that were having difficulty caring for their children, as well as handling cases of child abuse or neglect (Costin et al. 1996). Beginning in the late 1960s, many states and counties established separate child protective services units, even agencies, charged with investigating reports of abuse, bringing court proceedings, and providing services and monitoring to prevent further abuse.[6] These units generally could not provide economic or other forms of hard services, however.

Third, CPS agencies were encouraged to provide services on a relatively short-term basis, with the primary focus being on trying to prevent the types of injury or harm that triggered involvement (Wald 1976; Wulczyn et al. 2005). While the scope of intervention expanded, CPS agencies lacked the mandate, the resources, and the trained personnel required to provide services to families focused on promotion of the child's emotional, social, or academic development.

Where We Are Now

Over the past 50 years, the reach of the child protection system has continued to expand, with the "discovery" of sexual abuse in the late 1970s, the impact of the "crack epidemic" in the late 1980s, and a new focus on domestic violence and educational neglect in the 1990s and early 2000s (Waldfogel 1998; Child Trends 2008). In recent years, CPS agencies have investigated allegations involving over 3,000,000 children each year, nearly 4% of all children. In 2009, approximately 700,000 children, about 1% of all children, were found to have suffered from maltreatment, as defined under various states' laws (USDHHS 2010).

These are annual numbers. Cumulatively, as many as 15% of all children born in the United States may be reported to a CPS agency at some point before their 18th birthday (Putnam-Hornstein and Needell 2011; Sabol et al. 2004). Unfortunately, for children from poor families and particularly from poor African-American families, that number goes up dramatically. Recent studies in California and Cleveland, Ohio, found that over 30% of African-American children were reported to CPS at some point before age 10 (Putnam-Hornstein and Needell 2011; Sabol et al. 2004).

While the BCS focused on a very specific type of harm—severe physical injury inflicted by a parent/caretaker—such injuries constitute only a small fraction of

[6] This change also was due in part to changes in the administration of the Aid to Families with Dependent Children program (Courtney et al. 2008).

cases reported to CPS (USDHHS 2010).[7] At present, approximately 18% of substantiated cases involve physical abuse; only a small portion of these cases represent situations where the child has been abused in a manner that caused death or significant bodily injury or created a significant risk of such harm.[8] Approximately 10% of substantiated cases involve sexual abuse. Most reports involve neglect, a broad concept involving various types of potential harms to children.[9] While neglect may lead to severe physical harm and even death—one-third of maltreatment deaths involve only neglect (USDHHS 2010)—the primary threat to many of these children relates to their academic, social, and emotional development over a long period of time, not their immediate physical safety (Chap. 8, Garbarino, this volume; Kaplan et al. 2009).[10]

While the scope of intervention has increased, it is not clear what each state is trying to accomplish through its maltreatment laws. There is great variation in level of reports, substantiations, and provision of services among the states. The rate of substantiated maltreatment per 1,000 children in the population varies from 31.7 in Massachusetts to 1.2 in Pennsylvania (Fig. 12.1).[11] Children are not 25 times more likely to be maltreated, or receive inadequate parenting, in Massachusetts as in Pennsylvania. There seems to be a very weak correlation between the level of reporting or substantiation in a state and the known risk factors for maltreatment that are present in that state (such as poverty rate). For example, many states with the highest percentage of poor, young, low-educated parents have lower reporting rates.

CPS Intervention and Children's Well-Being

Unfortunately, there is relatively little research on the impact of CPS intervention on the development of children, especially children who are not placed into foster care. Certainly in 1962, many children lived in dangerous situations that were not brought

[7] This has been true since the 1960s (Wulczyn et al. 2005).

[8] This is evidenced, in part, by fact that less than 10% of substantiated cases of physical or sexual abuse lead to removal of the child (USDHHS 2010). The greatest threat in most physical and sexual abuse cases is to the child's emotional development, rather than their physical well-being.

[9] Neglect is also present in some physical and sexual abuse cases. The focus on neglect in the United States is very different from other countries, where physical abuse cases constitute the majority of interventions, perhaps because these countries have a greater social welfare safety net (Waldfogel 1998; Trocme 2008).

[10] Neglect can also lead to physical health problems and there is increasing evidence that highly stressful home environments can cause damaging brain changes (Center on the Developing Child 2007).

[11] The rate in Pennsylvania reflects the fact that its' reporting law includes only serious abuse. However, under a separate law, state agencies do deal with thousands of cases of "general neglect." The reasons for variation among other states has not been studied, but likely relate to value choices, the structure of reporting laws, resources, worker training, and a variety of other policies and practices.

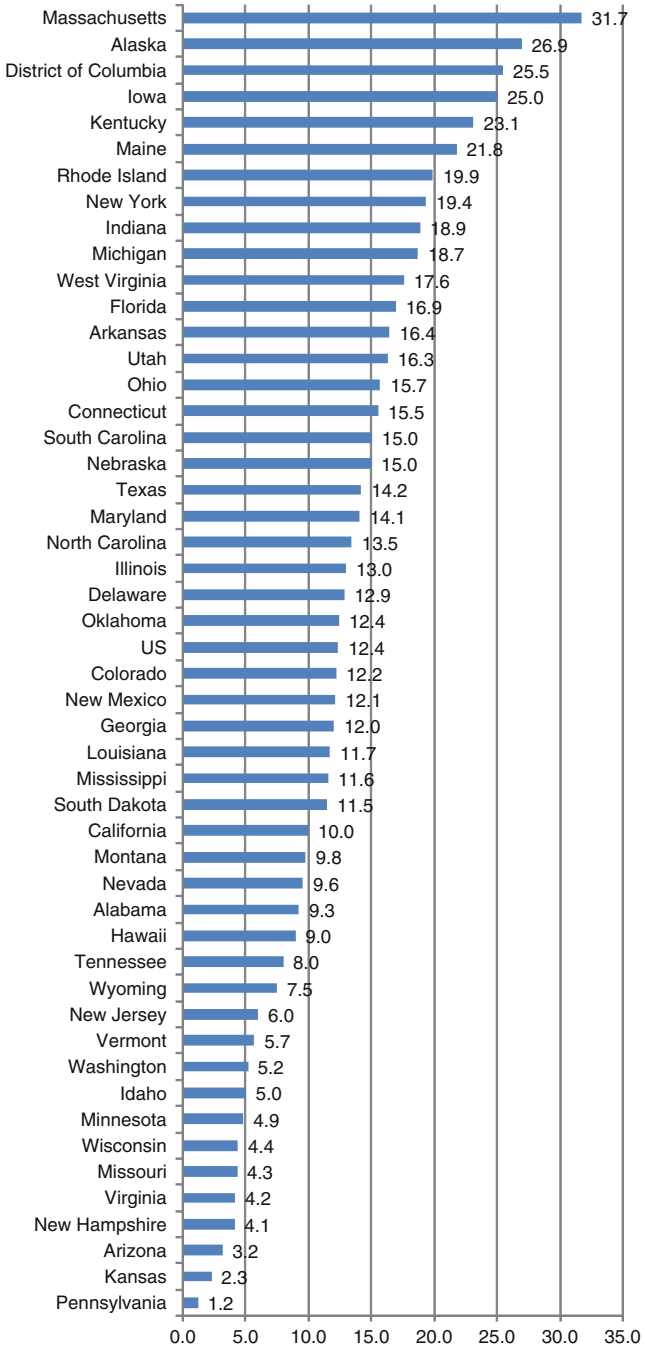

Fig. 12.1 Child maltreatment victims aged 0–5 per 1,000 population in FFY 2009, by state (Source: Child Trends: Early childhood highlights, Vol. 2, Issue 2, April 29, 2011)

to the attention of child welfare agencies. Although it is unclear whether there has been a significant decline in the number of children who die or are seriously injured as a result of intentional actions by their parents,[12] it seems likely that many children who have been seriously physically abused or sexually abused are helped by the CPS intervention. At least a portion of the children who are at very high risk of continued abuse are removed permanently from their parents and successfully adopted (Lloyd and Barth 2011). In cases where the children are not removed, some of the children receive mental health counseling or other services, and most abused children are not re-reported following CPS intervention. Although the causes are not clear, the rate of physical abuse and sexual abuse reports has been declining steadily since the early 1990s (Finkelhor and Jones 2006; Child Trends 2008).

In contrast, neglect cases have increased. Yet, there is little reason to believe that children brought within the ambit of CPS for reasons other than the threat of physical harm or sexual abuse benefit as a result. In terms of outcomes, most research has focused on whether investigation or services prevented the recurrence of the reported maltreatment. Various studies have found that between 20% and 40% of families get reported again (Fluke et al. 2008); the rate is highest with respect to neglect. The evidence is mixed on relationship of services to re-reporting. Some studies find reduced re-reporting when the parent received services; others find higher rates. But in the latter situations, higher re-reporting may be due to increased surveillance (Fluke et al. 2008). There also is evidence that in cases where children have been placed in foster care and then reunified with their parents, the parents had not appreciably changed their parenting behavior at the point of reunification, despite receiving services.

Most of these studies do not, however, provide information on the condition of the children, neither of those children reported again or those not re-reported. The majority of children reported to CPS have developmental problems, which may have started years before CPS involvement (Wulczyn et al. 2005; Barth et al. 2008). Several longitudinal studies have found that the long-term development of children reported to CPS agencies is considerably worse than the development of children from similar socioeconomic households and neighborhoods who have not been reported to CPS, in terms of emotional health, school achievement, and problem behaviors (Lansford et al. 2002; Hussey et al. 2005; Mersky and Topitzes 2010), indicating that the poor parenting adversely affected these children and that being known to CPS was not sufficient to prevent bad outcomes for many children. Moreover, the limited research that does look at children's development

[12] Unfortunately, as with many other aspects of the child protection system, there are no comparable data over time. There have been large declines in injury death rates of children over the past 40 years. The number of children who are found to have died as a result of maltreatment each year has varied over time, generally between 1,500 and 2,000 children each year. However, many more states now review child deaths to determine the cause, so the likelihood of uncovering and labeling maltreatment-related deaths has increased. The fact that the overall number of deaths attributed to maltreatment has remained relatively steady may indicate, therefore, that there has been an actual decline in maltreatment-related deaths, not just in accidental injury deaths.

following active CPS involvement finds that children who receive services do not generally fare better than those who do not (Waldfogel 2009a). This raises questions about the utility of services, although it is possible that services are provided primarily to more difficult cases. There are clearly some very good services being provided to some of the children and parents in various CPS systems. However, given that a large percentage of the parents and children receive no services,[13] and that when services are provided they are generally neither intensive nor lengthy (Waldfogel 2009a), it would be surprising if CPS involvement did alter the development of the majority of children who come to the attention of CPS.

The Limits of CPS

Clearly, the scope of CPS system has moved far beyond the focus of the BCS. I believe that categorizing most of the inadequate parenting that now comes to the attention of child protective services is conceptually wrong and counterproductive in terms of protecting children's basic development. The concept of *maltreatment* does not adequately reflect the nature of the parental behavior that brings many families to the attention of the system. Most of these parents are not intentionally doing things that hurt their children—such as severe physical treatment or using them as sexual objects. In most situations, it is not a specific action, or even inaction, such as lack of supervision, which substantially impairs their children's development. Rather, the harm comes from the stress and inconsistency in the home environment, the failure of the parent to respond in a minimally adequate manner on an everyday basis to the child's physical and emotional needs, to make the child's needs central to the parent's daily lives, to interpret the child's behavior accurately, and to employ behaviorally competent actions in a relatively automatic manner.

Generally, these parents are highly disorganized or "chaotic" in their parenting (Ackerman and Brown 2010; Fiese and Winter 2010) and unable to put their child's needs above their own needs. They often suffer from depression or other mental health problems, experience high levels of domestic violence, and many abuse drugs or alcohol. They are extremely poor, often live in the most isolated parts of the communities where the least resources are available to them, the children go to the worst schools, and they have limited access to health services, all exacerbating the impact of the limited or negative parent–child interaction (Coulton et al. 2007).

CPS involvement is not likely to lead to the types of responses necessary to alter their behavior and situation. Conceptualizing the parents' behaviors as maltreatment often focuses interventions on factors, such as the physical quality of the home or not leaving children unattended, that fail to address aspects of the parent's behavior

[13] In recent years, more families are getting services, largely through differential response systems. See discussion below.

and situations that are the real threat to the child's development. Helping many of these parents acquire the skills necessary to meet their children's basic development requires very intensive, high-quality services, delivered over a lengthy period by well-trained professionals. Many parents need to be motivated to accept and continue in intensive services, especially when these services do not include material support or the other resources they need in order to cope with the context in which they are forced to raise children.

CPS is not going to be made into a system that does this. Although the CPS system theoretically is not based on blame, and many workers try to offer support as well as services, in fact, blame is often in the minds of the parents, the community, and many workers when a child is labeled maltreated. Being labeled as abusive or neglectful often undercuts parents' willingness to make the necessary commitments (Lieberman 2008; Drake and Jonson-Reid 2007). Labeling these parents as neglectful also may influence community willingness to invest the necessary resources needed by the parents.

Moreover, CPS systems in the United States experience great difficulty in helping the seriously endangered children who are currently in the system; the same is true in other countries, which I believe reflects the difficulty of designing a positive system focused on maltreatment (Lonne et al. 2008). The deficiencies have been well documented; I will just point out some major issues. Of central importance is the fact that CPS agencies do not control the health, education, financial, and other community resources needed to work with these families. Few, if any, child protection systems are able to provide high-quality services that are needed by parents and children in poor, disorganized families (Wulczyn et al. 2005). In fact, many families receive no services at all. While some children benefit from out-of-home placement, the poor quality, instability, and length of foster placements remain a major problem, despite large expenditures on foster care (Lloyd and Barth 2011). In addition, child welfare agencies have trouble hiring and keeping qualified staff, creating adaptable organizational structures, keeping leadership, and maintaining political support.

The difficulties experienced by CPS agencies are not surprising given the vast increase in caseloads, shifting legislative mandates, and the challenges presented by many of the families. This situation is highly unlikely to change significantly. There is no realistic prospect of budget increases to child protection agencies sufficient to allow them to provide the needed services. As a practical matter, CPS agencies are competing with schools, preschool and afterschool programs, and health-care organizations for public funds targeted at supporting children. There are not enough resources to fund all of these demands. This is true at the local, state, and federal levels. In most states, there is not much room in the budget to reallocate significantly more resources for children.[14] It is unlikely that most political leaders will support

[14] In California, for example, general children's programs, primarily schools, account for more than half the state's budget, and medical care for the poor absorbs another 25% (California Department of Finance 2008). Everything else competes for what is left.

the level of resources needed to develop high-quality programs targeted at preventing maltreatment, which will be seen as affecting only a small portion of children (Wald 2009). Nor will they mandate integrated approaches among multiple systems, guided by the CPS.

There have been improvements in CPS in recent years. Some of the current efforts at system reform, for example, the use of risk assessment protocols and structured decision-making to achieve greater consistency and focus in making decisions regarding interventions, attempts to improve and monitor service delivery through mechanisms like quality service reviews, better use of data to establish and monitor outcomes, and greater involvement of extended family in decision-making and services may help improve outcomes for some families. Conceptually, these reforms may make sense for dealing with situations that belong in a protection system—situations where children may need to be removed from their families or provided protective supervision to prevent serious and imminent harm. But they are not going to produce the types of services and relationships needed to alter other types of inadequate parenting.

One concern about reducing the reach of the child protection system is that, in the absence of other ways of identifying "high risk" families and moving them toward services, limiting CPS would leave many children at risk of serious harm. In part to address this concern, and to provide services to more families who would otherwise not receive services, at least 20 states have developed a two-tier system, often called differential response (Waldfogel 2008, 2009b). Under differential response, reported cases that involve less risky situations are not just closed. Instead, these families are referred for "voluntary" services. While the services generally are provided by community agencies, not the CPS agency itself, reports to the child protection system serve as means of identifying families needing services and allows for surveillance, as well as for the provision of different types of services than CPS provides.

While it is too early to assess these efforts fully, I have substantial reservations that differential response approaches can adequately address the needs of the children and parents I am discussing. Most seem targeted at less difficult family situations, with less disorganized families.[15] The services generally are not of the necessary intensity to work with highly disorganized families. In addition, differential response does not create a *system* for helping these families. Instead, it generally consists of referrals by CPS to a range of local programs that may vary greatly in quality, approach, and effectiveness. A system, by which I mean a programmatic response with a dedicated funding stream, clear mandates regarding outcomes, and clear criteria for who is served, is needed to reach hard-to-serve families with multiple needs. Having a system with responsibility for working with an identified population of families, rather than referrals in a nonsystematic manner to a disparate

[15] The vast majority of cases referred to alternative response systems involve families where it has been determined that the child is not a victim of maltreatment (USDHHS 2010; Waldfogel 2009b).

group of local agencies, greatly increases the likelihood that that there will be a consistent theory of service provision, development of performance standards, accountability measures and regular monitoring, and consistent data collection and evaluation, all key elements in providing effective services.

Conclusion

It is now 50 years since the work of Henry Kempe and his colleagues helped generate thinking and debate about the role state policies and programs should play in protecting children and promoting their basic development. While there has been significant progress in protecting children from sexual abuse, and perhaps severe physical abuse, as noted above, as many as 15% of all children will be reported as maltreated at some point during their childhoods. Many more children live in similar households with respect to quality of parenting but do not come to the attention of CPS (USDHHS 2009).

It is time for a new national (and international) discussion of how societies can best protect the basic safety and development of children. I believe that the debate should focus on at least three issues. First, it must be decided what outcomes, besides physical safety and freedom from sexual abuse, society should try to guarantee for all children *through policies related to parenting.* For example, society might want to try to insure a focus on the types of parenting that greatly increase the likelihood of a child dropping out of school, becoming incarcerated, or suffering serious emotional or behavioral problems. Second, the means of reaching these outcomes must be examined. Addressing inadequate parenting will be one, but not the only factor. Third, it must be determined how to best provide high-quality services to families where there is evidence of very poor parenting that has resulted, or is highly likely to result, in these outcomes.

In exploring these questions, it is necessary to think through the implications of the fact that one in every five or six children are now reported to CPS. What is occurring in our society that results in so many parents being considered as abusive or neglectful? The United States, relying primarily on CPS, has not made a serious dent in reducing highly inadequate parenting over the past 50 years. It is time for a new approach.[16] Were he alive, Henry Kempe would be leading the charge to think through this approach.

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[16] In a forthcoming piece, I will propose a new approach for helping children in other families where there is very inadequate parenting, including many of the cases of neglect that now dominate the child protection system.

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Chapter 13
Mandated Reporting Laws and Child Maltreatment: The Evolution of a Flawed Policy Response

Natalie K. Worley and Gary B. Melton

The child protection system has reached a milestone anniversary, namely, the "discovery" of the battered child syndrome by pediatrician C. Henry Kempe and his colleagues 50 years ago (1962). As is customary with any anniversary, it is a time of reflection on all that has transpired in the years between then and now. Kempe et al.'s groundbreaking work on child maltreatment had a reverberating impact on child protection in the United States and internationally. The *JAMA* article and subsequent advocacy led directly or indirectly to the establishment of *Child Abuse and Neglect: The International Journal*, the founding of the International Society for Prevention of Child Abuse and Neglect, the creation of a grassroots national and global movement for prevention of harm to children, and perhaps most significantly, the adoption of mandated reporting laws in all US jurisdictions and many other countries. Despite these legal mandates to report and an increased awareness of the prevalence of child maltreatment, we continue to fall far short of Kempe's vision of protection of the most vulnerable children (Sege and Flaherty 2008).

Flawed Assumptions Lead to a Flawed Response

Many in the field of child protection argue, in fact, that Kempe et al.'s well-intentioned but largely erroneous conclusions have contributed to the current failure of child protection efforts (Kalichman and Brosig 1992). In hindsight, it is easy to

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see how flaws in Kempe et al.'s early assessment of the cause and scope of child maltreatment led to an oversimplification of the problem and an inadequate policy response. Kempe and his colleagues grossly underestimated the prevalence of child abuse and neglect. As a result, policymakers initially determined that the problem could be fully identified and addressed with existing resources—in effect, that the problem was case-finding (Melton 2005). From this erroneous starting point, policymakers developed vague and inconsistent statutes designed to mandate a broad range of professionals to report suspected cases of child maltreatment. Rather than detecting a narrow band of cases for early intervention, this system of mandated reporting has resulted in a child protection system so overburdened by the requirement to investigate reports of suspected child maltreatment that it is unable to respond adequately to genuine needs. By largely absolving professionals and communities of the responsibility to keep children safe (in effect, to do more than report), the evolution of our current system falls far short of fulfilling Kempe's intended objective.

Relying on surveys of prosecutors and emergency room administrators, Kempe and his colleagues declared that child maltreatment affected somewhat more than 700 children annually in the United States, a calculation which, we now know, woefully underestimated the actual scope of child abuse and neglect in this country. During 2009, 3.3 million referrals of alleged maltreatment were received by child protective service agencies; more than 700,000 children were confirmed through CPS investigation to be victims of abuse and neglect, a rate of 9.3 victims per 1,000 children in the population (U.S. Department of Health and Human Services 2010), but only a fraction, even of children subjected to severe abuse, as reported by their mothers (Theodore et al. 2005).

By themselves, these data describe a malfunctioning system. As Lukens (2007) asked, "Can a reporting system designed to protect children be adequate when it is not only incorrect 66% of the time, but [also] fails to identify a significant number of incidents where children are mistreated?" (p. 180). Although Kempe properly receives credit for his prominent role in originating a worldwide movement focused on the safety of children, it is also appropriate—indeed, morally and scientifically necessary—to reexamine the effectiveness of the policies that are part of his legacy.

When Kempe and his colleagues (1962) identified battered child syndrome, they attributed child abuse to the deviant actions of a limited number of parents with significant mental health problems. From this perspective, abuse was defined "on the basis of the characteristics of the abuser rather than the maltreating behavior or its consequences to the child" (Hutchison 1990, p. 64). By classifying child maltreatment as a disease of the abusing perpetrator, Kempe and colleagues placed the responsibility on health professionals for the detection of child abuse. Illustrating clinicians' concerns for decades to come, the American Medical Association quickly protested this narrow categorization. Limiting the responsibility of mandated reporting to physicians, they argued, would deter parents from seeking medical attention for a child for fear that they might be accused of maltreatment (Paulsen 1967). In a short time, many statutes were expanded to mandate other professionals, such as teachers and social workers, to report suspected maltreatment before it escalated to serious injury (Webster et al. 2005).

In part as a result of broadening the professional categories of mandated reporters, the number of official reports of suspected maltreatment skyrocketed, rising by more than 347% between 1976 and 1993 (Schene 1998). This trend was anticipated by some experts. Correctly predicting that social welfare agencies would be overwhelmed by the resulting number of reports, the US Children's Bureau advised against expanding the classification of mandated reporters beyond the medical field (Paulsen 1967). In the intervening years, however, individual states have amended their own child protection statutes to refine—but often expand—definitions of abuse and neglect and of mandated reporters and, in so doing, often to dilute the response system that Kempe and others originally intended (Rosenzweig 2008).

There is no question that modern child protection and the efforts to introduce mandated reporting were rooted in the best of intentions. As we now know, however, these good intentions and the resulting actions were based on an oversimplification of a widespread social phenomenon that is significantly more complex than "a handful of people whose individual pathology causes them to mistreat their children" (Stein 1984, p. 311). Unfortunately, even with our current understanding of the shortcomings of mandated reporting and formal child protective services (CPS), our society seems reluctant to remodel what is known to be a broken system. Indeed, few policies have proven so resistant to reform, notwithstanding the dissatisfaction of both human service professionals and the general public.

The Current State of Child Protective Services

As a public agency vested with civil authority (Waldfogel 1998), CPS is singularly responsible for receiving and responding to concerns about child maltreatment from all facets of society: "public and private agencies in the community report child maltreatment, but seldom address it themselves" (Schene 1998, p. 35). Given the sheer volume of reports that fall under CPS's jurisdiction and the statutory obligation to investigate those cases, the formal child protection system responds to accusations, not needs for help. CPS's principal statutory duty in most jurisdictions in the English-speaking world is to determine whether legally cognizable abuse or neglect occurred, not to eliminate the situations that threaten children's safety.

Child protective services face dual obstacles to providing appropriate responses to reports of child maltreatment. Inevitably, the system is overburdened and underfunded (Kalichman and Brosig 1992). Nearly three decades ago, Stein (1984) cautioned that "we must recognize that some children at serious risk may have suffered because *limited resources* have been spread thinly across a great many cases—cases that the evidence suggests should not have come to the attention of protective services in the first place" (pp. 309–310). We must also recognize that mandated reporting laws are only as good as their implementation, and their implementation is only as good as resources allow and as workers' knowledge provides a valid foundation for action (Paulsen 1967). More fundamentally, the *design* of our current CPS system is far from acceptable.

One of the most significant obstacles to effective implementation of mandated reporting is the ambiguity of many of the concepts contained in the policy. Kempe originally framed battered child syndrome in terms of the abuser's behavior rather than the harm brought to the child. Although some jurisdictions retain this original focus (Meriwether 1986), many others have revised or expanded their definitions of maltreatment to include both physical and emotional elements of abuse or signs of neglect such as a child who is dirty or hungry (Stein 1984; Switzer 1986).

Professionals are mandated to report suspected abuse when there is a "reasonable suspicion" to believe that such abuse has occurred, but they are offered little guidance in practical appreciation of such a threshold (Kalichman and Brosig 1993; Levi and Crowell 2010). Professionals who err on the side of caution contribute to the overburdening of the CPS system by reporting many marginal cases that should not require CPS investigation or intervention.

Clouding the issue even further are lingering questions about who can and should be classified as mandated reporters. Within a few years of the adoption of statutes mandating reporting of suspected child maltreatment, concerns were beginning to be raised about expanding the professional base of mandated reporters (Ainsworth 2002). Occasionally, courts have held that the expansive language resulting from such amendments was unconstitutional because of the vagueness of the boundaries of their application.

Such ambiguity exacerbates a much bigger problem. Child protection policy has been increasingly ill-matched to the problem that it is intended to address. The *Child Maltreatment 2009* report issued by the US Children's Bureau demonstrates the principal trend: "child abuse has become much less common; child neglect has not" (Melton 2010a, p. 94; Finkelhor and Jones 2006). Of the reported cases investigated by child protective services in fiscal year 2009, children in 75% of the cases suffered neglect, while 15% were victims of physical abuse. The volume of reports of child neglect underscores the need for a vital distinction, namely, that between willful neglect on one hand and conditions of poverty on the other.

Ample research demonstrates that most allegations of neglect brought against parents are the result of "poverty-related circumstances" (Lukens 2007, p. 205). Although children in the child welfare system are almost always from poor families, we must not draw the erroneous conclusion that parents in poverty are necessarily abusive parents. Rather, parents in such adverse circumstances often do not have appropriate access to resources to help them succeed as parents. Ironically and tragically, they often suffer from not only economic and sometimes social deprivation but also greater societal scrutiny of their parenting skills (Duquette 2007). For example, if the physical environment is decaying, it is simply harder to keep children safe; daily life is hazardous. It is not only unfair ("blaming the victim"; Ryan 1976) but also ineffective to punish parents for failing in such situations.

Rosenzweig (2008) noted the irony that "fully two-thirds of the cases reported to the public systems allege neglect, a condition strongly associated with *poverty*, while millions of families dealing with incarceration, addiction, mental illness, violence against women, and even physical and sexual abuse escape the attention of any public system" (p. 116). The tendency to diagnose the issue inappropriately as

voluntary neglect as a result of poor parenting, as opposed to involuntary consequences of poverty, leads to misdirected efforts at solutions such as those currently in place.

Errors in Reporting

Many of the issues in our current child protection system can be characterized as errors in reporting, both overinclusion and underinclusion. Overinclusion affects those families who are referred to CPS but should not be, while underinclusion affects those families who should be referred to CPS services but are not (Waldfogel 1998). Both trends of erroneous reporting continue to occur on a large scale (Meriwether 1986) and have the potential to bring unintended harm to children and families (Lukens 2007).

Moreover, the errors are often not matters of accuracy of classification according to the law. Rather, as a matter of policy if not of law, errors occur when the children referred to child protection services are not those whose safety is likely to increase as a result of whatever services may be activated by such referrals. (The size and characteristics of that group are not known. Neither are the reliability and validity—both actual and potential—of such predictions.)

The prevalence of overreporting is the product, in part, of the scope of mandated reporting. Under the pertinent statutes, professionals who fail to report suspected maltreatment may face criminal penalties, deterrents designed to induce professionals to err on the side of overreporting suspected maltreatment. As expansion occurred in the list of professionals mandated to report suspected maltreatment, the CPS system soon became overburdened with notifications of alleged child maltreatment.

Overreporting has effects beyond the inability of CPS to respond appropriately to serious instances of abuse or neglect. Unfounded cases can lead to families being stigmatized by the community, parents losing employment because of the demands of formally refuting abuse allegations, or unnecessary removal of children from their homes to be placed in foster care, itself a risk factor for psychological harm (Fincham et al. 1994). The investigation itself, even if it fails to end in substantiation of abuse or neglect, also can fractionate the family and destroy relationships with people outside the family. Indeed, it inevitably results in a substantial invasion of privacy and almost certainly in concomitant increases in anxiety and helplessness.

Lay persons also contribute significantly to the problem of overreporting. Lacking formal training in identification of signs of abuse or neglect, community members are more likely than professionals to interpret their observations of a child in need as signs of maltreatment (Stein 1984). Lay persons, including neighbors, relatives, and anonymous sources, accounted for nearly 28% of reports of alleged abuse to CPS agencies in 2009 (USDHHS 2010). These sources were most likely to report neglect (Bae et al. 2010), which is even more difficult for the untrained eye to discern.

Compounding the problem of overreporting is the fact that race and ethnicity continue to influence perceptions of what constitutes child maltreatment. African-American families are more likely to be reported to CPS (Sege and Flaherty 2008).

This burden is persistent; African Americans are also disproportionately subjected to unsubstantiated re-reports of abuse or neglect (Bae et al. 2010). Despite what are likely good intentions to connect a neighbor in need with an outlet for assistance, community members often inadvertently exacerbate the stress experienced by an overburdened family by introducing CPS into their lives through unnecessary reports of suspected maltreatment.

The other error in reporting (underinclusion) is a clear demonstration that mandated reporting statutes are ineffective in their current form. Kempe's initial proposal for mandated reporting was expressly designed to overcome health professionals' purported tendency toward inaction in instances of suspected child maltreatment (Paulsen 1967). However, many practitioners still exercise civil disobedience in their responses to suspected child maltreatment. Research has shown that teachers (Webster et al. 2005), medical providers (Sege and Flaherty 2008), and psychologists (Kalichman and Brosig 1993) often prefer to exercise professional discretion when evaluating which cases of suspected abuse or neglect to report. In one study of professional psychologists, this proportion was estimated to be as high as 40% and was consistent across all levels of training and experience (Kalichman and Brosig 1993).

The reasons for failure to file reports tend to be similar across studies and professions. A commonly cited reason is the belief that CPS is already overburdened and therefore unable to offer an appropriate resolution to the report (Lukens 2007). Similarly, there is a common belief that professionals already serving a family are better able to respond to suspected child maltreatment than an inefficient CPS agency unfamiliar with the family (Sege and Flaherty 2008). Other reasons for failure to report include the beliefs that engagement with the CPS system could prove detrimental to the child, that filing a report would cause parents to terminate their relationships with helping professionals, and that filing a report of suspected maltreatment would lead to negative personal consequences, notwithstanding immunity for clinicians from civil liability or criminal prosecution for reports made in good faith.

In short, although three-fifths of the reports of suspected child maltreatment submitted to CPS were provided by professional service providers (USDHHS 2010), many providers nonetheless have sufficient concern about the harm that the child protection system may inflict that they risk criminal and civil sanctions for non-reporting (Kalichman and Brosig 1992). Indeed, clinicians "frequently experience reporting as an ethical dilemma rather than a legal mandate" (Kalichman and Brosig 1993, p. 84).

The Decline in Community Responsibility

In that context, the implicit and sometimes explicit message communicated by child protection authorities often is to get out of the way. Just as third parties' entanglement in investigation of a crime may obstruct justice (whether purposefully or unwittingly), analogous engagement of third parties may disrupt social workers' investigation of suspected child maltreatment.

Moreover, both professionals and the general public have long been well socialized in the message that the proper response to suspicions of child maltreatment is to file a report—a message that contributes to the illusion (wishful thinking?) that the phone call will immediately and reliably elicit help for the family. Indeed, both confidentiality laws and workers' overload often prevent any feedback to the reporter about the findings of an investigation and any interventions that may have occurred.

When community members become aware that a neighbor or family is in need, too often the first response is to call the police or a child welfare hotline. By so doing, reporters are absolved in both law and common belief of further responsibility to ensure their neighbor's well-being (Duquette 2007). This message is especially unfortunate in the light of the substantial body of research showing that social isolation and poor neighborhood quality are major factors in child maltreatment and indeed in children's problems in general (Ben-Arieh 2010; Coulton et al. 1995, 2007, 2009; Coulton and Korbin 2007; Garbarino and Kostelny 1992; McDonell 2007, 2010; McDonell and Skosireva 2009; McDonell and Waters 2011; Melton 2010a, b; Runyan et al. 1998; Sampson et al. 1999; Twenge 2006, 2011; Zolotor and Runyan 2006). Tragically, such alienation and disconnection are endemic in contemporary society (Melton 2010a, b; Putnam 2000; Twenge and Campbell 2009).

In this context, Schene (1998) attributed the reliance on reporting to the value that US society places on privacy and independence. Neighbors may be more likely to invoke the assistance of a formal authority than to attempt an informal mediation and run the risk of violating their neighbors' privacy. (It is ironic, however, that this effort to preserve the family's privacy leads to great intrusion by CPS and ongoing suspicion by the community as people assume that CPS would not intervene without just reason.)

The current system of reporting thus has undermined a greater sense of community responsibility by allowing concerned persons to intervene with a single impersonal contact with an outside third party rather than take an active, integrated role in the well-being of other community members. Despite the generally negative reputation of CPS in society, a call to CPS is still often the first and, too frequently, the only action taken by concerned community members. There is no question that "our society expects too much of the child welfare system" (Duquette 2007, p. 317). This overreliance on an ineffective CPS system has greater implications beyond service delivery for at-risk families. As Rosenzweig (2008, p. 115) wrote, "Neighbors—even family members—now expect public agencies to be responsible for families with needs, further deteriorating social ties while overburdening public systems. It is time to consider an update."

As Duquette (2007) argued, "child protective services cannot be the beginning and end of child welfare services in America" (p. 332). A growing body of research suggests that the most effective way to address child maltreatment is not through punitive or controlling measures aimed at parents but rather comprehensive efforts to develop supporting, nurturing community environments for children and families alike (Dodge and Coleman 2009; Duquette 2007; Fisher and Gruescu 2011; Garbarino and Kostelny 1994; Hutchison 1990; Melton 2010b, c; Melton and Holaday 2008; Thompson 1995; Wilson and Melton 2002).

A Half-Century Is Enough

The Resistance to Change

Policymakers and society at large generally agree that our current system of child protection, largely dependent on mandated reporting, is seriously flawed. However, they often seem reluctant to explore alternative solutions (Lukens 2007); the system has been remarkably resistant to change (Melton 1997; Nelson 1984). This mentality is reflected in allocation of resources: "Total direct state and federal expenditures for child protection systems exceed $15 billion annually. Efforts directed at strengthening and supporting families received less than 5% of that amount" (Rosenzweig 2008, p. 116).

The most ardent supporters of US-style, investigation-centered child protection policy might quibble with us about the potential scope of an effective "friendly" system. However, the proponents of mandated reporting—including, as this book illustrates, Kempe himself—generally have envisioned a system in which preventive and supportive forms of care are hallmarks, maybe even the leading attributes (Drake and Jonson-Reid 2007; Mathews and Bross 2008).

A detailed point-by-point refutation of the typically inapposite counterarguments and related data presented by the steadfast proponents of the status quo is beyond the scope of this chapter. It is important, however, to address the core arguments of the defenders of the current system. The gist of the case for retention of mandated reporting seems to rest on three arguments:

1. The system actually is working.
2. If the system is broken, the failures are the product of gaps in resources and training, not the design of the system.
3. Even if the system fails to secure the safety of children in general, it must stay in place to protect the small number of identifiable children who might be less protected, at least in the short term, if mandated reporting were repealed.

In short, the arguments against repeal of mandated reporting and its replacement with a new, largely voluntary neighborhood-based child protection system like the one envisioned by the US Advisory Board on Child Abuse and Neglect (1990, 1991, 1993) are empirical, conceptual, and moral. In the end, however, they all are flawed, just as the assumptions on which the system was based were erroneous. After a 50-year trial with billions of dollars in investment, a lack of demonstrated effectiveness in securing children's fundamental rights, and strong evidence of substantial adverse and even paradoxical effects, it is time to adopt a new strategy. Mandated reporting is a policy that originated without reason and that has been sustained, although bankrupt. Let us turn now to an examination of the arguments by the proponents of continuation of the existing policy.

The Problem Is Real

Defenders of the status quo use inapposite and sometimes incomplete data to support their claim that the system is working: for example, the frequency of reporting (Mathews and Bross 2008); the proportion of child protective services' workers' time spent in various functions (Drake and Jonson-Reid 2007); differences in the nature and frequency of professional and nonprofessionals' reports (Drake and Jonson-Reid 2007; Mathews and Bross 2008), and purported satisfaction with the system, as indicated by surveys of professionals (Drake and Jonson-Reid 2007) and clients (Drake and Jonson-Reid 2007; Mathews and Bross 2008).

Such questionably relevant data mask the inescapable conclusion that the problems of contemporary child protection are *inherent* in the system that has been dominant in much of the world since the mid-1960s in the United States. For example, it does not matter if most reported cases ultimately do not go to court if workers' primary legal mandate is to conduct investigations. It does not matter who the reporters are if their notion of "child protection"—well inculcated by generations of billboards, public service announcements, and newspaper stories—amounts to a report and an investigation. It does not matter if human service professionals view the system as having contributed to child protection in some instances if they engage in civil disobedience because of their root distrust of child welfare authorities (Kalichman 1999), and thereby undermine the social contract that is fundamental to their work. It does not matter if clients give positive responses to satisfaction surveys (data that are famously suspect) in regard to their particular experience if community members in general (perhaps especially those most in need) fear, mistrust, and at best dislike the agency.

Indeed, for many children, the operation of the child protection system is *wrong*, no matter what its empirical effects may be. As the US Advisory Board on Child Abuse and Neglect (1990, 1991, 1993; Melton and Thompson 2002; Thompson and Flood 2002) strongly contended, the child protection system seldom is truly child-centered:

> …Too often, legal fictions overcome children's own experience. For example, children are assumed either to be in their parents' care or in substitute care (most of which is well short of a full substitution) is ignored. Similarly, if children are placed in foster care, it is assumed that the only options are "reunification" or "adoption"; the overwhelming value on "permanence" disregards the reality of ambivalent but nonetheless important relationships. The assumption that there is severe harm as a result of even fleeting exploitation or abuse—no matter whether there is evidence of such *harm*—ignores the central question of whether a child has been *wronged.*
>
> Even more egregiously, the current child protection system objectifies the children whom it seeks to protect and the parents whom it accuses. The ostensible mission of the system is lost as children are treated as evidence and "treatments" are designed to provide verification of parents' failures. In effect, a culture of caring is replaced by a culture of surveillance. (Melton 2009, p. xii)

In short, we see little reason, unfortunately, to doubt that the child protection system is indeed failing in the mission that it *should* have: the assurance of conditions of safety for all children. As Wald eloquently argues in this volume, this conclusion is especially warranted for the vast group of children alleged to have been neglected. There is no persuasive evidence that compulsion increases treatment adherence and effectiveness (Melton et al. 1995). We need a forward-looking system throughout the community—a system that is directly related to the factors involved in children's safety in everyday life, not an evidence-gathering agency to determine whether legally cognizable maltreatment once occurred.

The Problem Is Inherent in the System's Design

Many advocates of the status quo believe, incredibly, that after a half-century, Kempe et al.'s proposed system has not yet been given a fair chance, notwithstanding the many millions of families whose lives have been directly affected by CPS and the hundreds of legal jurisdictions—countries, states, provinces, counties, and municipalities—that have been subject to mandated reporting. Hence, these advocates argue for *implementation*, not *reform* or even radical overhaul of the current child protection system. The contention that full implementation has yet to occur *anywhere* is damning in itself. It is hard to understand how persistent, massive failure in many jurisdictions over decades justifies continuing application of the strategy!

The clear reality is that the mandated reporting system—necessarily including mandated investigation or at least mandated screening (in effect, a truncated "investigation")—often results in coercive intrusion and little, if any, help. As noted in Melton (2005), state social service directors themselves acknowledge that many families who enter the formal child protection system (probably the majority, not just a few families in unusual circumstances) receive no "service" other than an investigation. In our experience in several states, the services that are offered (e.g., parent education classes) are often (a) discrete and brief, (b) minimally related to the reasons for intervention, (c) accordingly unlikely to result in positive changes in children's safety, and (d) fashioned at least in part for easy gathering of evidence by the state (e.g., recording attendance; eliciting "voluntary" statements or behavior supportive of further, often more intrusive state intervention)—all too often constituting, in effect, a separate, intrusive, and facially inadequate service system for ethnic minority families. Given these realities, which are common in countries, states, and provinces with mandated reporting (Lonne et al. 2009), there is no plausible basis for assuming that the current system is or could be beneficial in the aggregate.

Failure to Reform Is Immoral

Without the promise of effective assistance in ensuring children's safety, the child protection system has no legitimate purpose, regardless of the reason for the failure

of response. Even if the balance tipped slightly in the direction of aggregate benefit, the proportion of families (including children) who are wronged by the existing system can hardly be said to have a rational basis, much less to conform to closer scrutiny, as both law and ethics require. Surely 50 years of such disturbing experiences should be enough!

Nonetheless, we admit to some anxiety about the third argument made, at least implicitly, by advocates for the current system. Even if advocates of the status quo concede that the effectiveness of a system based on mandated reporting has not yet been demonstrated, they contend that any aggregate improvement that might occur in the well-being and security of children in an alternative system would be negated by the harm that would occur to some of the most vulnerable. Put most starkly, in reformers' desire to protect the many, the advocates of the status quo fear that the reformers would knowingly accept severe maltreatment of a small number of children—although *very* few, given the typical possibility of criminal justice intervention in such instances—who otherwise would have come to the attention of child protection authorities.

The weight of this argument against adoption of a new voluntary system is overwhelmed by the evidence of the bankruptcy of the current coercive system. The great majority of the millions of children and families who enter the existing formal child protection system each year have no prospect of an improved quality of life (including greater personal security) as a result of their involvement. Tolerance of that situation at all—much less tolerance of it for a half-century—is itself egregious. Even if one accepts that the proposed system is "unproven" (an overly broad assertion), the existing system appears to be resulting in substantial social harm. The current system itself is unquestionably "unproven" to better the well-being of most of the children and families who enter it. Moreover, as a matter of logic, it seems clear that mandated reporting is at the root of an inherently unworkable child protection system because the strategy is neither coextensive nor even compatible with the mission of ensuring that children grow up in safety.

A New Statutory Approach

Nonetheless, there is clearly a moral duty to minimize any risks associated with a voluntary system—and, more fundamentally, to do so in regard to *any* system. One approach that may meet that test is embodied in the recommendations of a highly diverse study group chaired by one of us (Melton) and commissioned by the Edna McConnell Clark Foundation to consider the nature of the "deep end" in a voluntary, neighborhood-based system of child protection. The operating principles on which the group based its recommendations were (a) that (as in Wald's analysis in this volume) coercion should be minimized, (b) that child protection should usually be a part of everyday life in primary community institutions, (c) that the coercive elements of the system should not be mixed with human services whenever possible, (d) that the child protection system should be forward-looking (i.e., reducing future harm and refraining within the civil system from de facto punishment for past

conduct by the parent), and (e) that both the law and community norms should support recognition and actualization of communal responsibility for children's safety.

Consistent with those principles, the Clark Foundation panel made three relevant recommendations. First, *individuals who have responsible positions involving work with children and families should have a legal duty to* ***act*** *to* ***prevent*** *harm, not to* ***report*** *harm that already has occurred.* Second, as a means of quality assurance and expression of community concern about children's safety, *when individuals who have responsible positions involving work with children and parents have reason to fear imminent danger of serious harm to a child, they should have a legal duty to* ***consult*** *a designated specialist.* The presumption would be, consistent with the first duty, that the community helper would maintain responsibility to increase or change monitoring and support as necessary. Third, *although the Child Safety Agency would have limited authority to act to reduce immediate harm without parental permission, the preference would be for voluntary family support in the community*. In that regard, the CSA would be expected to defer to community helpers (whether professional or nonprofessional; whether paid or volunteer) as much as possible, maintain a wall (conceptually) around the coercive elements of the system, and rely on negotiation and passive intervention (e.g., changing the setting to increase monitoring and support) more than commands and direct family intervention (at the extreme, permanent removal of the child from the family). The focus of all actors in the system would be forward-looking (i.e., reducing future harm), not investigative.

The risk involved in an almost always voluntary child protection system is likely not to be appreciably greater (and indeed would probably be noticeably less) than in the current system based on reporting and investigation. In the current system, when children are believed to have been subjected to severe physical or sexual abuse or severe willful neglect, the criminal justice system is apt to take the leading role. We believe that such intervention should be limited to those instances in which retribution is justified. That is, child welfare per se ("treatment") should not be the basis for punishment of parents; we should conscientiously avoid punitive impulses within the service system. (To be clear, however, the severity of wrongs to victims, no matter what their age, should be a factor in the justifiability of retribution.) Nonetheless, the egregious cases that stimulated our concern about casualties of a voluntary system would continue ordinarily to be treated as criminal matters, with attention to the safety of victims addressed accordingly.

Conclusions

The evidence indicates that a focus on community-wide prevention of child maltreatment would result in a substantial increase in children's safety. Moreover, in most instances in which children come into the current child protection system, a voluntary system could be applied with greater effectiveness than is present in the status quo. Such a system is apt to be more responsive to everyday needs for help, more responsive to extraordinary family needs at times of crisis, less costly on a

per-child basis, and consistent with core values in the society. A friendlier system would also likely have enormous positive side effects on children, families, and communities. In essence, communities that are supportive of families, regardless of their level of need, are likely to be better places to live.

After a 50-year struggle with a system that is known to have been ill-conceived, it is well past time to move in a new direction—toward repeal of mandated reporting and toward adoption of community-strengthening approaches that result in improved welfare for children in general and a stronger commitment to ensuring children's safety. As we readily acknowledge, full implementation of a new neighborly strategy would not be easy (cf. Melton 1997, on obstacles to adoption of meaningful reform in human services). However, we are absolutely convinced that the likelihood of safety for children would be far greater than in the current system. Tweaking is not enough!

It is time to harness the concern that is reflected in millions of calls to child protective services in the United States each year and, for that matter, in the hundreds of thousands of instances of civil disobedience by individuals who believe that a report to CPS is likely to do more harm than good. Notwithstanding the difficulties that may occur in implementation, we are optimistic. A community in which people watch out for children and their families—in which neighborly help is the norm—would be a good place to live. Such a network of relationships would be welcomed by almost everyone in our increasingly disconnected society.

Whatever else can be said about the aftermath of Kempe et al.'s article, it did stimulate public concern. However, it also contributed to the misperception that child protection is the appropriate function only of a small social service agency. Child protection practice has suffered accordingly. As a society, we are long past the time when the public must be convinced that child abuse exists. We are far short, however, of a situation in which most community members—maybe even most professionals engaged in child protection—understand the complexity of child neglect and routinely take steps to provide support to families in distress.

Nonetheless, there are signs that the conventional wisdom about the requisites for effective child protection has shifted greatly, even since the US Advisory Board on Child Abuse and Neglect articulated the need for a new strategy in the early 1990s (Melton 2002). This shift may be at the root of the great reduction in physical abuse and sexual abuse since that time (Finkelhor and Jones 2006). With new norms of compassion and reciprocity, we expect to go further to provide much more effective means of preventing and responding to child neglect.

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Part III
Preventing Child Abuse

Chapter 14
Introduction and Commentary: Preventing Child Abuse

Richard D. Krugman

C. Henry Kempe was an accomplished pediatric infectious disease specialist before he got involved with battered children. He was involved with the testing and development of measles, rubella (German measles), and smallpox vaccines during his career. His training in both pediatrics and infectious diseases made it inevitable that he would be looking for ways to *prevent* and not just recognize the problem and treat the child and family after the injuries had occurred. In this part, we reprint his George Armstrong Lecture, which I had the privilege of attending as a junior faculty member in Henry's department in 1975. Following a sabbatical in England where he observed the National Health Service's "Health Visitor" program in which all new babies born in the United Kingdom were visited after they went home from the hospital with their parents, Henry and his colleagues started a small program with two trained lay health visitors – Christie Cutler and Janet Dean – between 1968 and 1975. Because infants have the highest morbidity and mortality from physical abuse, his focus was on trying to predict which parents and children were most susceptible. Identifying those who were at high risk for abuse or neglect and providing them support so that they could get help *before* they abused their children became the focus of his work in Denver. I recall as an intern in pediatrics attending deliveries in Colorado General Hospital and having to fill out a one-page form that had three questions on it: When the mother and father (if he was present) saw the baby for the first time, how did they *look*? What did they *say?* And what did they *do?* These simple observations helped sort those who were low risk from those who were presumed to be high risk for abuse.

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The first commentary in this part is written by Janet Dean who was one of the research associates working in the Prediction and Prevention Project in Denver in the late 1960s and early 1970s. The studies on prediction and prevention of child maltreatment led to the efforts described in the later commentaries by Deb Daro, Ann Cohn Donnelly, and David Olds. There is healthy debate within these chapters as to whether health visitors should be professional nurses, trained lay people or other volunteers. Now, 36 years after the Armstrong lecture, there are numerous health visitor programs throughout the United States. It may be that the plethora of lay and nurse home visitors is partly responsible for some of the reported decline in physical abuse over the last 15 years in the United States.

The prevention of physical abuse also clearly relies on social and community support systems. Efforts in these areas have also been going on over the years, notably in North and South Carolina in projects supported by the Duke Endowment. The amount of resources that has been spent over the last 50 years on the child welfare-based and child protection systems dwarfs the amount of funding that has been allocated for prevention efforts in the United States. The gap would have probably been substantially greater had Henry not been so focused on prevention from the earliest times of his work in this new field.

Chapter 15
Approaches to Preventing Child Abuse. The Health Visitors Concept

C. Henry Kempe

A better title for this lecture would be "A Vindication of the Rights of Children," after the classic essay, "A Vindication of the Rights of Woman," written in 1792 by Mary Wollstonecraft, which set forth the plight of women in those days.

Children in the Western world (though not yet in the southern hemisphere) have made striking progress in the past 200 years. Seen against a background of virtually being nonpersons, they are slowly emerging as citizens with rights of their own. In 1763, the poor-law governors (that is, the welfare department) of the parishes of St Andrew's and St George's in London were entrusted with 59 infants: of these, all but two had died two years later. But not only the poor died. Between 1767 and 1769 in London, in the absence of epidemic disease, there were 16,000 baptisms and 8,000 infant burials reported–half the children died. Because of this appalling mortality in the first years of life, George Armstrong opened his clinic for poor children in 1769, focusing on the period from birth to age 4. He quickly achieved success in lowering the mortality of his patients, though it was at great personal and financial sacrifice. He was what in this day would be called a "bleeding heart," but he did not just show constant pity for the needy young; he also possessed three other qualities: he was a hard worker, he was an activist, and he was a visionary. He worked very hard, making his rounds on his paying patients in Hampstead in the morning and then, generally, walking five miles to his clinic downtown. He saw over 4,000 patients each year, spending about 2 1/2 hours in his clinic each day.

Read as the Armstrong lecture before the annual meeting of the Ambulatory Pediatric Association, Toronto, June 9, 1975.

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He was greatly concerned with the importance of ensuring easy access to care. He was an activist in instituting the first infant clinic anywhere. Early on, when he sought support from patrons, each paid one guinea per child per year to sponsor a child and then two guineas for the second child per sponsored year. In time, the overworked clinic helpers tried to limit his patients to those with sponsorships in hand, excluding those without—in other words, those patients who didn't have their clinic card. Let me quote Armstrong: "This hindered their coming more than can well be imagined. The circumstance, by the by, may afford a useful hint: to be very cautious of any obstacle that is thrown in the way, if we mean to render charity generously useful." He was primarily concerned with "a good start," the time from birth to age 4 years. And he was a visionary: preventive medicine was his long suit—good hygiene, feeding, health care of the youngest.

A hundred years later, in 1874, Mary Ellen, a child living with step parents in New York, was cruelly treated, and it required the Society for the Prevention of Cruelty to Animals (there was no Society for Prevention of Cruelty to Children) to intervene on her behalf as a member of the animal kingdom. She was removed to safer quarters. Soon came child labor laws and universal, free education. In the last 50 years increasing attention is being paid to the health of young children and we are now, in 1975, addressing the civil rights of children.

Prenatal, Perinatal, and Postnatal Observations

Throughout the Western world it has become almost routine for children to have periodic health assessments. As part of this assessment, we do a standard history and physical examination, the technique of which is pretty well accepted all over the world. I propose that these be supplemented by standardized observations in the prenatal, perinatal, and postnatal care of families. Table 1 lists ten warning areas in prenatal care indicative of need for extra services.

You will note that none of these observations, nor those made during and after delivery, has anything to do with social class, education, or financial status. They deal with attitudes and feelings.

If prenatal observations are not possible, then much of this information can be obtained, along with delivery room observations, on the first postpartum day.

During delivery, mother, doctor, and nurses are very busy. But they are busy with the perineal end of the mother, and birth is often a struggle between the obstetrician and the uterus from which he skillfully extracts the child. The mother's head is three miles upstream.

I and my colleagues encourage fathers to be present in the delivery room, and more than 90% come. We ask our nurses to look at the mother (and the father, if he is present) and answer just three questions: How does she look? What does she say? What does she do? The parents' reactions to their newly born child are carefully observed. Are the parents passive, showing no active interest in the baby, not

Table 1 Observations of Parents-to-be in Physician's Office or Prenatal Clinic

1. Are the parents over concerned with the baby's sex?
2. Are they overconcerned with the baby's performance? Do they worry that he will not meet the standard?
3. Is there an attempt to deny that there is a pregnancy (mother not willing to gain weight, no plans whatsoever, refusal to talk about the situation)?
4. Is this child going to be one child too many? Could he be the "last straw"?
5. Is there great depression over this pregnancy?
6. Is the mother alone and frightened, especially by the physical changes caused by the pregnancy? Do careful explanations fail to dissipate these fears?
7. Is support lacking from husband and/or family?
8. Where is the family living? Do they have a listed telephone number? Are there relatives and friends nearby?
9. Did the mother and/or father formerly want an abortion but not go through with it or waited until It was too late?
10. Have the parents considered relinquishment of their child? Why did they change their minds?

holding it? Are they disappointed in its sex? Are their reactions hostile or their comments inappropriate? Is there eye contact?

Observation of reactions after the baby goes home is also important. Significant warning signals are listed in Table 2. Positive factors, which may partially offset these, are listed in Table 3.

My colleagues and I have tried to determine whether our child abuse and "failure to thrive" patients came from the group we thought to be in need of extra services. We studied 300 consecutive births and concluded that 20% of them seemed to be in need of extra services. We divided these families into two groups by random numbers: The control risk group received the best care that is routinely provided, including a single visit by a visiting nurse, regular well-baby appointments and, also, a telephone call to the physician caring for the family, in which we voiced our concern about the parent's attitude toward the baby. The second risk group received active intervention through the extra services shown in Table 4. Detailed results of this study will be reported separately, but we found no instance of child abuse by the 240 mothers about whom we had no concern, and that the modest intervention given to half of our risk families significantly reduced the incidence of many problems including abuse and "failure to thrive."

Similar efforts are in progress in California, New York, Colorado, North Carolina, the District of Columbia, and elsewhere, using mostly visiting nurses, although a number of these programs have begun to utilize lay health visitors. The intervention we propose can be carried out simply. It is available to each of us in our current pediatric settings. However, since a large percentage of children who need help are not brought to us for "checkups" and do not have meaningful contact with any type of health personnel on a regular and ongoing basis, it is clear that something else is needed.

Table 2 Observations to be Made at Postpartum Checkups and Pediatric Checkups

1. Does the mother have fun with the baby?
2. Does the mother establish eye contact (direct in face position) with the baby?
3. How does the mother talk to her baby? Is everything she expresses a demand?
4. Are most of her verbalizations about the child negative?
5. Does she remain disappointed over the child's sex?
6. What is the child's name? Where did it come from? When did they name the child?
7. Are the mother's expectations for the child's development far beyond the child's capabilities?
8. Is the mother very bothered by the baby's crying? How does she feel about the crying?
9. Does the mother see the baby as too demanding during feedings? Is she repulsed by the messiness? Does she ignore the baby's demands to be fed?
10. What is the mother's reaction to the task of changing diapers?
11. When the baby cries, does she or can she comfort him?
12. What was/is the husband's and/or family's reaction to the baby?
13. What kind of support is the mother receiving?
14. Are there sibling rivalry problems?
15. Is the husband jealous of the baby's drain on the mother's time and affection?
16. When the mother brings the child to the physician's office, does she get involved and take control over the baby's needs and what's going to happen (during the examination and while in the waiting room) or does she relinquish control to the physician or nurse (undressing the child, holding him, allowing him to express his fears, etc.)?
17. Can attention be focused on the child in the mother's presence? Can the mother see something positive for her in that?
18. Does the mother make nonexistent complaints about the baby? Does she describe to you a child that you don't see there at all? Does she call with strange stories that the child has, for example, stopped breathing, turned color, or is doing something "on purpose" to aggravate the parent?
19. Does the mother make emergency calls for very small things, not major things?

Table 3 Positive Family Circumstances

1. The parents see likeable attributes in the baby and perceive him as an individual.
2. The baby is healthy and not too disruptive to the parents' life-style.
3. Either parent can rescue the child or relieve one another in a crisis.
4. The parents' marriage is stable.
5. The parents have a good friend or relative to turn to, a sound "need-meeting" system.
6. The parents exhibit coping abilities, i.e., the capacity to plan, and understand the need for adjustments because of the new baby.
7. The mother is intelligent and her health is good.
8. The parents had helpful role models when they grew up.
9. The parents can have fun together and with their personal interests and hobbies.
10. The parents practice birth control; the baby was planned or wanted.
11. The father has a steady job. The family has its own home, and living conditions are stable.
12. The father is supportive of the mother and involved in the care of the baby.

Table 4 Special Well-Child Care for High-Risk Families

1. Promote maternal attachment to the newborn.
2. Phone the mother during the first two days at home.
3. Provide more frequent office visits.
4. Give more attention to the mother.
5. Emphasize nutrition.
6. Counsel discipline only for accident prevention.
7. Emphasize accident prevention.
8. Use compliments rather than criticism.
9. Accept phone calls at home.
10. Arrange for regular home visits by a public health nurse or a lay health visitor.

The Health Visitors System

I propose that we in the United States develop a system of lay health visitors, although nurses can be used when available, and that these health visitors work with traditional health professionals in assuring that the basic health needs of every child are met, especially during the first four years of life.

This program for utilization of health visitors should be a national one, but any state, or any one of our 3,362 counties, could start right now. Any county could–but no county yet has. In most places the health visitor will not be a nurse. Instead, the ideal candidate will be a successful mother who is able and interested in sharing her experience and goodwill with less experienced young families. She could well be chosen by her neighbors as one of their trusted own. The health visitor will form a bridge between these families and the health care system.

It is true that virtually all European child health visitors are trained nurses and that they do very much good, but it must also be said, in all candor, that their orientation is largely toward mother-crafting skills. They tend to shy away from matters of feelings, and they are relatively passive in dealing with the families who don't want their services. Recently, one experienced European health visitor told me, "If they won't let me in, I don't do a thing. It's their kid, after all, and I have no right to interfere." She said that this was the general feeling of the nurses in her local district. This attitude is also often found in Scandinavian countries where I visited: all have good health visitor systems; nobody wants to violate the rights of parents.

So the system itself is not enough. One has to have meaningful access. Lay health visitors can be trained in a period of a few days, because they will be learning just a few facts to be grafted on the important foundation that they already have, namely, their success as mothers and their intimate knowledge of the community that they serve.

Our first concern has to do with the parent-child relationship. We know that difficulties are often encountered when there is a prolonged separation such as in prematurity or early illness in infancy, when there are obstetrical complications such as cesarean section or maternal illness–all these interfere with bonding in some families. I was taught that some mothers couldn't love their newborn babies because they suffered from postpartum depression. I now know that as many postpartum depressions are caused by the mother's finding that she doesn't love her baby. The health visitors will also be involved in helping to fulfill the health needs of siblings, fathers, grandparents, and others.

Ideally, the health visitor should get to know the family during the pregnancy period. She should have knowledge of what happened at delivery and during the first few postpartum days so that she may be more able to assist effectively when she makes postnatal visits. The physician may want to notify the health visitor very early in the pregnancy so that she can be of support to the mother-to-be. She can provide advice on how to prepare for the child's arrival, types of supplies that will be needed, and she may even provide some supplies. Many of our mothers have greatly benefited by gifts of disposable diapers and infant formula so they could

have one hour of rest each day. To be more specific, we should subsidize young mothers. We are the only Western nation that does not do so.

If the health visitor's first contact with mother and father is in the hospital, she can gain critical information at that time. On the first or second day after the arrival of the family at home, she will visit, leave her telephone number, and encourage calls. This will be the essential lifeline between the family and herself. It is nonthreatening and therefore useful.

If the need is there, visits will be frequent. Doctors will have an invaluable resource in the health visitor when they are troubled about the progress of a young infant, and they will be able to gain great insight into the possibility of a postpartum depression, serious marital problems, financial crises, or existing attachment difficulties. Such problems are more likely to come to the attention of the trusted lay health visitor as she visits in the home than in the brief, well-child visit in a busy office or clinic.

I propose that health visitors be utilized regularly, not only in the first months of life, but at least twice yearly in the second year of life and until the child reaches school age. At that time many of the health visitor's duties will be taken over by the teacher, the school nurse, or the school nurse practitioner.

On the basis of our experience to date, my co-workers and I think that one health visitor can care for 50 to 60 children, provided she works about four or five hours a day. Since there are millions of mature women whose children are in school and who are otherwise not gainfully employed, we already have a large number of excellent candidates for a very worthwhile career in which they would make a maximum contribution by helping others. These women have developed important skills of mothering, and I would rather that they share these skills than take jobs in a bakery. On the basis of the current birth rate of 3.2 million per year, we would gradually plan to phase in, over five years, 60,000 health visitors–a goal that could be easily attained.

What would such a program cost? It would cost less than 1% of our defense budget or less than 6% of the requested increase in military spending for next year. But, since most of us don't like to hear what we spend on defense, let me say instead that it would cost one third of the money already set aside for stand-by authority for the bureaucracy needed for gas rationing, if that unhappy event should come to pass.

Role of the Health Visitor

What will the health visitor do and where will she function? She will go out to the home where she will weigh the child and graph its progress on a weight chart, but most importantly she will look at the child, at the mother, at the setting in which the family lives, and determine how things are going, what problems exist, and how the family is coping with these problems. It has been found that health visitors are fully capable of determining which children are at risk, whether they are thriving adequately or not doing well, whether the child is unloved or deprived, whether the

mother's inexperience or the father's lack of support are interfering with the care of the child. Is the child seeing a health professional on schedule? Have recommendations been carried out? Does the family understand what services are available and can they be induced to obtain them?

The health visitor will help to educate the family on the need for basic immunization, good nutrition for the whole family, and periodic examinations by the physician. The health visitor can also see the child when it is brought to her office, which may be in a local grammar school, a fire station, a health department office, a neighborhood shopping center, a high-rise apartment house, or a housing development—anyplace.

Of great importance is the fact that the health visitor can, between visits, be available by telephone for parents who are in need of advice and assistance. If the family moves, she can be the one who assists in a transfer to a health facility in another city as well as arranging for a health visitor from the new neighborhood.

Children's Rights to Protection and Health Care

It should be emphasized that the use of health visitors should be a universal phenomenon. This is not a kind of detection service to identify child abuse. It is not a service for the poor or the minorities but rather an expected, tax-supported right of every family, along with fire protection, police protection, and clean water–societal services that we all deserve to have and from which no one can be easily excluded.

The concept of the health visitor as a compulsory, universal service for the child is similar to the concept of compulsory, universal schooling. In preparation for this talk, I've been reading about how public education came about, a hundred years ago. All the hue and cry that we hear about this concept of free, universal, adequate health care for children were precisely the ones raised against the concept of free, universal public education a hundred years ago. But that debate is over; today, free, effective basic education is a right. This came about because society decided that each young person must be able to take his place in the labor force as an independent, self-supporting citizen and, in order to do so, he had to read and write.

By the same token we must now insist that each child is entitled to effective comprehensive health care, and that when parents are not motivated to seek it, society, on behalf of the child, must compel it. It seems incomprehensible that we have compulsory education, with truancy laws to enforce attendance and, I might add, imprisonment of parents who deny their child an education, and yet we do not establish similar safeguards for the child's very survival between birth and age 6.

A free society does not want to interfere with the rights of parents to be let alone and to raise their children in any way that they desire. But, far too often, children are considered the property or chattel of their parents, many of whom think that they are entitled to dispose of them at will. Unfortunately, such a system ignores the rights of children and results in tragic failures that will adversely affect the children's lives or even result in their deaths.

When an airplane takes off, the pilot is required to go through an unvaried series of safety checks. He has no choice—they must be carried out. Often there are double checks of those things that are considered especially important. If the successful operation of an airplane requires such routine supervision, it is all the more important that the takeoff and subsequent passage of a young family be similarly supervised to assure a safe arrival.

Under our traditional system of pediatric care, which depends on parent motivation, we often find that we are spending a good deal of our time and effort in giving excellent service to many families who don't really need much of it. We do so because they come to us for such care, they are delighted to keep their appointments, they are a joy for us to have in our offices, and they make our days pleasant and fulfilling ones. Such motivated families provide a sunny interval in our work and are a great boon to our mental health: in fact we couldn't practice without it, and they do deserve excellent care. But it is the very isolated families—those who are unmotivated, who break appointments, who are unappreciative and unresponsive—to whom we must reach out protectively. When we see such a family, instead of saying: "Well, we tried …" and giving up, we must say, "This behavior is so unusual and worrisome that we must intervene actively." We must do this first by persuasion and education and trying to be as helpful as we can, but if that fails, we must initiate active intervention through child protection services. We cannot sit helplessly by and mistakenly believe that there is nothing we can do. In a very well-organized infant care service, such as is provided by Sweden, where over 95% of all newborns are followed up in child health centers for periodic care in the first year, only 2.5% of the battered babies were reported from these centers. The assumption is that either routine well-baby care, as we know it, misses a lot or the 5% who elect not to be in the system account for most of the problems.

Curiously, professionals are far behind the citizenry in their desire to provide effective protection to the threatened child. Will the health visitor be seen as someone who can be truly useful and accepted like a member of the old, lamented, extended family, particularly to those who are frightened and alone, or will they be looked on as another bureaucratic layer of busybodies who come between those who need help and those who can provide it? I believe that, to a large extent, this will depend on whether the program is started for all people, rich or poor, black or white, brown or red, or whether it is limited, once again, to the disadvantaged or the minorities. To my mind, only a universal program will develop quality and be successful. I think private practitioners will welcome the health visitor as a universal outreach program of their practice that will become operative when patients miss appointments and when follow-up visits in the home seem desirable and more social information is needed. Let me stress that this is not a program to bring every child to a clinic. It is a program to facilitate and make sure there is *access to comprehensive health care for each child.*

Everybody agrees that every child should be under the care of somebody in the health field, particularly in the first years of life, and I think the health visitor plan is the only way to bring this about.

If it should turn out that local or state health departments are not very interested or are unwilling to undertake the health visitor program, there may be other approaches for its implementation. The state of Michigan, for example, has placed the charge on the Department of Education to assure that everyone is "educable." In theory this gives the Department the right to provide screening procedures and comprehensive health care to make every child school-ready. But if neither the Department of Health nor the Department of Education in a given state can be brought to be involved in this program we might then fall back on a system that already exists in many places.

We can utilize our hospitals as a base to establish a system of aftercare. Admittedly, it is aftercare that lasts five years. Once we decide that a skilled delivery is only the beginning and that we then must provide follow-up, then, I think, it's very easy to see that the hospital could extend its postnatal care into the health visitor concept. Some do so now for premature infants and for certain chronic diseases.

It is economically quite feasible to insist that the young child have access to health care in the broad sense. France actually pays families to seek regular and compulsory child care; such a subsidy is thought to be a very good investment in the ultimate health of its citizens. Similarly, a program to prepare all children for regular school in Amsterdam and in other Dutch cities provides excellent, comprehensive day care for a great number of children who are mentally disturbed or emotionally deprived. In many countries, government leaders believe that it is better to invest money in the first five years of a child's life than to have to develop special programs and institutions for the provision of special education for those whose problems were not recognized early in life. Although the United States spends a lot of money to detect preventable disease, to a considerable degree these funds are misdirected. For example, it is hard to believe that there is currently in Congress a bill that proposes that all our newborns be screened for adenine deaminase deficiency disease, which occurs in approximately one in 200,000 births. This would, of course, be an important screening test for the 15 children in whom this condition is detected each year, but even among those 15 children, it would only matter for those who are also lucky enough to have an identical tissue-type twin as a transplant donor–an unlikely event.

The Cost of Child Abuse

We need to bring some order to our priorities. It would seem to be more important that we give sufficient emphasis to the assessment of the child who might be neglected or abused, since suspected child abuse and neglect is now being reported approximately 300,000 times each year in our country. About 60,000 children end up with significant injuries; some 2,000 of them die and 6,000 have permanent brain damage. The cost of institutional care for a severely brain damaged child in our country is $700,000 for a lifetime. Many other children are scarred by sexual abuse,

incest, and rape. Those who do recover are likely to have significant emotional difficulties and most manifest this in the form of serious learning problems in school. Although in most fatal cases of child abuse the family's problems have been recognized before the child's death, many others have never been active participants in any segment of the health care system.

The late effects of child abuse may manifest themselves in ways that are not generally recognized. My associates, Brandt Steele, MD, and Joan Hopkins, RN, studied delinquent children on the first occasion they were seen in a detention center in a mixed urban-rural county near Denver. The population of youngsters was approximately 85% Caucasian, 14% Chicano, and 1% black. Of 100 well-documented cases, which involved interviews with not only the delinquent young but also their parents, all the hospitals, physicians, and schools, it was found that 84 of those youngsters had been abused before the age of 6 years. Ninety-two had been bruised, sustained lacerations or fractures, or were involved in incest in the preceding year or so prior to being identified by the authorities. Only one of this group of 100 delinquents came from a family on welfare, and only three had an alcoholic parent. These were not children from broken homes or the ghettos, but the type all of us are likely to see.

Our country literally wastes hundreds of thousands of our precious children. Even though we confess that they are our future and therefore our most valuable national asset, we don't act as if they were.

Recently, considerable emphasis has been placed on the provision of "early periodic screening, diagnosis, and treatment" (EPSDT), but for only those Medicaid clients who are motivated to present their children for screening. It is another helpful attempt to provide health care for many children. One would expect that this would include extensive attention to the emotional growth and development of the child. But that is not to be. Most of our screening tests ignore the significant problems of parent-child interaction. To a considerable degree the emphasis is on those conditions and diseases that had had the greatest attention from various pressure groups or lend themselves to a quick checklist. It has been argued that it is far easier to have a checklist and a screening test when you are dealing with easily quantitated observations and that in the field of maternal attachment and the child's emotional health such observations cannot be readily made. Nonsense! Pediatricians have for years made such observations competently, and to exclude them from instruments sanctioned as national policy in the health care field of children does not make sense.

Specific diseases, even those that are quite uncommon, should be prevented whenever possible, but this should not be done at the expense of giving adequate attention to the whole child, his family, their total health status, including those emotional as well as physical factors that might affect the child's welfare. There is something I know about every battered child I've seen–he does not have phenylketonuria. There is more to a child's life than teeth, hearing, and vision.

In many ways it would be better to start this program at the grass roots level; perhaps our state governors should take the lead. The people in the community, laymen as well as health professionals, will have to work together in developing an

understanding that health is a personal asset that every child deserves and should have even if it would require limited intrusion into family privacy by society. Just as any fireman will enter a burning house and try to put out the fire even though he doesn't receive a specific request to do so by the owners, so those of us who are qualified to assess and correct the problems that produce child abuse and "failure to thrive" should have the authority to intervene effectively for the good of the suffering child. Let us face the fact that there are large numbers of American children living with troubled families whose emotional house is on fire. Something must be done before their lives are forever distorted and destroyed.

When marriages fail, we have an institution called divorce, but between parent and child, divorce is not yet socially sanctioned. I suggest that voluntary relinquishment should be put forth as a desirable social act–to be encouraged for many of these families. When that fails, legal termination of parental rights should be attempted. However, such termination is a difficult thing to achieve in our country because the laws are so vague. In my state of Colorado, for example, parents must be proved to be untreatable, and remain so, before the state will uphold terminations by our juvenile court judges, a process that could take five to ten years. But each child is on a schedule of his own emotional development. He doesn't give us the luxury of waiting five years. He needs loving parents right now, and the same parents, not a series of ten foster homes. For 20 years, courts have lectured me on the rights of parents, but only two judges in my state have spoken effectively on the rights of children. Courts only interpret laws passed by legislators and the actions of legislators reflect us and our communities–they reflect the voters. Regrettably, children don't vote. Unless we change the conscience of our adult voting communities, child abuse will continue to be managed by partial, Band-Aid solutions. I think all of us have the duty to educate and to be a conscience for our communities. It is significant that not one of our nation's presidents nor any one of our many governors in our 200-year history is remembered as a champion of children.

Where the state is supreme, this particular problem is easily managed: in a dictatorship each child belongs to the state and you may not damage state property. The really first-rate attention paid to the health of all children in less free societies makes you wonder whether one of our cherished democratic freedoms is the right to maim our own children. When I brought this question to the attention of one of our judges, he said, "That may be the price we have to pay." Who pays the price? Nobody has asked the child.

"A man's home is his castle," but all too often the child is a prisoner in its dungeon. It is a dungeon of constant anger, dislike, aggression, or even hatred. We must guarantee that the child will be saved when there is danger to his health and life resulting from failure in parenting. In order to do this we must see the child, and the child must have access to us.

Current national health insurance proposals are largely directed toward sickness care and financial management of the high cost of hospitalization. None specifically provide for universal and outreach health care for our young children as a right. For every federal dollar spent on our older citizens, just 5 cents goes to the preschool-age child. Obviously, people of all ages need good health care, but the investment in

our children's health care has been tightfisted, fragmented, devoid of planning, and therefore in many instances has never accomplished what it set out to do. In the coming battles for health insurance we must be absolutely certain to advance the cause of comprehensive child care; otherwise, most of the money will go to the hospitals. The state of California, to its credit, has mandated a health evaluation for all its 5- and 6-year-old children in order to receive a school health certificate before the child can enter first grade. But, obviously, this new change is far too late for many children.

In the past we have accepted inadequate and limited programs—EPSDT, Mother and Child, and Children and Youth, as well as many other categorical efforts—hoping that, like pieces of a jigsaw puzzle, there would evolve a complete picture when the last piece fell into place. We have settled for small steps in the belief that something is better than nothing and that a comprehensive system would eventually result. Instead we have a nonsystem, fragmented, oriented not toward comprehensive health care, but at the very best, gradually moving from episodic sickness care to screening only for organic disease. But that has never been the philosophy of pediatrics as we know it. It has especially not been the philosophy of this distinguished organization. Let us, therefore, now ask for what really makes sense by placing our priority on "the good start," as George Armstrong suggested, on the infant from conception to school age with the understanding that "the good start" has to involve attention to the rights of the child for tender care and love. No child can thrive without it.

Conclusion

1. In a free society the newborn child does not belong to the state nor to his parents, but to himself in care of his parents. When parenting is defective or blatantly harmful, prompt, effective intervention by society is essential on behalf of the suffering child and also his suffering parents.
2. Universal, egalitarian, and compulsory health supervision, in the broadest sense of the term, is the right of every child. Access to regular health supervision should not be left to the motivation of the parents but must be guaranteed by society.
3. Predicting and preventing of much child abuse is practical, if standard observations are made early.
4. As a bridge between the young family and health services, the utilization of visiting nurses or, more often in most places, indigenous health visitors who are successful, supportive, mature mothers acceptable to their communities, is to my mind, the most inexpensive, least threatening, and most efficient approach for giving the child the greatest possible chance to reach his potential.

   It is truly grand that we can pay tribute here to a modest and innovative man, 200 years after his time. George Armstrong serves as a model for us. May we, like him, strive to be "bleeding hearts," hard workers, activists, and visionaries. We are, after

all, the principal health advocates of all our children. Let us now resolve to fight for their total civil rights. Let us not, I beg of you, settle for anything less.

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Chapter 16
Reflections on Henry Kempe's Contributions to Child Abuse Prevention

Janet Dean

Henry Kempe was a visionary in the prevention of child abuse and neglect. He possessed intuitive and incisive wisdom about the limitations of society to address the plight of our youngest members. He saw that the fragmented and superficial services that existed to serve families did not sufficiently impact the parent–child relationship or protect children in a meaningful way.

Kempe's deep commitment to protecting infants and young children from the devastation of maltreatment was perhaps born from his sensitivity to abuses of power he witnessed as a young boy in an increasingly threatening Nazi Germany. Henry had a gift of uncanny understanding for the emotional needs of his young patients and would often credit the gentle guidance of his wife and child psychiatrist, Ruth. In the biography, "A Good Knight for Children" (Kempe 2007), his family speculates upon the influence of his prolonged childhood hospitalization on the nature of his compassion and activism. Increasingly, his observations and treatment of abused children and troubled families and his close work with colleagues such as pediatrician Ray Helfer and psychiatrist Brandt Steele, led to his conviction that with a more systematic therapeutic approach, the tragedy of child abuse could be prevented.

Many of us working with Henry in the early 1970s signed on to a journey that would change our lives and bring fresh insights into the complex problem of preventing child maltreatment. As one of Kempe's research associates, I was involved in two of his research studies aimed at understanding the predictive variables of child abuse and neglect and investigating promising preventive strategies (Gray et al. 1977; Dean et al. 1978).

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Although the University of Colorado School of Medicine and Colorado General Hospital were the sites of Kempe's pioneering investigation into the prediction and prevention of child abuse and neglect, the early threads of this research effort actually began in Great Britain in 1969 where he spent a sabbatical year as a visiting lecturer and researcher. It was there that he was introduced to the British Health Visitor system. The health visitor, a trained midwife and nurse, provided unparalleled access to supportive services for new parents. Curious about the roles of health visitors in the prediction and prevention of child abuse, Kempe and fellow pediatrician Ross Mitchell began a study involving 5,000 mothers and infants in Aberdeen, Scotland. Aberdeen was a perfect place for a long-term study because, for the most part, the entire population was born, lived, and died there.

As a research assistant, I was sent to Aberdeen after the last child in the study turned two. My job was to do an exhaustive search into hundreds of child health records, hospital admissions, emergency room visits, and coroner reports in order to see how many and which of our study children had needed medical attention in their first 2 years and whether any observations or comments made by the health visitors were useful predictors of future abuse or neglect. Kempe and Mitchell had created a questionnaire that the health visitors administered to mothers 3–4 weeks after the birth of their first baby. Questions included how the mother responded to the baby's cry, how her life was going, the type of support she got from her family, and in general how she felt. There was a space at the end of the questionnaire for informal comments and observations of the health visitor. As it turned out, these comments proved invaluable. Infants about whom health visitors showed moderate to serious concern were most likely to have been abused or neglected in their first 2 years. However, the health visitors themselves were unaware of the relationship between the conditions that caused them concern and any actual abuse and neglect. For example, one health visitor, commenting on the fact that a child had a number of emergency room visits for unexplained injuries, said "yes, the mum is overwhelmed, but she would never do any harm to her baby."

This naiveté was common. The health visitors had had training in the recognition of child abuse but had no partnering supervision that would help them understand that their initial instinctive concerns could actually predict real risk for the infant. Those of us involved in the study concluded that if health visitors could have supervisory relationships with professionals knowledgeable about child abuse and neglect, and if they could engage in a reflective dialog about what they were observing in the home, the team would have a greater chance of preventing incidences of abuse in the first 2 years of children's lives. This result and observations of the health visitor system that emerged from the Aberdeen study informed Kempe's prediction and prevention research in the USA.

For the US study (Gray et al. 1977), he decided that the in-home study teams should consist of a pediatrician, and, instead of a professional nurse, a trained "lay health visitor." Henry thought that the ideal lay health visitor would be a mother, recognized by her community as a supportive, noncritical presence. However, it turned out that the two "lay health visitors" working in the study, namely, Christy Cutler and I, were recent college graduates and not yet mothers. Fortunately, what we lacked in

experience as mothers, we made up for with boundless energy, emotional availability, and persistent outreach. Mothers typically described a "felt sense" of safety in their relationships with us "young visitors" and came to see us as supportive lifelines. Ruth Kempe would often say, "the two of you have an ability to get under someone's skin in a positive way…. You seem to find a way to engage even the toughest of mothers." In actuality, we were too naïve to be deterred by resistance or rejection.

Throughout the research and our service to families, Henry instilled in all of us three principles of preventive practice. The first principle was his belief in multidisciplinary teaming. The Prediction Study team combined pediatrics, social work, and two research associates, also the lay health visitors, with anthropology and Italian literature backgrounds, not medical training. Indeed, Henry's comment when offering me a position in the study was "we need an anthropologist to help us think more broadly about parents and what they are telling us…anthropologists understand context differently and this is important." Henry cautioned us that no one should do this work alone. He believed that decisions, especially those related to the well-being of infants, should be made by a team. We were all living the concept of collaboration. We came to appreciate each other's thinking and different perspectives. This was part of Henry's brilliance: He set the stage and expected that everyone would bring the best part of themselves to the conversation.

The second principle was creating "meaningful access." Henry thought that intake should *take in*. He was impressed by the egalitarian approach to human services in Europe. All families, rich, poor, and middle class, needed access to support after the birth of a baby. He would often say "we should not provide all of this expertise in pregnancy only to abandon families at the hospital door." His belief was that families needed meaningful access, which would include significant outreach and nonjudgmental relationships. While he applauded European programs for their access and universality of service, he felt they put too much emphasis upon the rights of parents and did not pay enough attention to the rights of the infant. When we enrolled a family in the intervention group, he expected that we would be tireless in our outreach. Indeed, we were, and a very low number of families declined our services.

The third principle involved the importance of learning through the observation of the parent–infant interaction. Observations began in pregnancy with questions about parental expectations of the unborn child and continued through labor and delivery and the postpartum period. Rene Spitz and his filmed observations of infants in orphanages had had significant impact upon Henry, so he decided that he wanted to film the parents' response to the baby at delivery and first feedings. In 1971, the invention of videotape made this effort feasible. It took the unbridled enthusiasm and energy of the two research associates to be able to videotape hundreds of parents and infants in the delivery room at all times of day and night. These early observations of parents' responses to their newborns challenged our stereotype of the "happy family bonding with baby." The video observations exposed undeniable and troubling realities, such as varying levels of maternal depression, lack of family support, and sudden emergence of mother's traumatic memories. These hitherto unforeseen emotional rejections of newborns were shocking to watch. Henry's goal in videotaping was not

to create a "child abuse detection" system. Rather, he wanted to create a universally accessible system of care with meaningful support and an emphasis upon the parent–infant interaction. He wanted to shift the concern of physicians from just the physical aspects of delivery and health of the newborn to the mental states of mother and father that could undermine the bonding success and the later parent–child relationship.

As I reflect upon the strengths of the early research and intervention, what stands out in my mind is the potency of the teaming between the lay health visitor and the pediatrician. This teaming created an epoxy of sorts, whereby the strength of intervention depended upon the professional diversity of the team and the consistency and predictability of communication. By offering a listening ear, connections to other resources, and a willingness to take worried calls from parents; and, most importantly, by providing timely access to the research pediatrician, the team created the kind of safe and supportive relationships that babies and parents need.

Team members first assessed the family risks and strengths (Gray et al. 1976). Any signs of serious stress – a job loss, the baby rolling off the bed, a small bruise, mild flattening of the baby's weight – all could be met quickly with tailored interventions and close follow-up. In this way, seemingly minor incidents and neglectful accidents could be recognized as possible precursors to something more serious. Jane Gray, the pediatrician on our team, had a welcoming and warm personality and the skill to help a parent become an effective advocate for her baby. As the lay health visitors, Christy and I would then continue to reinforce Gray's message and her gentle and kind style. Apparently this made a difference. During the study, five children in the control group required hospitalization for treatment of serious injuries thought to be related to abnormal parenting practice, but no such hospitalizations occurred in the intervention group (Gray et al. 1977).

While the prediction study results were a positive endorsement of the general intervention model to prevent child abuse and neglect, we were left with an uneasy feeling about families with attachment difficulties. One mother's haunting comment was: "I don't feel like hitting him anymore, but I sure don't like him any better." We had to ask ourselves what type of prevention model might better address unresolved traumas and/or serious mental illnesses of parents that caused attachment difficulties. In the years following this study, it gradually became clear to me that we needed to incorporate more mental health expertise.

The impact of unresolved personal trauma, and economic distress has taken a tragic toll upon many families. As a result of Kempe's groundbreaking research, subsequent prevention efforts have become increasingly comprehensive and thoroughly researched. The Nurse Family Partnership model, which employs nurses as home visitors, is one such example (Olds et al. 1997). Difficulty with access to mental health expertise, however, still looms large and has growing implications for early intervention models.

One example of the evolution of Kempe's principles and the inclusion of mental health expertise took place in Boulder, Colorado in 1983. At that time, Boulder was a hub of agency collaboration, forward-thinking county commissioners, and a visionary Mental Health Director Phoebe Norton. A 3-year-old's death from abuse galvanized the community and provided the emotional energy and financial

commitment to initiate efforts toward the prevention of child abuse and neglect. Because of my early experience with Kempe, I was brought in as a consultant to help the community think about possible program models. In my mind, this was the long awaited opportunity for a community to integrate evidence-based models of prevention into its system of care. Boulder's system was flexible enough to combine evidence-based practice with practice-based evidence. The county had good multiagency leadership, a history of cooperation, and broad consensus that it was time to provide an approach to prevention that included mental health expertise to address maternal depression, unresolved loss and trauma, and attachment disorders which manifested in an infant's poor developmental trajectory (Brown et al. 1987).

On a national level, most home visitation models lack immediate access to mental health expertise. Many families with an infant will not seek out mental health services, nor are there adequate community mental health services to which one can refer families. The most common complaint I hear when training throughout the country is that there are simply not enough parent–infant-oriented mental health services available. This hole in the system leaves the home visitor, be it a nurse or paraprofessional, extremely isolated, and it raises the level of psychosocial risk to infants and families.

Directly preceding the planning phase in Boulder was the publishing of "Clinical Studies in Infant Mental Health," by Selma Fraiberg (1980). Kempe and Fraiberg were colleagues and Fraiberg had spoken at a number of child abuse conferences in Colorado. Her writings became the bible in understanding the potency of "ghosts in the nursery" and the early unresolved abusive experiences with which parents were struggling. The question of "how to best reach out" and partner with a mother or father to overcome the "past in the present" was now being addressed. Like Kempe, Fraiberg was an activist. She made a strong argument for mental health practitioners to get out of the office and into the kitchen. She coined the term "kitchen psychotherapy." Fraiberg's contributions launched the field of Infant Mental Health and outreach to families in the home, and provided a more robust template for preventive intervention.

Considering the importance of Kempe's multidisciplinary approach, I supported and assisted in building teams that combined nursing and mental health professionals, rather than the paraprofessional or single nursing model in order to expedite access to mental health services. Psychotherapists and public health nurses with specialized training in the prevention of child abuse and parent–infant interaction would constitute the preventive intervention team. This would be an approach that would complement other models and provide a resource for a targeted population that needs mental health services. The primary access to families would be through home visits, would include families in pregnancy through toddlerhood, and also take in families expecting their first or later children. We wanted to provide services to the many families not enrolled in programs, which only include first-time mothers. Families would be referred from hospitals, health clinics, Child Protection, WIC programs, and other family-oriented programs in the community.

Consensus around these ideas, foundation seed money, and matching monies from the county commissioners facilitated the launching of the Community Infant Program in 1984. We integrated the principles of practice from Kempe's studies in the prevention of child abuse and neglect (Gray et al. 1977; Dean et al. 1978), the field of Infant Mental Health (Fraiberg 1980; Lieberman et al. 1991), and Nurse Home Visitation (Olds et al. 1997). Research from these areas has demonstrated that these program models have the ability to effect positive change in family functioning, reduce the chance of harm to an infant from physical abuse and neglect, reduce the chance of unwanted pregnancies, and be cost effective when compared to other services not aimed at prevention. We blended the best of these efforts and molded a home-based, preventive outreach program robust enough to intervene with therapeutic intensity (Gray et al. 1977; Olds et al. 1997; Lieberman et al. 1991; Huxley and Warner 1993). Our collective experience directed us to create a multidisciplinary, multicultural system of service delivery, employing parent–infant psychotherapists and nurse home visitors as our primary service teams. This model fulfilled a previously unmet need for preventive intervention with a strong mental health component (Brown et al. 1987).

The year 2012 will mark the Community Infant Program's 28th year of service to Boulder County. There are a number of insights that we can share in this development of a comprehensive approach to prevention that builds upon Kempe's early ideas. We began with an approach that encompassed different disciplines and was financially supported and sponsored by mental health, public health, and social services. The beginning of the program found the nurses and psychotherapists working more in parallel rather than the highly integrated teaming I experienced with the Kempe study. We found creating this level of integration to be an initial challenge. What shifted the "challenge of teaming" into real collaborative relationships was a restructuring of supervision. At the outset, the nurses would often join the supervision of the mental health therapists. Over time, the nurses asked their Public Health Administrators if they could become an integral part of joint supervision meetings with the therapists. The nurses commented upon the difference between reflective styles of supervision compared to the administrative supervision they received in Public Health. They reported being listened to in a way that created a safe partnering of personal vulnerabilities and encouragement around professional capacity. This was the real beginning of a working relationship between nurses and therapists. Looking back, it is hard to remember that it was difficult at first to orchestrate effective teams. This high level of communication is now part of our cultural DNA. As one nurse stated, "I can't imagine doing this difficult work with families without a team. It would be very isolating and scary. For our families to have access to a therapist and psychiatrist when they suffer from postpartum depression is a godsend."

Kempe's sensitivity to families and his commitment to meaningful access have translated into our field's ability to create better ways to connect with families. This has meant listening closely to what families have been telling us: that they need increased access to groups in order to lessen their isolation and they need to learn skills in order to regulate their own moods, build effective interpersonal

communication, and develop the capacity to focus. As one mother so poignantly commented, "how can I handle my baby's crying if I can't handle my own feelings?" A significant problem for many of our parents suffering from unresolved trauma is their inability to focus or attend. They have understandably developed adaptations to frightening situations that include dissociation. A component of our current programming involves assisting parents in learning mindfulness skills in order to improve their capacity for reflective functioning. Feedback from parents has been highly positive around this added program component. Parents have commented, "I finally have a skill that I can take in and belongs to me" and "Mindfulness helps me focus on my baby. I used to be so out of it." We approach families with serious emotion dysregulation by adapting Dialectical Behavioral Therapy, a treatment aimed at emotion regulation skills and EMDR, a treatment supporting the resolution of past trauma. (Linehan 1993; Shapiro and Forrest 2004) These approaches are examples of well-researched treatment modalities used preventively.

Henry Kempe's initiation of early observations with video has expanded in our current setting. We continue to develop our analytical skills about parent–infant interaction and have found new ways to effectively and safely use video feedback with parents, dramatically increasing the parents' reflective capacity. They are better observers of their own behavior and have become more responsive to their child's needs.

Kempe's principles are always in the forefront of our work, but his vision for a national comprehensive approach to the prevention of child abuse is far from being fully realized. Although we have made significant progress, we have more to do. We cannot allow ourselves to get discouraged from this pursuit; Kempe's legacy is one of resolute and determined advocacy for our youngest members. He said once, "The future of our children and the world are one." These words have never been more true than they are today.

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Chapter 17
Legacies That Stem from Kempe's 1976 Call for a System of Prevention

Anne Cohn Donnelly

Introduction

In 1976, Dr. C. Henry Kempe published his article on the efficacy of home visitation for new parents in preventing child abuse and issued his innovative call for a national home visitation effort (Kempe 1976). The article was based on work done earlier by Kempe and his colleagues which informed his proposal that a mandatory, universal system of home visitation for new parents be established. While not the first piece of writing about preventing child abuse, the article seemed to galvanize thinking about the virtues of and possible approaches to prevention and appears to have had a continuing impact on the explosion of prevention efforts here in the United States and around the world.

Certainly not all of what came after Kempe's call for action perfectly followed his dictates; in fact some can be seen as quite polar to Kempe's thoughts. Yet there are clear connections between Kempe's article and much of what followed over the next 35 years. In sum, the article does appear to have been the catalyst for a broadening understanding of what prevention might include, who might be involved, and how it might best be done. Reviewing Kempe's proposal for home visitation creates a basis for understanding what has followed.

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The Kempe Home Visitation Proposal 1976: Key Elements

As a result of his clinical work, and motivated by a study of some 300 parents, Kempe developed a vision for a national system of home visitation for new parents to prevent them from abusing their children. In the study, he and his colleagues found that approximately 20% of new parents appeared to be in need of extra services to be successful parents. They divided these "high-risk" parents into two groups, providing the control group with the services new parents at his hospital routinely receive (e.g., medical care and one home visit) and the experimental group with far more active intervention, including intense home visitation. Unlike the control group, no abuse was detected in the experimental group, confirming the clinicians' hypothesis that high-risk parents benefit from intense intervention which includes help in the home (Kempe 1976).

Kempe was dedicated to the notion that as a society we have an obligation to ensure that children are not abused and that a prevention system that includes all new parents is essential. In articulating the need for egalitarian, compulsory home visitation for new parents, Dr. Kempe identified a number of what he regarded as critical elements. These included:

- Universal coverage is essential, e.g., all new mothers must receive the service.
- Prediction of who will abuse or at least is at risk to abuse is practical to do and must be done.
- The use of indigenous mothers as the home visitors—"successful moms" who want to share their expertise with other moms can be very effective—whether those moms are trained nurses or lay health workers.
- The services provided should address health as well as household needs but also include a focus on parenting skills and emotional needs.
- The services should be provided over a period of time, e.g., ideally starting during the prenatal period but certainly starting around the time of birth and continuing, with declining frequency, over a 3–5 year period.

Some of his observations of note, which others later have taken issue with in practice (albeit rarely in the literature), include:

- The use of "local" moms or lay visitors is the most inexpensive, least threatening, most efficient approach to giving children a chance to achieve their full potential; there has been quite a debate about whether lay visitors can do this work at all or do it as effectively as those with professional training such as nurse practitioners.
- Lay visitors do not need much training, ("only a few days") because they only need to learn a few facts to "graft" on to their foundation as successful, and local, parents; programs that have been established subsequently offer extensive training, of weeks or months of duration.
- A home visitor, if full time, could work with 50–60 families at a time, performing a wide variety of functions as far ranging as parental coaching to helping a family move to a new community; programs developed subsequently

greatly limit the number of families home visitors work with to 5, 10, or maybe 20 families.
- As a universal service, not one just restricted to certain population groups, the home visitor would more likely be accepted by all and be more effective; there has been resistance to any form of home visitation in some population groups who see it as too intrusive regardless of whether the service was to be universal or not.

Kempe certainly felt his proposal was realistic. After all, he and his colleagues had seen these concepts effectively in play in various European countries which offered universal health coverage to new parents, albeit not as a child abuse prevention service.

His article was only one part of the efforts of Kempe and his colleagues to educate others about this concept. He himself presented his ideas at the First National Conference on Child Abuse and Neglect, held in Atlanta, Georgia in 1976. He outlined a system he believed was compatible with the child abuse problem in the United States: a system of 60,000 lay visitors providing support to 3.2 million new parents a year—a system he thought could be up and running in 5 years. A number of other articles, like those referenced in this chapter, and presentations by the Kempe team at a variety of national, international, and local conferences followed.

This thinking was new in the United States. And, in 1976, many central questions were not addressed. Would the universal concept fly? Was there enough research evidence to justify the proposed system? If not, how much would be needed? Would funding for such a system really be available as one goes to scale? How could one maintain quality in going to scale? And, would our nation truly embrace the notion of prevention, notably in the home?

The work of Kempe can be seen as the trigger for addressing these questions and for the proliferation of programs and research focused on preventing child abuse before it occurs. Interest in home visitation as a child abuse prevention approach has grown in the past three-and-one-half decades since Kempe's call to action. This paper traces some of the extant literature as a proxy to document that growth.

Pre-1976: Approaches to Child Abuse Prevention

So, what was going on in child abuse prevention (e.g., stopping child abuse from happening in the first place) before the publication of Kempe's paper? In a word, not much.

The first and second editions of the textbook *The Battered Child*, edited by Ray Helfer and C. Henry Kempe, are revealing.

The Battered Child, initially published in 1968, is a textbook intended for clinicians working with child abuse cases (Helfer and Kempe 1968). Other than an article on early case finding as a means of prevention, concepts of prevention of abuse before the fact and of home visitation were not addressed. The focus of the content was more on definition, understanding causality, identification, and legal and psychosocial implications. In 1974, when the second edition was published,

while the content reflects significant gains in understanding the problem, questions of prevention and how to do it remain unaddressed (Helfer and Kempe 1974).

A small number of service programs emerged around that time. A few offered parent aide support in home, others provided a "family crisis center" for parents and children and yet others ran a hotline. Little or no funds were available to study these programs and determine their relative effectiveness and thus little about them is documented in the broader literature (Donnelly 1975). Funds from the first federal legislation related to child abuse had just begun to flow and when they did prevention was not an early focus (USDHHS 1974). In addition, little differentiation was made between programs that served parents who had already abused versus those that sought to intervene earlier. The distinctions between prevention and treatment that seem so clear today were not distinct or thought of differently at that time.

With little to precede it in the literature or in actual service delivery, one could argue that it was the clear picture of the home visitation service model delineated in the 1976 Kempe paper that galvanized early thinking in the area and served as a challenge to others to try Kempe's model or design their own—with the newly defined intent of keeping abuse from happening in the first place. This thinking became far more evident in the literature and in practice by the early 1980s.

Work in the 1980s

The third edition of *The Battered Child* appeared in 1980 (Kempe and Helfer 1980). While many of the topics covered in the earlier editions remained, albeit with a far more sophisticated understanding of the problem, how to define it and identify it and treat it, the first formal introduction of prevention was included. The article by Gray and Kaplan heralded the home visitation concept (Gray and Kaplan 1980). Ann Wilson discussed the importance of promoting positive parent and baby relationships in her article and finally C. Schneider addressed the value of prediction (Wilson 1980; Schneider et al. 1980).

In 1981, *An Approach to Preventing Child Abuse* was published by the National Committee to Prevent Child Abuse (Donnelly 1981). The result of several intense think tanks with emerging leaders in the child abuse prevention arena, the purpose of the document was to present a comprehensive approach to prevention—e.g., what would be the range of services, program areas, and supports that would be needed in any given community to most effectively prevent child abuse.

The focus was squarely on preventing abuse before it ever occurred. At the top of the list of preventive services was "support programs for new parents," described as an essential starting point for prevention. Home visitation is cited as one of the approaches. The increasing interest in child abuse prevention programs is described alongside the challenge in locating sufficient funds to offer such services to high-risk new parents, let alone all new parents. The conclusion is that a great deal of progress has been made in responding to the child abuse problem since Kempe's article.

By the early 1980s, the numbers of those thinking about approaches to prevention and variations on the Kempe model were in abundance. And, the people and the programs came from a broad array of backgrounds…not just the medical or public health sectors (e.g., Healthy Families America, while based on the Hawaii Health Department's Healthy Start, was taken nationwide by a collaboration of social service agencies and child advocates in partnership with health departments; Parents as Teachers was a program with strong educational roots; and Early Head Start was an outgrowth of an early childhood education effort).

This broadening of players and conceptual frameworks for prevention was seen in the Fourth Edition of *The Battered Child* published in 1987 (Helfer and Kempe 1987). The book dealt in greater depth with the different kinds of child maltreatment but also in thoughts about prevention, with articles as wide ranging as parental needs to avert abuse as well as national priorities for prevention (Helfer 1987; Wilson 1987; Donnelly 1987).

The first edition of the American Professional Society on the Abuse of Children's (APSAC) *Handbook on Child Maltreatment* was published shortly thereafter in 1989 (Briere et al. 1989). This textbook, like *The Battered Child,* was written for professionals working in the field. It contained a section on "Prevention and Reporting"—that section has a single article which focused on preventing abuse before it happened; again, a concept professionals who treat child maltreatment had been slow to embrace. The article discussed the value of a broad or comprehensive approach to prevention and the need for research in this area (Daro 1989).

Work in the 1990s

Not long thereafter, in 1991, the U.S. Advisory Board on Child Abuse and Neglect issued a comprehensive report, *Creating Caring Communities: Blueprint for Effective Federal Policy on Child Abuse and Neglect,* which recommended well over 100 different actions which, based largely on the extant literature, seemed to be necessary in order to prevent child maltreatment in the first place (U.S. Advisory Board 1991). The report emphasized that the logical place to begin is with new parents, helping them get off to a good start and thus head off any patterns of abuse and neglect which might otherwise emerge. Further, while the advisory board acknowledged that many approaches to working with new parents had been formulated, the members recommend a voluntary program of targeted home visits to all new parents and their babies, even recognizing that this is not the panacea or sole answer to the problem. Fifteen years after Kempe's article was published, and after a decade and a half of exploration and testing of approaches to prevention, the foundation of Kempe's model was promoted nationally and by a well-respected, national body.

By 1997, the fifth edition *The Battered Child* was published (Helfer et al. 1997). It contained a complete section on prevention which included a description of the different levels of prevention (primary, secondary, and tertiary) and prevention as being based on a public health approach. It discussed the value of taking a comprehensive

approach to prevention (e.g., providing a full continuum of services in each community) and of tailoring prevention services to different population groups and to the kind of neglect or abuse one wanted to avert (Donnelly 1997).

This article summarizes prevention work in the field to that point with promising directions. The article emphasizes that while the belief remains that a wide variety of supports to families need to be available in a community to effectively prevent child abuse, the best place to start is with new parents. (While recognizing that home visitation is not the panacea or sole answer to abuse, the article does reenforce the earlier position of the U.S. Advisory Board on Child Abuse and Neglect of the importance of a voluntary program of targeted home visits to new parents.) This article documented the work of Kempe, which led to his 1976 article and the numerous studies of home visitation programs which had been done since (Donnelly 1997).

In addition, the article articulated the elements or critical steps suggested in the literature that are important to implement effective home visitation services. They "parrot" many of Kempe's original tenets such as initiating services prenatally, providing universal intake service for all new parents, conducting universal needs assessments using standardized protocols, and, offering high-risk parents home visiting services in a positive, voluntary way.

Also in 1997, the article "An International Survey of Classic Papers in the Child Abuse Field" was published (Oates and Donnelly 1997). The "classic papers" were identified as those which had had the greatest impact on the thinking and work in the field, as determined by a survey of child abuse professionals from a variety of professional backgrounds (medicine, public health, law, psychology, social work, and the like) and from around the world. The resulting 25 articles offer an interesting insight, particularly in hindsight, into what issues and subjects occupied the thinking of practitioners in the field at the time.

A wide scope of subjects are covered by these articles—efforts to explain and understand different types of abuse and their causes was of great interest; sexual abuse is far more prevalent in the work and thinking of those in the field than was previously the case; and importantly, several of the articles address issues of prevention and prediction, including the prevention and prediction study which offers a starting approach to Kempe's ideas, a randomized trial of the effectiveness of home visitation for new parents and the argument, based on evaluative research, for a greater focus on prevention in contrast to treatment. (Klaus et al. 2000; Gray et al. 2000; Olds et al. 2000) These 25 papers were later published in a compendium entitled *Classic Papers In Child Abuse* (Donnelly and Oates 2000).

Work in the Last Decade

The base of literature in the field was beginning to reflect a growing interest in and commitment to primary prevention—an interest which certainly can be traced to Kempe's 1976 article.

By the time the second edition of the *APSAC Handbook on Child Maltreatment* was published in 2002, an entire section was devoted to prevention, rather than a singular article as was true in the first edition (Myers et al. 2002). Prevention, primary and secondary, had become concerns of the most widely recognized professional association in the child abuse field in the United States. One chapter reviews the dramatic growth in the number and variety of programs aimed at prevention and treatment (Daro and Donnelly 2002a). The continuing high rates of abuse are noted. And, the paucity of efforts implementing prevention strategies which are truly "comprehensive" is seen as one probable cause. The chapter notes the need for increased efforts such as public education about the problem which would lead to public engagement, universal home visitation—taking what exists to scale, and the inclusion of center-based and group services for high-risk parents which focus on enhancing parenting knowledge and skills. In essence, the authors argue that the Kempe approach to home visitation for new parents is necessary but not sufficient if the main objective of prevention work is to decrease the overall numbers of abuse and neglect. They argue that many other family supports and services such as a group counseling, job training, child care, or alcohol counseling, need to be available in any given community, as does heightened community awareness of the issues of abuse and neglect. The issue is simply too complex for a singular response.

"Charting the waves of prevention: two steps forward, one step back," which appeared in the International Journal on Abuse and Neglect in 2002, describes "waves" of prevention efforts over the previous three-and-one-half decades (Daro and Donnelly 2002b). The first wave, 1974–1980, featured Kempe's vision of a national home visitation system. The second wave, 1980–1990, in response to a sense that the problem had been oversimplified, looked at more comprehensive approaches. Home visitation was an important piece, but only one piece of an approach to prevention. With the third wave, 1990 to the present, and with a new paradigm, home visitation again plays a central and important role as an intervention with its own mission (helping new parents) and as a gatekeeper to other efforts. The paper outlines common mistakes that have been made with prevention: oversimplifying the problem and the solution; overstating the potential of prevention programs; not having the resolve to take efforts to scale; and failure to engage the public and create a public will to more aggressively address the problem.

In a current contribution to the literature, the Third Edition of the APSAC *Handbook on Child Maltreatment* appears with a new framework for discussing maltreatment and an expanded section on prevention (Myers 2011). A central article, "Prevention of Child Abuse and Neglect," offers an overview of prevention and presents the range of responses to the different types that are well recognized (Daro 2011). It addresses home visitation quite directly, citing the early Kempe model but building on it with the pilot testing done since. There could be no more clear tie between the work of Kempe in 1976 and what is going on today in the child abuse field.

Legacies That Stem from Kempe's Article

In reviewing the literature of the past 35 years, the legacy of Kempe's work in prevention and with new parents is clear. While establishing a clear causal relationship is a stretch—many other players in the field were involved with activities that certainly helped spark the growth in breadth and depth of prevention efforts, a connection between Kempe's prevention work and that which followed is apparent.

At the same time, while many of the expansions in prevention were true to the teachings of Kempe around home visitation and working with new parents, others went beyond those tenets, usefully broadening both the concepts of what prevention might include, who might do it, and how it might be done. And, issues such as funding and quality, who should do the work of home visitation, whether or not intervention in the home was appropriate, and whether or not the service needed to be universal, alluded to but not elaborated on in Kempe's work, took center stage for many coming to this arena to work. Yet, one can make the argument that Kempe's 1976 article had a major impact on work to come. Some of the connected, even if not direct, outcomes of Kempe's work that can be traced in the literature include:

- A beginning focus on the value of home visitation for new parents and an explosion of ways beyond home visits to think about reaching out to high-risk new parents (such as parenting groups, counseling hotlines, parenting classes).
- The evolution of thinking about more comprehensive approaches to prevention that included home visits but extended well beyond services for new parents and included a wide variety of community supports for all families (such as family support and drop-in centers, housing assistance and child care).
- An expansion of the use of paraprofessionals to do the work of prevention (parent aides, nurse practitioners, lay therapists—paid and volunteer) to supplement the work of professionals.
- Increasing numbers of researchers who became interested in prevention, with a focus on proving it did, or didn't, work.
- A concerted effort to establish home visitation and related prevention programs nationwide in an effort to become universal—for example, the Nurse Family Partnership; Healthy Families America; Early Head Start; Parents as Teachers.
- The development of organized advocacy efforts to create funding streams for prevention—from Children's Trust Funds beginning in Kansas in 1979 and then expanding to all states, to the recent federal legislation, passed in 2010, that provides $1.5 billion dollars over 5 years to states to replicate proven prevention programs (including Early Head Start—Home Based, Healthy Families America, Healthy Steps, Home Instruction for Program for Preschool Youngsters (HIPPY), Nurse Family Partnership, Parents as Teachers, Public Health Nursing Early Intervention Program for Adolescent Mothers); $1.5–$2 million is set aside for evaluation (USDHHS 2010).

The Next Chapter

The legacies are impressive; the remaining questions that must be addressed are as well. In a forthcoming article, to be published in *Prevention of Child Maltreatment* (Daro and Donnelly in press), challenges for the next decade are identified. In "*Emerging Opportunities for Prevention: Lessons from the Past"* the authors revisit and review progress in prevention since the publication of the Kempe paper in 1976 and the declaration by Ed Zigler in that same year, 1976, that "child abuse prevention was an effort doomed to failure" (Daro and Donnelly in press). They underscore the great strides made in defining the problem, in building a service continuum (with home visitation at its core), and in developing a paradigm to study and think about the issue.

The authors also clarify how far we still have to go to conclude that we have made any significant dent in the size of the child abuse problem. They point to the things that they believe must be attended to now to successfully build on Kempe's call for action and the resulting flurry of efforts over the last three-and-a-half decades—things the Kempe paper did not address. These include a need to motivate and engage the public, an effort to recognize, engage, and strengthen the many possible nonprofit partners, and a commitment to alter our paradigms. They articulate some central questions for the field to address:

- Are we committed to creating a sustained and aggressive effort to motivate the public to support more extensive investment in addressing child maltreatment and to accept personal responsibility for insuring child protection?
- Is it possible to address social values which hinder our efforts such as the prevailing belief that parenting is solely a personal issue and any intervention, voluntary or not, is unwelcome, and thereby create opportunities for parents at risk to reach out for help?
- Can collaboration and partnerships become the hallmark of the child abuse field, allowing communities to take advantage of the expertise and wisdom of all disciplines and all participating organizations, thereby maximizing the use of all available fiscal and human resources?
- Can public institutions take full advantage of what the nonprofit sector has to offer the field and create opportunities for full and equal participation in decisions regarding the structure of key service delivery systems?
- Can the research community fully embrace and equally value diverse ways of measuring the implementation and impacts of prevention programs and policies?

Dr. Kempe would have been a great ally in ensuring that these questions get addressed and that the answers are acted upon—and that the impact of his work continues.

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Chapter 18
Crafting Effective Child Abuse Prevention Systems: A Legacy of Vision

Deborah Daro

Over the past 40 years, efforts to prevent child maltreatment have moved through various stages – public and professional recognition of the problem, experimentation with a wide range of programs that address one or more factors believed to increase a child's risk for maltreatment or mitigate its consequences, and the development of systemic and contextual reforms to better integrate and sustain these diverse interventions (Daro and Donnelly 2002). At each evolutionary stage, those developing, implementing, and funding child abuse interventions have been driven, in part, by what they were learning from current practice. As a result, public policies responding to this problem have evolved from simply capturing its extent, to understanding its underlying causes and determining how best to treat, and ultimately, prevent its occurrence (Daro 2009a).

Henry Kempe operated well ahead of this policy curve in advocating early for innovation, even in the absence of certainty. While others had examined the problem of child abuse, observed its consequences and sought effective interventions (Caffey 1946; Silverman 1953), Dr. Kempe's earliest work established an important precedent in the relationship between those seeking new knowledge and those seeking new programs. His national survey of hospital emergency room data and the records of district attorneys provided an empirical estimate of the problem that up until that time had been defined largely by single-subject clinical case studies (Kempe et al. 1962). This diverse database allowed him to articulate a set of indicators and specific symptoms which physicians and other service professionals could use to detect children at risk or who had been victimized. Finally, and most importantly, he suggested a specific legislative policy (mandatory reporting) that offered an important vehicle for formalizing public recognition of the problem and establishing

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the foundation for a societal response. This recommendation was never viewed by Dr. Kempe or other scholars examining the problem at the time as the singular solution to the maltreatment problem. Rather it was conceived as a first step toward building a response system that would, over time, become sufficiently comprehensive to achieve meaningful and sustained impacts (Steiner 1976).

As with all visionaries and leaders, Dr. Kempe shifted his focus over the years to crafting that more comprehensive system and thinking intentionally about how to prevent maltreatment. While a key theme of his 1976 article on prevention was the development of a universal system of home health visitors for new parents, his keen understanding of how best to shape the relationship between learning and doing is perhaps the more enduring legacy reflected in this paper. Individual programs come and go. They are reformed and rejected on an ongoing basis. When the planning process works well, we conceptualize, we implement, we recognize our limitations, we change our practice, and we implement again. Programs and policies that fail to embrace this commitment to continuous quality improvement quickly become ineffective and irrelevant.

Vision Versus Evidence

The perplexing question Dr. Kempe faced, which is the same question today's policy makers face, is how much evidence do you need before you can begin formulating a solution. Kempe's position was clear. He saw prevention as a question of human rights – the right of a child to have access to a safe and secure living environment. He defined a moral imperative to act not simply because we had data that suggested an intervention would work but rather because it was simply the right thing to do. This balance between acting from a position of knowledge versus acting from a position of rights or justice remains a matter of substantial debate. Indeed, concern over the lack of sufficient evidence on the problem of child abuse and how best to address it lay at the heart of the debate over the Child Abuse Prevention and Treatment Act of 1974. Dr. Kempe and those moved by the need for action felt that enough was known to move forward with a policy, which, while imperfect, would generate a chain reaction they believed would improve child safety. The database was insufficient and in need of expansion but robust enough to justify immediate action.

In contrast, Edward Zigler, Yale professor and first director of the Federal Office of Child Development (now the Administration on Children, Youth and Families), viewed the knowledge base in the child abuse arena as "much too limited to direct us to any socially acceptable and realistic interventions of far reaching effectiveness." (Zigler 1976). In the end, the visionaries won out over the pragmatists and the legislation passed. One can certainly argue (and many have in this volume and elsewhere) that moving forward without complete data overpromises impacts and complicates future decisions (Coalition for Evidence-Based Policy 2009; Haskins et al. 2009). In truth, all policy decisions carry some risk and require the need to act

in the absence of empirical evidence supporting consistent and sustained impacts. Placing an issue on the public policy and practice landscape requires that policy makers and practitioners have some action they can use to leverage the infrastructure needed to support a more empirically based and integrated programmatic response. Such early efforts are often justified by strong theoretical models regarding how change might occur and repeated positive clinical experiences across diverse settings and diverse populations (Daro 2009b).

More recently, a similar battle played out in determining how best to direct federal investments in the area of early home visiting. Building on the notion that policy should be guided by a rigorous scientific framework, President Obama's initial FY 2010 budget proposed the broad expansion of a single home visiting model that had been the subject of repeated, randomized clinical trials, a research design frequently described as the "gold standard." In response to this proposal, several researchers (including ironically Dr. Zigler who initially opposed the early Federal legislation precisely because of a weak empirical evidence base supporting any intervention) argued that such an approach would not achieve maximum impacts and benefits for the next generation of young Americans for three principle reasons:

- Building a national initiative solely on the basis of evidence generated by randomized clinical trials provides little guidance on how to replicate the model at sufficient scale to serve the national interest
- Building a national initiative solely on the basis of a single model's target population and provider characteristics will leave many of the most at-risk infants unserved and states unable to continue other high-quality interventions they are already employing to serve these groups
- Building a national initiative that does not embrace a universal understanding that all parents face challenges in raising their children undermines the collective responsibility and public will to support and sustain a robust early intervention system (Daro and Dodge 2010)

In response to this letter and the efforts of numerous advocacy groups who underscored the importance of addressing the problem with diverse strategies, the final legislation supported multiple models and embraced a more nuanced use of research and evidence in guiding policy (Haskins et al. 2009). When finally signed into law as part of the Patient Protection and Affordable Care Act of 2010 (P.L. 111–148), the Maternal, Infant and Early Childhood Home Visitation (MIECHV) program supported a $1.5 billion public investment to assist states in building a comprehensive early childhood system to promote the health and safety of pregnant women, children 0–8, and their families. Although the program places primary emphasis on replicating evidence-based targeted home visiting programs, it provides states with a broader array of program options than the single model initially proposed and the option of investing up to 25% of these resources in promising models, including those that offer services universally. It also requires state agencies to work collaboratively to integrate their investments and identify synergies that may exist across the health, child welfare, and early education systems.

Targeted Versus Universal Prevention

In contrast to many Federal initiatives that promote the replication of a single service model, the MIECHV legislation supports a number of home visiting models. Models initially identified in the legislation included

- Early Head Start (EHS) – A multiyear intensive home-based program for low-income pregnant women and families with children from birth to age 3 years to enhance child development and parental capacity.
- Family Checkup – A targeted program offering at-risk families and children a limited number of home visits to assist parents in addressing emerging behavioral health challenges in children to avoid more serious or problematic behaviors.
- Healthy Families America (HFA) – A multiyear intensive home-based program for new parents identified during pregnancy or birth who demonstrate an elevated risk for maltreatment on the basis of a standardized risk assessment administered to all births within the program's service area.
- Healthy Steps for Young Children (Healthy Steps) – A program offered through medical practices or other health care providers that offer patients a limited number of home visits between a child's birth and 30 months of age to enhance the relationship between health care professionals and parents and to improve child health outcomes.
- Home Instruction Program for Preschool Youngsters (HIPPY) – A multiyear intensive home-based program offered during the school year to assist parents who lack confidence in their ability to prepare their preschoolers for kindergarten to improve school readiness.
- Nurse Family Partnership (NFP) – A multiyear intensive home-based program targeting pregnant first time, low-income mothers and their children to improve maternal child health and development.
- Parents as Teachers (PAT) – A multiyear intensive home- and group-based program provided to any parent requesting assistance with child development knowledge and parenting supports.
- Public Health Nursing Early Intervention Program for Adolescent Mothers (EIP) – A home-based program serving first-time, teen parents from mid-pregnancy through the child's first year of life to improve maternal and child health and parental capacity.

Collectively, these programs offer states a range of options for meeting the needs of their diverse populations. While sharing Dr. Kempe's emphasis on early childhood health, development, and safety, the models vary in terms of their primary target populations, program focus, and service intensity. Although most of the models initiate services during pregnancy or at birth, HIPPY focuses on families with preschoolers. NFP and EIP exclusively utilizes nurses while other models such as PAT, HFA, Healthy Steps, and EHS employ a more diverse pool of professional service providers including nurses, child development specialists, and social workers. Recognizing the unique and important skills nurses and other health care professionals bring to the

service delivery process, Dr. Kempe also underscored the unique advantages of lay visitors including "their success as mothers and their intimate knowledge of the community they serve" (Kempe 1976). While today's home visiting workforce is dominated by professional service providers, HFA and HIPPY utilize these important community resources as direct service staff. Such diversity offers states a robust set of options for building a home-based early childhood system that will maximize the opportunity to achieve key legislative benchmarks. These benchmarks include, among other domains, strengthening parental capacity, improving health outcomes, and preventing child maltreatment.

Dr. Kempe's model also emphasized the conduct of a systematic assessment to determine both the physical and emotional needs of the new parent and her infant. His assessment focused on a range of health indicators and basic child caring skills, placing particular emphasis on observing parental "attitudes and feelings" – in other words, the primary goal was discerning if the parent had the emotional capacity to care for her child. In some instances, eligibility criteria for the MIECHV models are based on specific socioeconomic characteristics, such as NFP's focus on low income, first-time parents who enroll prenatally and EHS's focus on low-income families. Other programs, such as HFA or Family Check Up, target services to those presenting a specific level of psychosocial risk. In still other cases, such as PAT and Healthy Steps, services are more universally available. Regardless of each program's eligibility criteria, careful assessment of participants across multiple domains is central to each model's service delivery process and is used to efficiently direct participants to additional services when needed.

Despite these similarities, there is a profound difference between Dr. Kempe's vision of home visiting and the current Federal home visiting initiative. Dr. Kempe's vision was not an early intervention program for the poor or the few, but rather a universal program that asserted the rights of children to safe and nurturing care regardless of their family's circumstances. He envisioned an intervention that would be "an expected, tax-supported right of every family, along with fire protection, police protection, and clean water – societal services that we all deserve to have and from which no one can be easily excluded" (Kempe 1976). His justification for such a system was not an evidentiary base that guaranteed positive outcomes. Rather his justification relied on the simple fact that every child was entitled to effective comprehensive health care. If parents were unable or unwilling to provide access to such a system, the public had to accept responsibility to make it happen. Much the way parents are compelled to send their children to school (or provide evidence that they are able to educate their children themselves), Dr. Kempe believed parents should be held accountable for the basic health and safety of their children. His system of home-based intervention was a vehicle to support *all parents* in achieving this goal at the earliest stages of a child's life.

In suggesting his universal system, Dr. Kempe underestimated the level of training and supervision home visitors would need, extended caseloads beyond what many would view as reasonable given the level of support we know high-risk families require, and underestimated the capacity of local health systems and public social services to meet the needs of those at highest risk. For example, his projection

that an average home visitor could manage 50–60 cases working 4–5 hours a day far exceeds the 20–25 cases recommended by the MIECHV home visiting models. Similarly, his notion that home visitors could be trained in a few days is at odds with the extensive training programs provided by the various national models that include week-long introductory training sessions, annual booster sessions, and hours of observation and reflective supervision. As he had done in estimating the number of potential cases that might be identified by a mandatory reporting system, Dr, Kempe had not recognized the very serious challenges in creating a universal service delivery system within a social context that places a high value on individual choice and family privacy. Faced with what we now know to be the scope of the problem and the difficulty in taking programs to scale, even when they are well designed and highly specified, one would be tempted to reject his universal home visiting idea as certain folly.

Learning by Doing

As challenging as this universal system would be to implement, requiring policy makers to entertain the *possibility* of accomplishing difficult tasks is, in the end, Dr. Kempe's most important legacy. As Brandt Steele noted in the first C. Henry Kempe Memorial Lecture delivered at the Sixth International Congress on Child Abuse and Neglect in 1986, Dr. Kempe specialized in getting small groups of people to accomplish extraordinary things. "It was characteristic of Henry," Dr. Steele noted, "to present an idea and then ask you to do something that you had never done before or ever thought of doing, with an expectation that you would automatically agree to do it… There was something about the way Henry believed in us and supported us that enabled us to do things and develop capacities which we had not previously known we had, always to do more than we thought we could" (Steele 1987).

No one would suggest we operate public policy in the absence of a well-defined theoretical framework or some evidence that the idea being proposed is capable of achieving the desired outcomes. Indeed, a critical element of solid public policy, and one which Dr. Kempe fully understood, is using empirical data to guide, not determine policy and practice decisions. It is equally important not to limit our scope to what has been proven. Electing to do only what is certain eliminates the possibility of accomplishing what is needed. In the case of early home visiting programs, simply implementing one or even several targeted models will not shape the robust prevention system of care required to foster early learning opportunities capable of reducing child maltreatment rates. Replication of high-quality early education programs has not dramatically improved the kindergarten readiness of the nation's population, expansion of charter schools has not altered the average performance in the nation's urban education programs, and expansion of targeted violence prevention programs has not reduced the nation's violence rate. This is

not to say that individuals enrolled in these programs have not benefitted from these opportunities. Unfortunately, these gains, from a population perspective, have been modest and far from transformative.

Even if federal investments in intensive home visiting reach the most optimistic levels being proposed in Congress, these resources will allow for doubling the number of families reached, to a total of 6% of all families with young children and 14% of those living in poverty (Stoltzfus and Lynch 2009). Given all the challenges inherent in accurately targeting those at highest risk, in enticing them to enroll and remain in voluntary programs, and in effectively achieving core outcomes, it remains unlikely that even this level of investment will provide the safe environment Dr. Kempe considered a child's basic right.

The relative high costs of intensive interventions underscore the importance of identifying an efficient way to match families with the appropriate levels of support. Achieving this level of efficiency is best done not through an eligibility system based on demographically determined risk but rather through a comprehensive assessment that identifies specific needs and refers participants to the most appropriate service as Dr. Kempe's system envisioned. While it is true that specific subpopulations do demonstrate a higher likelihood to engage in physical abuse or neglect, the vast majority of poor families, those birthing their first child when they are teenagers, those lacking a spouse or partner, and those living in neighborhoods experiencing violence and social disruptions manage to raise their children in a nonabusive or neglectful manner. Labeling all of these families as high risk and in need of multiple years of intensive intervention would require investment levels far beyond any estimated cost for extending initial assessments and appropriate service linkages to all new parents.

Identifying appropriate prevention investments demands a research and policy agenda that recognizes the importance of balancing knowing and doing. In the end, we cannot ask more of "research" than we are willing to ask of ourselves. Limiting our policy options to further implementation of evidence-based program models or practice strategies will not create the context necessary to insure these programs will flourish. Changing context will require that the rigor with which we test existing service models be applied to conceptualizing, and then testing, innovative strategies that focus on the broader questions of system reform and integration, the development of robust universal early intervention systems that mirror our universal investment in public education, and the creation of a social imperative that instills a sense of personal responsibility in all of us to support and nurture *all* children within our sphere of influence.

Advances in resolving difficult social dilemmas lie partly in better research and partly in our ability to imagine different solutions, ones which ask all of us to do better and to act in different ways. Dr. Kempe was not bounded by existing research or knowledge in formulating his solutions to the child abuse dilemma. Sustaining his legacy requires that we do the same and look beyond what we know to what we hope we can achieve.

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Chapter 19
Moving Toward Evidence-Based Preventive Interventions for Children and Families

David L. Olds

In 1975, Henry Kempe was awarded the George Armstrong Award for calling worldwide attention to the appalling problem of child abuse. In his acceptance speech, he made an impassioned plea for its prevention and a case for developing a lay home-visitor system in the USA to protect the health of young children (Kempe 1976). Having observed nurse-delivered health visiting in Europe, he concluded that European systems were not reaching the most vulnerable parents, and attributed the limited reach of those nurse visitors in part to governments' concerns about violating the rights of vulnerable parents who appeared reluctant to accept nurses into their homes (Kempe 1976).

Dr. Kempe reasoned that lay health visitors who were mothers themselves would have greater access to vulnerable parents than would nurses, because lay visitors would be trusted members of the community. He suggested that lay visitors could be trained to work with at-risk families in just a few days because they already had "the most essential knowledge" – which comes from being a successful mother and a member of the community (Kempe 1976). Kempe's vision became the framework for Hawaii's Healthy Start paraprofessional home-visiting program (Duggan et al. 1999), which in turn formed the foundation of Healthy Families America (Healthy Families America 2011). Both programs started by identifying families in the newborn period as being at risk for maltreating their children, using a variant of a screening tool recommended by Dr. Kempe (1976), with those at risk being offered home visiting. Since Dr. Kempe's speech, we now have three decades of research on home visiting, grounded in randomized controlled trials, with which we can examine these pioneering ideas. I should note that I am not an unbiased commentator. My colleagues and I have developed and tested, beginning in 1977, a program of prenatal and infancy home visiting by nurses known today as the Nurse–Family Partnership

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(NFP), and we have conducted research that examines the impact of this program when delivered by paraprofessional visitors.

In 2009, Harriet MacMillan and colleagues published a highly regarded review in *The Lancet* that synthesized the literature on the prevention of maltreatment and associated impairments (MacMillan et al. 2009). It concluded that programs delivered by paraprofessional home visitors (including the Hawaii Healthy Start program and Healthy Families America) were not effective in reducing child protection reports or associated impairments, and that the evidence on self-reported abuse from trials of these programs was inconsistent. MacMillan et al. noted that some earlier reviews of this literature had concluded that home-visiting writ generically produced benefits, but her team questioned the conclusions of these reviews on the grounds that the reviewers grouped programs and studies in ways that obscured important differences among them (2009). MacMillan concluded that two home-visiting programs were effective in preventing maltreatment: the NFP (Olds et al. 1986a, 1997, 1998, 2002, 2004a, 2007; Kitzman et al. 1997), which they referred to as having the "best evidence," and Early Start (ES), a program of infancy and toddler home-visiting delivered by bachelors' prepared nurses and social workers in New Zealand (Fergusson et al. 2005).

ES serves families identified during the newborn period as having risks for child abuse and neglect using a variant of the Kempe Family Stress Inventory pioneered by Dr. Kempe. ES visitors have five goals: (1) to improve child health; (2) to reduce the risk of child abuse; (3) to improve parenting skills; (4) to improve family socioeconomic and material well-being; and (5) to encourage stable partnerships (Fergusson et al. 2005).

ES has been tested in a single trial in New Zealand ($n=443$) and found to reduce attendance at hospitals for injuries in the first 3 years of life when compared to controls (17.5% vs. 26.3%). ES parents reported less severe physical assault of their children, but there were no intervention-control differences in child protective service encounters, probably resulting from greater surveillance of the ES families for maltreatment (Fergusson et al. 2005). MacMillan and colleagues recommended replication of this study.

The NFP is focused on socially disadvantaged mothers bearing first children registered prior to the 28th week of pregnancy. Nurses delivering the NFP have three goals: (1) to improve the outcomes of pregnancy by helping women improve their prenatal health; (2) to improve children's subsequent health and development by helping parents improve their care; and (3) to help parents become more economically self-sufficient by helping them develop a vision for their future and make concrete plans for accomplishing them (Olds 2002).

The NFP has been tested in a series of randomized trials in which the background of the families served was intentionally varied from one trial to the next to gain an understanding of the extent to which the program would benefit major ethnic groups in the USA: 89% whites in Elmira, NY (total $n=400$) (Olds et al. 1986b, 1997, 1998), 88% blacks in Memphis, TN ($n=1{,}139$ for the prenatal phase and $n=743$ for the postnatal phase) (Kitzman et al. 1997; Olds et al. 2002, 2007), and 46% Hispanics and 35% non-Hispanic whites in Denver, CO ($n=735$) (Olds et al. 2002, 2004b). In all of these trials, very large portions of the target populations were registered – 75–88%,

and large portions of the samples were retained for up to 17 years after the end of the program at child age 2 (almost always over 80% of those randomized). We measured outcomes of clear public health importance and used objective methods of measurement whenever available.

In the first trial of the NFP, during the first 2 years of the child's life, nurse-visited children had 32% fewer emergency department encounters overall in the child's second year of life (0.74 vs. 1.09 visits) and 56% fewer ED encounters for injuries and ingestions in the second year of life (0.15 vs. 0.34 visits). These treatment-control differences were more pronounced among mothers with limited sense of control over their lives measured during pregnancy prior to randomization (Olds et al. 1986a). By child age 15, nurse-visited children had 48% fewer substantiated reports of child abuse and neglect overall (0.29 vs. 0.54), an effect that was more pronounced for children born to mothers at greater socio-demographic risk by virtue of their being unmarried and from low-socioeconomic status (SES) households at registration (Olds et al. 1997). The program effect on child maltreatment was attenuated in households with moderate to high levels of intimate partner violence (IPV) (Eckenrode et al. 2000). The full set of program impacts, including reductions in prenatal tobacco use (Olds et al. 1986a, b), families' use of welfare (Olds et al. 1997), maternal and child arrests (Olds et al. 1997, 2004a, b), and increases in intervals between first and second births (Olds et al. 1997) can be found in the original reports.

In the second trial of the NFP, the official rates of child abuse and neglect were too low and surveillance bias too high to serve as a viable outcome, so we hypothesized that we would see program effects on children's injuries found in the medical record. By child age 2, nurse-visited children had 23% fewer health-care encounters for injuries (0.43 vs. 0.56), and were hospitalized for injuries and ingestions for 79% fewer days (0.04 vs. 0.18) (Kitzman et al. 1997). These differences were more pronounced among children born to women with low psychological resources (lower intellectual functioning, sense of mastery over their lives, and higher rates of depression and anxiety). Importantly, nurse-visited children born to mothers with low psychological resources had higher levels of language development and math achievement than did their counterparts in the control group through child age 12 (Olds et al. 2004a, 2007; Kitzman et al. 2010). Again, the full set of program impacts on maternal and child health, including impacts on closely spaced subsequent pregnancies (Kitzman et al. 1997, 2000), families' use of public assistance (Olds et al. 2010), and children's depression, anxiety, and emergent use of substances (Kitzman et al. 2010), can be found in the original publications.

The Denver trial was designed to help us sort out why paraprofessional-led home-visiting programs tested in randomized controlled trials produced disappointing results (Olds and Kitzman 1993; Gomby et al. 1999). Was it because of the visitors' backgrounds or was it that the visitors had been given programs that were underdeveloped from a clinical perspective? In the Denver trial, 735 at-risk pregnant women were randomized to one of three conditions: control, paraprofessional-visited, or nurse-visited (Olds et al. 2002, 2004b). The paraprofessional visitors were educated in essentially the same program model (with appropriate adaptations to their backgrounds) that nurses had delivered in Elmira and Memphis; they were recruited from existing paraprofessional home-visiting programs

in the Denver metropolitan area, and they were given twice the level of clinical supervision as their nurse counterparts.

In the Denver trial, we were unable to examine children's medical records because of the complexity of the health-care settings in which they obtained care, and individual encounter data on injuries were not available during the course of this study from Medicaid, so we deepened our measurement of parental caregiving and children's early emotional development (Olds et al. 2002). We found, among other things that nurse-visited women, compared to controls, reduced their use of tobacco over the course of pregnancy, and nurse-visited children were less likely to express emotional vulnerability in response to stressful fear stimuli at 6 months of age (Olds et al. 2002). Nurse-visited children born to mothers with low psychological resources, compared to control-group counterparts, were less likely to exhibit low emotional vitality at 6 months of age, fewer language delays at 21 months (Olds et al. 2002), and had higher levels of language development and executive functioning through child age 4 (Olds et al. 2004b), 2 years after the end of the program at child age 2. As in Elmira and Memphis, nurse-visited women had fewer closely spaced subsequent pregnancies (Olds et al. 2002, 2004a, b). The corresponding benefits for paraprofessional-visited mothers and children were rarely statistically significant, with effect sizes about half the size of those for the nurse-visited group (Olds et al. 2002, 2004b). It was striking that the paraprofessional-visited group tended to fall right in between the control group and the nurse-visited group on almost every outcome on which nurses made a difference. The paraprofessional-visited group did have significant improvements in observed qualities of caregiving at child age 4 (Olds et al. 2004b), however, which may contribute to long-term benefits for children. The full set of program impacts can be found in our original publications (Olds et al. 2002, 2004b).

In attempting to sort out why paraprofessional-visitors had not produced impacts similar to the nurse visitors, we examined features of program implementation delivered by the nurses and paraprofessional visitors (Korfmacher et al. 1999). Mothers rated their paraprofessional and nurse visitors equally highly. Nurse-visited families, however, were less likely to drop out of the program and had more completed home visits than their paraprofessional-visited counterparts. The higher rates of completed visits were not attributable to nurses making greater efforts to connect with their clients. Paraprofessional-visited families simply did not open their doors as frequently as did those visited by nurses (Korfmacher et al. 1999). This finding has driven home an essential point – counter to Dr. Kempe's assumption that vulnerable families would not open their doors to nurses – that families were *more* likely to open their doors to nurses than to paraprofessionals. One possible explanation for this finding is that families must have confidence that their provider will be able to address issues of fundamental importance to them – and for pregnant women bearing their first children much of this may relate to their own health, labor and delivery, and care of the newborn. And visitors must have the training and skills needed to deliver on the implicit promise that they will help, and of course this extends, importantly, beyond issues of physical health. It probably does not hurt that nurses are consistently rated as the professionals with the highest standards for ethics and

honesty (Gallup 2010). These findings underscore the need to systematically evaluate hypotheses that thought-leaders bring forward as promising approaches to improving the lives of vulnerable children and families.

It is important to note here that in 2006, the British government invited us to develop the NFP in England as a specialized service for its most vulnerable first-time mothers (Barnes et al. 2011). Its Social Exclusion Task Force had observed that their existing Health Visitor Service was not reaching many of the most vulnerable families, just as Dr. Kempe had observed 30 years earlier. The Family–Nurse Partnership, as it is called in the UK, is now being tested and expanded even during the current economic downturn, and preliminary results indicate that the FNP nurses are highly valued and accepted enthusiastically into families' homes (87% of those offered the service accept it) (Barnes et al. 2011, n.d.). More definitive evidence on its impact in England will be available in several years, once results of a randomized controlled trial commissioned by the UK government become available.

The findings from the NFP trials led President Obama to propose to Congress in early 2009 that a nurse-delivered program of prenatal and infancy home visiting for low-income, first-time parents be funded at a level of $8.6 billion of mandated funding for a 10-year period, so that it eventually would serve about 50% of Medicaid-eligible first-time pregnant women (Haskins et al. 2009). The final version of the president's proposal, after undergoing Congressional review, included $1.5 billion of mandated funding over a 5-year period (about 90% of what would have been funded in the first 5 years of the original 10-year proposal). It included funding for a variety of home-visitation types as long as they had evidence of impact in at least one moderate-quality quasi-experimental study (or randomized controlled trial) in at least one of the legislatively identified outcome domains in which the NFP trials had found benefits: (a) improved maternal and newborn health; (b) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; (c) improvement in school achievement and readiness; (d) reduction in crime or domestic violence; (e) improvements in family economic self-sufficiency; (f) improvements in the coordination and referrals for other community resources or supports. No reference was made to the size or importance of effects that would qualify a program for funding or to whether findings were replicated.

Once the bill passed, the Department of Health and Human Services (HHS) commissioned a review of the home-visiting literature (USDHHS n.d.). This review led HHS to conclude that eight existing home-visiting programs met the minimal legislative threshold for federal funding: Early Head Start, the Early Intervention Program, Family Check-Up, Healthy Families America (HFA), Healthy Steps, Home Instruction Program for Preschool Youngsters, NFP, and Parents as Teachers (PAT). States are required to select among these programs to serve high-risk communities, to show plans for state-level integration of maternal and child health services, and to monitor implementation and determine impact of the programs. A national evaluation is planned on top of the states' evaluations.

In August, 2011, the Coalition for Evidence-Based Policy weighed in on this initiative (Coalition for Evidence-Based Policy 2011). The Coalition is a neutral, objective party whose mission is to evaluate evidence and promote state and federal

Table 19.1 Home-visiting programs funded under the Maternal, Infant, and Early Childhood Home-Visiting legislation and levels of confidence that they will produce important life improvement (Coalition for Evidence-Based Policy 2011)

Model	Level of confidence that the model will produce important life improvement
Nurse–family partnership	Strong
Early intervention program	Medium
Family check-up	Medium
Early head start – home visiting	Low
Healthy families America	Low
Healthy steps	Low
Parents as teachers	Low
Home instruction program for preschool youngsters	Insufficient evidence

policy making, based upon the results of rigorous research. The Coalition uses evidentiary standards similar to those employed in the federal review, except that it gives much greater weight to interventions tested in well-conducted randomized controlled trials, to those that produce impacts of policy or practical value, and to those in which the findings have been replicated and sustained. The Coalition built upon the government's review by determining whether the results showed important improvements in the lives of at-risk children and parents (e.g., whether there was a sizeable decrease in hospitalizations or improvement in academic achievement). The two home-visiting programs given medium ratings were delivered by nurses (Early Intervention Program) or Masters- or Ph.D.-prepared parent educators (Family Check-Up). Healthy Steps visitors are Masters-prepared nurses, social workers, or mental health professionals. Visitors in other programs are primarily paraprofessionals. The Coalition's summary of the likelihood that particular programs will produce meaningful impact is contained in the Table below. They conclude that the federal program's overall impact will depend upon which models states implement (Table 19.1).

According to Peter Orszag, President Obama's budget director when the home-visiting program was launched, the programs funded under this initiative were meant to provide a new standard for public policy – to focus funding on programs that met the "Top Tier" (the Coalition's standard) of evidence, while making some funding available for promising programs that did not yet meet this evidentiary threshold (Orszag 2009). As the Coalition's analysis indicates, this initiative actually includes funding for a much broader array of programs than Orszag envisioned.

One of the purposes of the home-visiting legislation is to improve the coordination of services in at-risk communities (Affordable Care Act 2010). Some have interpreted this to mean that a range of home-visiting programs should be funded in order to ensure that a larger portion of families in need will be provided services. Some programs set no limits on the backgrounds of the families they serve, which means they include multiparous women, often making special efforts to recruit those with

histories of having abused substances and maltreated their children – the very types of families identified as being in need, based upon Dr. Kempe's Inventory. Randomized controlled trials of home-visiting programs focused on populations with histories of maltreatment (MacMillan et al. 2005) or substance abuse (Suchman et al. 2006), however, have found that programs focused on these populations have not produced compelling impacts, at least so far. Part of the relatively small impacts produced by some home-visiting programs, thus, may have to do with their attempt to serve all in need. Other interventions for parents who have already abused their children, such as Parent–Child Interaction Therapy (Chaffin et al. 2004; Thomas and Zimmer-Gembeck 2011), have shown significant promise, so there is reason for hope.

Data on the prevention of maltreatment and the new federal initiative offer two policy approaches: One allocates scarce dollars in ways that reach larger segments of the population because there is need, even though there is insufficient evidence that we can make a difference with all those we wish to help. The other targets taxpayers' dollars on programs with "Top Tier" evidence that they work well with particular groups of vulnerable women, children, and families, and then goes about developing and testing new interventions that eventually may make a difference with those not currently helped. I believe, the second course gets us closer to Dr. Kempe's vision. We honor Henry Kempe by embracing his commitment to prevention, by investing in programs with rigorous evidence that they reduce harm to children, and by investing in research to develop new interventions to improve the lives of those not helped with existing interventions. In doing so, we honor vulnerable children and their families – ultimately, the highest form of praise for him.

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Part IV
Child Sexual Abuse

Chapter 20
Introduction and Commentary: Child Sexual Abuse

Richard D. Krugman

Sixteen years after the presentation of the Battered Child Symposium in Chicago, the Annual Meeting of the American Academy of Pediatrics was held in New York City in 1977. The C. Anderson Aldrich Award was to be given to C. Henry Kempe during the conference. The night before the award, he developed severe chest pain and was admitted to Bellevue Hospital, where he spent 6 weeks in the Coronary Care Unit before returning to Denver.

Just as the publication of the Battered Child crystallized action around an issue that was not new, the Aldrich lecture and later the publication of "Child Sexual Abuse, Another Hidden Pediatric Problem" helped pediatricians understand what they *had not* been seeing for years. The key to being able to make this diagnosis, of course, is to, first, be aware of the existence of the problem and, second, to be able to ask about the possibility that sexual abuse might have occurred.

From the beginning of the public awareness of the problem and subsequent policy responses, sexual abuse has been treated differently from physical abuse. In part, this has occurred because the field had evolved from two different routes. One route, which anteceded the Kempe paper, evolved through the expansion of the Women's Movement in the USA (and worldwide) with the recognition of how poorly the health-care system was responding to the sexual assault of women. "Rape Crisis Centers" began in the early 1970s and provided forensic examinations and crisis intervention for the victim through forensic medical, mental health, and legal services. These centers focused mostly on adults, but as the recognition grew of the younger ages of sexual abuse victims, many of these centers began to provide exams and treatment for children. The common thread of these programs was to help prosecute the "perpetrator" and assist the victim and her – almost always *her* – mother to get on with their lives without him. The approach that Kempe and others (such as the

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Giarretto Institute) took to child sexual abuse was similar to the approaches that had historically been taken throughout the USA to physical abuse and neglect: assure that the child was in a safe place so whatever happened would not happen again, and then try to treat and rehabilitate the family. These two approaches are quite different, have different paths, and have different consequences. And, it should be stated, now 35 years later, there are no outcome data on these approaches, much less an evidence base to support them.

One of Kempe's central principles was that the purpose of child protection was just that: the protection of the child had to take precedence over other issues (such as the prosecution of the abuser). He recognized that having to prove who had abused the child "beyond a reasonable doubt" made it unlikely that children (as a population at risk) would be protected from further harm. The child protection system in the USA and elsewhere in the world has found this a daunting principle to uphold.

The three papers in this part look back at the beginnings of the approaches to recognition, intervention, and treatment that Kempe espoused. These are very different approaches than are found in much of the jurisdictions in the USA and the UK that struggle to deal with the large caseloads of sexually abused children they process annually. In the first, Patricia Mrazek relates the approaches that followed from the Aldrich lecture and subsequent work at the Kempe Center. The other two papers are by two colleagues from the UK, David Jones and Arnon Bentovim. There is a lot to be learned from them, but one has to be sanguine about the likelihood that resource-poor public child protection and mental health systems will ever be able to attain the goals Henry had for us.

Chapter 21
Sexual Abuse, Another Hidden Pediatric Problem: The 1977 C. Anderson Aldrich Lecture

C. Henry Kempe

Pediatrics started, about a hundred years ago, around the single critical issue of deaths due to diarrhea, caused by unsafe milk. Pediatrics has progressed to a comprehensive approach to child health, with intermittent episodes of acute illness and the skilled management of chronic illnesses. The modern pediatrician, modeling himself after Dr. Aldrich, will attempt to return the child to his normal and optimal state of health as soon as possible and to try to minimize the deleterious effects of illness on the normal growth and development of the child, from both the emotional and the physical point of view.

I have chosen to speak on the subject of sexual abuse of children and adolescents as another hidden pediatric problem and a neglected area. More and more clinical problems related to sexual abuse come to our attention every year. In our training and in our practice, we pediatricians are insufficiently aware of the frequency of sexual abuse; it is, I believe, just as common as physical abuse and the failure-to-thrive syndrome.

Just as the "battered child syndrome" rang a responsive chord among pediatricians 20 years ago, it is my hope that with this brief discussion I might stimulate a broader awareness among pediatricians of the problems of sexual abuse. I shall try to do so from a developmental point of view, since the child's stage of development profoundly influences the evaluation and treatment we give.

During last year's influenza vaccination campaign, a 10-year-old girl was seen in consultation with the possible diagnosis of Guillain-Barré syndrome. She was, in fact, suffering from hysterical paralysis. Everyone was relieved by what she did not have, but not so impressed with the discovery that her hysterical paralysis stemmed from the fact that she had been the subject of an incestuous relationship with her father. This had become increasingly intolerable to her, with the resulting symptoms. Physicians and, surprisingly, nurses generally shunned her and were not very sympathetic. She was somehow in the wrong. There was some discussion that

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she was "seductive," and that she "might have been asking for it." Another group didn't believe the diagnosis in the first place. I found her to be a lonely and almost suicidal youngster in need of immediate rescue through active intervention. Her masked depression was characterized by inability to eat or sleep.

Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles.

Sexual abuse includes pedophilia (an adult's preference or addiction for sexual relations with children), rape, and all forms of incest. "Sexual exploitation" is another term frequently used, and it is true that these children are "exploited," because sexual abuse robs the child and adolescent of their developmentally determined control over their own bodies, and they are further robbed of their own preference, with increasing maturity, for sexual partners on an equal basis. This is so regardless of whether the child has to deal with a single overt, and perhaps violent, act, often committed by a stranger, or with incestuous acts, often continued for many years, which may be carried out under actual or threatened violence or may be nonviolent or even tender, insiduous, collusive, and secretive.

Scientific studies of incidence are even rarer in the field of sexual abuse than in the field of physical abuse. Data collection has been impaired by what has been euphemistically referred to as a "family affair" In discovered acts of pedophilia, such as occurs in fondling or exhibitionism, the child complains to his parents, the police are involved, and an incidence report is made. The same holds true of child rape. In these situations, incidence data are at least minimally correct. As far as the child is concerned, family and professional support for the victim is strong, and criminal conviction rates are relatively high. Pediatricians here are often informed early on, and they do participate in the diagnosis and even the early treatment of victims. In instances of nonviolent pedophilia, particularly a single act involving a stranger, simple reassurance of the child and more massive reassurance of the parents are all that is required. Forcible sexual abuse and child rape involving strangers, aside from the management of the sexual injuries, often call for long-term supportive therapy to each member of the family.

The discovery of incest, on the other hand, finds the family and the community reacting in a different way. If reports are made by the victim, they rarely result in family support, nor do they often result in successful criminal prosecution. Moreover, it is common for children, who are regularly cared for by their pediatrician, to be involved in incest for many years without their physician knowing. Incest makes pediatricians and everyone else very uncomfortable.

Some physicians routinely ascribe specific complaints of incest, and even incestuous pregnancy, to adolescent fantasy. Often, pediatricians will simply not even consider the diagnosis of incest in making an assessment of an emotionally disturbed child or adolescent of either sex. Still, a history of incest is so commonly found among adults coming to the attention of psychiatrists, marriage counselors, mental health clinics, the police, and the courts—10 or 15 years after the events—that the failure to consider the diagnosis early on is somewhat surprising. Most of the youngsters we now see are under the care of a pediatrician in private practice or a

clinic setting. With remarkable regularity they represent the children of professionals, white- and blue-collar workers, as well as of the poor, in a way that reflects a cross section of our community. And so it is with the racial distribution, which, contrary to published reports from welfare departments and the police, reflects that no race in Denver is overrepresented in sexual abuse, provided one considers all levels of society who come to our attention.

Underreporting is massive. In incest there is often long-standing active or passive family collusion and support. Disruption of the ongoing set relationships is generally resisted, and understandably so; disclosure will result in public retribution, with the firm expectation of total family disruption, unemployment and economic disaster, loss of family and friends for the victim, and likely incarceration for the perpetrator, at least until bail is posted. There is also the public shame of failure for each person involved in their own role as father, mother, and child, with resulting further loss of self-esteem by all. The Children's Division of the American Humane Society reported 5,000 cases of sexual abuse for the United States in 1972. Since only a small fraction of instances of sexual abuse are reported at the time of occurrence, as opposed to those that come to light ten or more years later, it is our view that the true incidence must be at least ten times higher. In the first six months of this year, the Denver General Hospital alone saw 89 cases. We are increasingly seeing younger and younger children who require urgent care. The group of children from birth to age 5 years has increased in recent years from 5% to 25% of the total, while the incidence during the latency age period from 5 to 10 has remained stable at 25%. Between 1967 and 1972 the number of sexually abused children increased tenfold in our hospital.

Incest is usually hidden for years, and comes to public attention only as a result of a dramatic change in the family situation, such as adolescent rebellion or delinquent acts, pregnancy, venereal disease, a great variety of psychiatric illnesses, or something as trivial as a sudden family quarrel. One half of our adolescent runaway girls were involved in sexual abuse, and many of them experienced physical abuse as well.

Nature of Sexual Abuse

Pedophilia

Pedophilia often involves nonviolent sexual contact by an adult with a child, and it may consist of genital fondling, orogenital contact, or genital viewing.

Case 1

A brilliant young lawyer, father of two children, on several occasions engaged in genital fondling of 6- to 8-year-old girls who were friends of his children. The

neighbors contacted us with a view toward stopping this behavior, while at the same time wanting to prevent the ruin of this attractive family and to get psychiatric help for the patient. Much of this compassionate and nonpunitive view was the result of their affection for the patient's young wife, whom they greatly liked. They insisted, however, that the family promptly leave the neighborhood. The patient moved to a distant city, where he entered psychotherapy and has had a long-term cure of his addictive pedophilia. His professional and family life has remained stable.

Case 2

A 53-year-old physician was accused of fondling the genitalia of his preadolescent male patients. A hearing before the medical board confirmed that he regularly measured the penis of all his male patients, much as he would examine their weight. His defense was that measurements such as these are part of comprehensive care, but the board held that the procedure was not routine anywhere, except when the specific medical problem concerned the size of the penis, as is the case in some hormonal disorders. He voluntarily resigned his license to practice but refused offers of help.

Violent Molestation and Rape

While all sexual exploitation of minors is illegal, society is particularly concerned with retribution to prevent repetition when rape or other forcible molestation occurs. It is not necessary for hymenal rupture or vaginal entry to occur to have the rape statute apply; frequently, vaginal tears and/or evidence of sperm or a type-specific gonococcal infection can be the ultimate proof. However, perineal masturbatory action often leads to emission of sperm outside the vagina, on the skin or the anus. Many molestors experience premature ejaculation, and others are impotent. We find sperm less than 50% of the time. Orogenital molestation may leave no evidence, except the child's story. This must be believed! Children do not fabricate stories of detailed sexual activities unless they have witnessed them, and they have, indeed, been eyewitnesses to their abuse.

Case 3

The 23-year-old unemployed boyfriend of a divorced middle-class woman was babysitting for the woman's two daughters, aged 6 and 14. He first began to sexually assault the 14-year-old girl and raped her, despite her efforts to resist by screaming, hitting, and biting. While she ran for help to distant neighbors, he

raped the 6-year-old and fled. When captured, he told the police that he had had two beers and remembered nothing of the events. The children both required hospital care for emotional as well as medical reasons. The 6-year-old had a 2.5-cm vaginal tear that was repaired. The older child had a hymenal tear and many bruises. Both had semen in the vagina, and both required antibiotics to prevent gonorrhea with which the attacker was afflicted. Loving and supportive nursing and, later, psychiatric care were given to both victims, who seemed to view the event as "a bad accident." The mother had much reason to feel guilt, since she had known of her friend's inability to handle alcohol without becoming violent. The psychiatric diagnosis of the perpetrator was "violent and sociopathic personality, not likely to change at any time." He remains in prison for an indeterminate sentence, but he is a model prisoner to date, and will eventually be paroled.

Incest

Father-daughter incest accounts for approximately three fourths of cases of incest, while mother-son, father-son, mother-daughter, and brother-sister account for the remaining one fourth. It is our belief that incest has been increasing in the United States in recent years, perhaps because of the great changes in family life: increasing divorce rates, birth control, abortion, and an increasingly more tolerant view of sexual acts between blood-related household members who come from divorced or previously separated homes. This is particularly true as it affects brother-sister incest between stepchildren, who are living as a family but are not related. We believe that cultural attitudes in regard to this latter group of adolescents are rapidly changing to a less concerned stance.

Father-daughter incest tends to be nonviolent, but in the preadolescent and early adolescent, the coexisting relationship between physical abuse and sexual exploitation is often striking, but rarely discussed. It is not uncommon for acting-out adolescent girls to be suffering from both physical and sexual abuse. We find men with psychopathic personalities and indiscriminate sexuality who view children as objects, and these men are often violent. Some nonviolent abuse is seen in pedophiles who seduce both their own and other children. Most fathers involved incestuously with their daughters have introverted personalities, tend to be socially isolated, and have an intra-family orientation. Many are gradually sliding toward incestuous behavior, with the extra push given, often, by a wife who either abets or arranges situations likely to make privacy between father and daughter easier. She may, for example, arrange her work schedule to take her away from home in the evenings and tell her daughter to "take care of Dad" or to "settle him down." It is not hard to see how a very loving and dependent relationship between father and daughter might result, first in acceptable degrees of caressing and later in increasingly intimate forms of physical contact. The silent agreement between husband, wife, and daughter is a triad in which each plays a role and which is generally free of marked guilt or anger unless a crisis occurs. One of these crises is public discovery. A daughter is,

of course, robbed of her developmentally appropriate sexuality and is often caught in the dilemma of forcing an end to a now embarrassing affair in order to live a more usual life with her peers and of losing the family security which, she believes, her compliance has assured her, her mother, and her siblings. It is a terrible burden to carry for these immature women, and relief may not come until they leave home and try to build a new life.

Writers have, for the most part, stressed unduly the seductive nature of young girls involved sexually with fathers or brothers as opposed to the more important participatory role played by mothers. Our experience suggests that the seduction that some young girls tend to experiment with to a certain degree and usually safely, within the family, is usually normal and does not explain incest, which is not initiated by the child but by the adult male, with the mother's complicity. Stories by mothers that they "could not be more surprised" can generally be discounted; we have simply not seen an innocent mother in cases of long-standing incest. Still, the mother escapes the punishment her husband will likely suffer.

Why do mothers play such an important role in incest between father and daughter? Often, a very dependent mother is frantic to hold her man to the family for her needs and the financial support he provides. The sexual role of the daughter is seen as one way of providing him a younger, more attractive bond within the family than she can provide. This is especially true if she is frigid, rejected sexually, or is herself promiscuous. Rationalizations for incest abound and must be dealt with in a direct manner. The "I only wanted to show her how to do it" school is often talked about but rarely encountered. The same is true for the "he just needs a lot of sex" attitude. The vast majority of incest situations find people literally caught up in a life-style from which they find no easy way out and in which discovery must at all cost be avoided. In order to preserve the family, even after discovery has occurred, admission is often followed by denial, and the immediate family tends to condemn the victim if she is the cause of discovery. She is then bereft of all support and has few choices. Far more often, of course, there is no immediate discovery and only after some time does the victim's emotional need bring about an understanding of her difficult past.

Case 4

An 18-year-old college student with many minor physical complaints and episodes of insomnia told freely of her anger at her father who, on her leaving for college, was having an incestuous affair with her younger sister. She maintained that she was not jealous but rather wanted him stopped; as she said, "I have given my best years to him to keep us together."'

Her father, a judge, had begun to sexually stimulate her at bedtime when she was 12 and commenced regular intercourse when she was 14, often six times each week. Her mother knew of these acts from the start, encouraged them subtly at first, and then simply would not discuss the matter. Whenever the patient threatened to leave

home, she was told by her mother that she kept the family together and that her two younger siblings would be forever grateful to her for preventing a divorce. The patient had had no boyfriends and few girlfriends. and was anxious until she left home to "have things stay the same."' On discussion with the mother, it appeared that she was frightened and angry, denied that her husband, "an important man in this community," could be so ungratefully accused, asked that he not be contacted, and disowned her daughter as a chronic liar. Her father admitted, in medical confidence, that his daughter was totally correct and that he was, indeed, involved with his second daughter. He entered therapy with an experienced psychiatrist and has, over the past years, been able to desist from all incestuous relationships. His eldest daughter will not see him, and he accepts this. He blames himself fully, is puzzled by his craving for love from his daughters, and finally blames himself for his wife's frigidity. He is chronically depressed, and takes medication, and he has been a borderline alcoholic in recent years.

Case 5

A 14-year-old girl was seen on request by the police because her 16-year-old brother, when arrested as a runaway, had told them that his father had an incestuous relationship with his sister. The parents denied the allegation and, initially, so did the patient. But on the second interview, she began to discuss her fears about pregnancy and venereal diseases and, with reassurance, described her four-year involvement with her father, a 35-year-old computer programmer with a college education. The patient was placed in foster care but repeatedly ran away. The father lost his job when he was first arrested and, while awaiting trial, attempted suicide. Subsequently, criminal prosecution was deferred, and both parents received joint treatment around their failing marriage and their relationship with both children. Both children elected to remain in different foster homes until graduation from high school. Criminal charges were eventually dropped, and employment was resumed. The marriage was stabilized. Both children, who are in college now, seem to be on friendly terms with both parents, although they never visit overnight.

Case 6

A 14 year-old girl was seen with a history of marked weight loss and a diagnosis of anorexia nervosa. Her 16-year-old brother was extremely worried about her deteriorating condition, and confessed to his father that he had carried on a brief incestuous relationship with her for four months and that he wondered if he had caused her illness. The patient recovered promptly, and both youngsters received individual therapy. Each requested a therapist of his/her own sex. Both remained in the household, and both have done well personally and professionally.

Case 7

A 16-year-old girl was seen because an unrelated household member, a boy of 16, had been treated for gonorrhea and listed her as one of his sexual contacts. She was asymptomatic, but her vaginal and rectal cultures were also positive, although for a distinctly different strain of the gonococcus organism. The remaining members of the large family were then cultured. Her stepfather was positive for gonorrhea with the same strain as were her 14-year-old and 18-year-old stepsisters. Throat cultures for the gonococcus were positive in her 9-year-old stepbrother, as was his anal culture. Her mother was culture-negative, as were two cousins and another, younger stepbrother. It is likely, but was not admitted, that the stepfather, who had a criminal record, and not the 16-year-old boy had infected by sodomy and vaginal intercourse the index patient, who was not clinically ill. The stepfather had further, through fellatio by his stepson on himself and by sodomy, infected the 9-year-old boy, and caused vaginal infections in the 14- and 18-year-old girls. The health department administered curative doses of penicillin to all members found to be infected. They noted, wryly, that the initial report of the 16-year-old boy was not related to the family infection, and ignored all other implications of this family's chaotic incestuous life.

Age of Partners

In pedophilia or child rape, the age of the child tends to be between 2 years and early adolescence, while incestuous relationships may begin at the toddler age and continue into adult life. The median age for incestuous behavior in recent years has been between 9 and 10 years, well within the age group routinely seen by pediatricians, including those pediatricians who shun the care of the adolescent patient.

Society tends to be more concerned with fathers sleeping with or genitally manipulating daughters or sons than mothers doing the same to sons or, rarely, daughters. This double standard is most likely based on the belief that the sheltering mother is simply prolonging, perhaps unusually but not criminally, her previous nurturing role. That mothers who regularly sleep with their school-age sons, referring to them as "lovers" and sexually stimulating them, are very seriously mentally ill, as are their children, is quite clear to us, but intervention is difficult because mothers are given an enormous leeway in their actions, while fathers and brothers are not.

Violent acts of sexual exploitation or rape are usually perpetrated by males under the age of 30, while father-daughter incest tends to involve middle-aged men between 30 and 50. Other incestuous relationships, such as those between siblings, can vary from mutual genital play in early childhood and during the school-age years to attempted and, sometimes successful, intercourse in adolescence. A grandson-grandmother relationship involved a boy, aged 18, and an exceedingly wealthy woman, aged 70. At least three physicians dealt with the emotional problems of her

delinquent grandson, but none of them was prepared to accept the diagnosis readily admitted to by both patients.

Girls involved with fathers or stepfathers are often the first daughters in preadolescence or early adolescence.

Subtle Clinical Findings

In cases in which the parents report a single episode caused by either a stranger, a babysitter, a relative, or a household member other than the parents, the diagnosis is made before the physician is ever involved. More troubling are those subtle manifestations that are not ordinarily thought to relate to the diagnosis and that call forth the pediatrician's best diagnostic acumen.

In the child under 5 years of age, aggressive sexual abuse, that is, any forced sexual act, often results in fear states and night terrors, clinging behavior, and some form of developmental regression. The pediatrician's role is to provide reassurance. In a stable family setting, it is the parents rather than the child who need repeated help. It may be that from time to time the event will have to be worked through with the child once again, but this can often be done in a nursery school setting with active support from loving teachers and parents, and again in adolescence, if needed.

In the school-age child, subtle clinical manifestations may include sudden onset of anxiety, fear, depression, insomnia, conversion hysteria, sudden massive weight loss or weight gain, sudden school failure, truancy, or running away.

In adolescence, serious rebellion, particularly against the mother, is often the presenting finding. The physician who is aware of a specific estrangement between the mother and daughter should consider this diagnosis. Girls involved in incest often will eventually forgive their fathers, but rarely will they forgive their mothers who failed to protect them. Further, if the pediatrician notices that the daughter has suddenly been assigned virtually all the functions ordinarily taken by a mother within the family group, by looking after the house and siblings, the diagnosis is often made. Parents have reassigned to the daughter the mother's function both in the kitchen and in bed. These youngsters must be given an opportunity to share their secret with a sympathetic person.

As children get older, we often find more serious delinquency, including massive loss of self-esteem ("I am a whore," "I am a slut"). We see prostitution, along with chronic depression, social isolation, and increasing rebellion and runaways. There are, on the other hand, some very compliant and patient youngsters who carry the load of the family on their frail shoulders, at great sacrifice to their personal development and happiness. These adolescents are in a terrible dilemma. They are in no way assured of ready help from anyone, but they risk losing their family and feel guilty and responsible for bringing it harm if they share their secret. Youngsters may come to the attention of the health care system or the law only through pregnancy, prostitution, venereal disease, drug abuse, or antisocial behavior.

Treatment of Sexual Abuse

There is a chance, particularly when dealing with nonviolent sexual exploitation, to use the criminal justice system to initiate treatment, when the condition is treatable. Filing of criminal charges and a deferred prosecution to await evaluation and treatment are possible, provided certain requirements are met:

1. Exploitation must assuredly be stopped and for good.
2. Law enforcement officials must be involved in planning and must agree to the proposed treatment plan.
3. The prosecuting attorney and the court must feel that the criminal system is not being thwarted but that rehabilitation is an acceptable course, if it is under the supervision, even if remote, of the probation department or law enforcement.
4. Treatment failure, including nonparticipation in an agreed-to program, should bring the criminal process back at once, because, while the bypass process is recognized as an option for the legal system, it is strictly limited to effecting a better outcome than can be foreseen by incarceration following conviction.

Pedophilia may never be cured, but it is often possible to bring all illegal acts under control (case 1). There is no certain cure for the aggressive sociopath who engages in violent sexual molestation and rape. Until we know what to do for such people we must be certain that they never have control of a child, who is always defenseless in their presence. Moreover, they are often a menace to all, and, in many cases, nothing but prison is left for their management if they are convicted or psychiatric commitment to a secure setting if they are judged to be legally insane and unable to stand trial.

The treatment of incest, on the other hand, is far more likely to be successful and to result in the three desired goals: (1) stopping the incest; (2) providing individual and, later, group treatment to victim and each parent; and (3) healing the victim's wounds so that he/she grows up as a whole person, with the ability to enjoy normal sexuality.

In our experience, it has not been possible to reunite families after incest has been stopped through either placing the child or removing the offender unless two conditions have been met: (1) the mother must be shown to be willing and able to protect her children, and (2) both parents must admit to the problem and have a shared desire to remedy it, while at the same time either improving their failing marriage or divorcing. Ultimately, treatment can be judged to be successful only many years later, when the child has grown up and made a success of life.

Projective psychological tests reveal that incest victims see themselves as defenseless, worthless, guilty, at risk, and threatened from all sides, particularly from their father and mother who would be expected to be their protectors. Improvement in these projective tests is a useful aid to progress of therapy. Projective tests also clearly differentiate the angry, wrongful accuser from the rather depressed incestuous victim, and are therefore most useful in early family evaluation when the facts of incest are denied. Questions to be answered early on are these: Can the child

forgive the perpetrators? Can the child regain self-confidence and self-esteem, and have a better self-image?

In a report from Santa Clara County, California, 90% of the marriages were saved, 95% of the incestuous daughters returned home, and there was no recidivism in families receiving a minimum of ten hours of treatment. Regrettably, we have been far less successful! In my experience, between 20% and 30% of the families have not been reunited, no matter what we have attempted, and I have come to feel that they should not be reunited. Reuniting families should not be the overriding goal. Rather, the best interests of the child should be served. Many adolescent girls do far better as emancipated minors, in group homes or in carefully selected foster home settings. Once they have broken the bond of incest, society must not condemn these victims to an additional sentence, but it must provide loving protection and supportive adults who are better models than their fathers and mothers can ever hope to be. They will, of course, still have ties of affection to their family, but they will see them in a more mature, compassionate way. In any case, the dependency on their family is over somewhat sooner than it would normally be.

Much less is known about the treatment of mother-son or homosexual incest between a parent and child, but these general observations can be made. The gray area of incest in the preadolescent cuddly behavior is not without danger. Even quite early, children receive cues about their role vis-à-vis each parent, and sexual models can be normal or highly distorted. After adolescence has begun, guilt, fear of discovery, low self-esteem, isolation, all extract a frightful toll. These problems must always be faced, either sooner or later, and later is generally much worse.

Prognosis of Sexual Exploitation

A one-time sexual molestation by a stranger, particularly of a nonviolent kind, such as a pedophilic encounter, appears to be harmless to normal children living with secure and reassuring parents. The event still needs to be talked out and explained at an age-appropriate level, and all questions need to be answered. Fierce admonishment such as “Don’t let anyone touch you there!” or “All men are beasts” is, at most, not helpful.

All victims of violent molestation and rape need a great deal of care. For many reasons, a brief, joint hospital stay with the mother may help to take care of injuries, such as a vaginal tear, and to satisfy the legal requirements for criminal evidence in a setting that is sympathetic and supportive. During examination, the presence of the mother, sister, or grandmother is essential. A female physician-gynecologist who is gentle and who explains the examination is equally important. With her help, a vaginal specimen can be obtained for possible identification of semen (which can be typed and compared to the accused offender’s) and for cultures for venereal diseases. The culture findings can be of use in understanding the chain of transmission within the family and in influencing treatment. At times,

children are so afraid and in such pain that an almost equally violent form of rape occurs in the emergency room on the part of inexperienced and rough physicians and nurses. It is far better to take time and try to do an that is needed under gentle guidance and among faces that are familiar to and beloved by the frightened child than to attempt force. It is best, at times, to give the child a brief anesthetic to allow for examination and obtaining samples while she is asleep. In any event, a terrifying experience must not be made even worse by those providing treatment. We have tended to resist the request for physical examination in nonviolent abuse cases. In children under 12, the story given or the acts demonstrated by children are to be believed because of the very nature of their detail and clarity of description. This is not fantasy!

Incest occurring before adolescence and then stopped appears to cause less havoc than incest continuing into or throughout adolescence. The principal and major exception to this is the not uncommon situation in which a very young girl is trained to be a sexual object and to give and receive sexual pleasure as the one way to receive approval. These girls make each contact with any adult male an overt sexual event, with genital stimulation sought, supplied, and rewarded. They have, in short, been trained for the profession of prostitution. Nothing is more pathetic and more difficult to manage, because these girls are far too knowing and provocative to be acceptable in most foster or adoptive homes. They are socially disabled until cared for, at length, by a mature and understanding couple. We have found that fathers involved in this form of early "training incest" are not curable. The outlook for the children also is not good, even with treatment, because of the timing and prolonged imprinting nature of their exploitation.

Incest during adolescence is especially traumatic because of the heightened awareness of the adolescent and the active involvement in identity formation and peer group standards. Frigidity, conversion hysteria, promiscuity, phobias, suicide attempts, and psychotic behavior are some of the chronic disabilities one sees in some women who experienced adolescent incest without receiving help. It is only in retrospect that these histories are obtained many years later, and, generany the affair never came to the notice of anyone outside the family.

Boys do much worse than girls! Either mother-son (or grandmother-grandson) or father-son incest leaves a boy with such severe emotional insult that it blocks normal emotional growth. They tend to be severely restricted and may be unable to handle any stress without becoming frankly psychotic. Incest is ruinous for the male, but can be overcome with or without help by many girls. In general, workers agree that early and humane working through of the complex emotions and distorted relationships is curative and that late discovery after serious symptoms have appeared is far less satisfactory. The focus of treatment is the family, but sometimes there really is no functional family, and the youngster must try to build an independent life with sympathetic help from others.

In contemporary society, many explain the incest taboos as having no function other than the prevention of close inbreeding, with its deleterious genetic effects.

Where this explanation has been accepted as sufficient, it has meant a weakening of the sanctions that, in the past, protected the relation between adults and children, including stepchildren. Mead feels that where the more broadly based sanctioning system has broken down, the household may become the setting for cross-generational reciprocal seduction and exploitation, rather than fulfilling its historic role of protecting the immature and permitting the safe development of the strong affectional ties in a context where sex relationships within the family are limited to spouses. Home must be a safe place!

We believe that *all* sexual exploitation is harmful and that it must be stopped!

This does not imply that criminal sanctions must always follow, though they are often an expression of public fury and demand for retribution. What is clear is that the child may need weeks and months of individual or group psychotherapy to come to terms with the event and to integrate the sometimes puzzling, sometimes frightening, and sometimes guilt-laden occurrence back into a normally progressing and safe environment. The growing child and adolescent increasingly assumes charge of his or her control over body and mind. Failure to treat the victim is a far more serious societal act than failure to punish the perpetrator.

Conclusion

Each week we find among our pediatric-adolescent patients, among youngsters at the Kennedy Child Development Center, and among the children seen at our child psychiatric service, increasing numbers of sexually abused children whose presenting chief complaint is nonspecific.

The nonspecific symptoms I have described may be the only clues we physicians have that we may be dealing with sexual abuse. One requires sensitive attention to the patient, good listening, taking time, and always going beyond the presenting "chief complaint."

The runaway who is simply asked "Why did you run away?" will say, "I had a fight with my folks." The next question is "What was your fight about?" The answer, "I was out late." Most professionals stop right there, but that's where we should all start. We simply have to know more. One needs to lead up to the relationships with the child's mother and father, and then one finally has to ask some direct questions, in as kind a way as possible, in order to give the child permission to relate his/her loneliness, shame, and fears.

Sexual abuse should always be viewed from a developmental point of view, and it is the point of each child's development which determines the ultimate impact that sexual abuse has. Early and decisive intervention, rescue, and supportive therapy work well, even if the family is not reunited. The child deserves a chance at therapy just as much as if there were any other insult to development.

Pediatricians routinely try to find children who have hearing and speech problems. Should we not be equally open and ready, intellectually and emotionally, for the condition of incest, which is the last taboo?

Thank you for allowing me to share with you this hour honoring the late Dr. Aldrich. I hope that I have done him honor.

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Chapter 22
How the Child Abuse Field Came to Include Child Sexual Abuse

Patricia J. Mrazek

C. Henry Kempe's 1977 C. Anderson Aldrich Lecture, "Sexual Abuse, Another Hidden Pediatric Problem," (Kempe 1978) was a watershed event in the interdisciplinary field of child abuse. Working alongside him in those days, I witnessed the decision-making process that led to the inclusion of child sexual abuse as part of the child abuse spectrum. Initially, he was hesitant about its inclusion. He realized the magnitude of what he was asking from pediatricians. His selection of the word "another" in the title of his lecture was truly how he felt; here was yet another problem that demanded attention. Dr. Kempe was certainly aware from his own clinical experience that children who had been sexually abused were seen in medical settings, but frequently the children presented with other physical problems. He was heavily influenced to embrace the issue of child sexual abuse on a national scale by his mental health colleagues, including his wife Ruth, a child psychiatrist. A careful reading of his 1977 lecture reflects her influence and wisdom on his thinking.

In his typical, enthusiastic style, once he had made a decision, Dr. Kempe followed through with actions on multiple fronts. Child sexual abuse became a focus of the Child Protection Team and the pediatric residents' training program at the University of Colorado. Evaluation and treatment protocols began to be developed. Treatment programs were initiated at the National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver, Colorado. These included services for both child and adolescent victims and for perpetrators. These programs were offered right alongside services for physically abused and neglected children and their families in the same building. This even included group treatment for fathers who had sexually abused their children.

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The concept of a "hidden" problem (also in the lecture title) was of special concern to him. He had had great international success in gaining recognition of the extent of "the battered child syndrome" by using incidence and prevalence data, and he wanted to quickly bring that same kind of recognition to sexual child abuse. He had significant ties with colleagues in England, where he had spent considerable time (and had learned of the concept of home visitation, which he later brought back to Denver for development). Believing that it would galvanize the international community and decrease any tendency to believe that child sexual abuse was only an American problem, he provided funding to initiate the first survey regarding the nature and frequency of child sexual abuse in the UK (Beezley Mrazek et al. 1981, 1983). He also recognized that both physical and sexual abuse had multiple subtypes, and that definitions regarding what had occurred were critical to any decision-making.

He also knew that publications that were a "first" in their field could garner attention. Just as he published *The Battered Child* to jump-start that area of work, he coedited *Sexually Abused Children and Their Families* (Beezley Mrazek and Kempe 1981) to have a similar effect. Also, *Child Abuse & Neglect: The International Journal*, which he founded, published a special issue on child sexual abuse (Mrazek 1983).

Principles of Practice: Similarities and Differences

Many of the principles Dr. Kempe applied in the intervention with physically abused and neglected children and their families also were used in cases of child sexual abuse. These included mandatory reporting; the thorough evaluation of the child and family; the physical separation of the child from his family if protection could not be provided; treatment interventions offered to both the child and parents; attempts to reunite family members, if separation had been necessary, in a time frame relevant for the child; termination of parental rights, if necessary; concern about long-term effects not only of the abuse but of the interventions; and use of interdisciplinary teams of professionals within the medical facility, social services, and the court.

Despite these similarities in practice guidelines between physical and sexual abuse, Dr. Kempe did see some differences regarding what needed to be done for sexually abused children. Overall, he was not as optimistic about uniting families where familial sexual abuse, particularly incest, had occurred. He never recommended that lay therapists were appropriate with these families, although he was a champion of their effectiveness with physically abusive and neglectful parents. He rarely saw "social admissions" to pediatric inpatient units as appropriate, whereas he used them to buy time while trying to understand a physically abused child's particular home situation. With physically abusive parents, he frequently advocated for the rehabilitation of parents rather than criminal prosecution. With sexually abusive parents/perpetrators he saw the use of the justice system, including the use of deferred prosecution, as a means of ensuring long-term treatment.

> In short, an alliance between the juvenile court, the criminal court, the district attorney, child protection services, and the therapists is essential for providing the required involvement in cases of sexual abuse (Kempe and Beezley Mrazek 1981, p 198).

He was extremely doubtful as to the effectiveness of one of the few treatment programs for child sexual abuse that existed in the late 1970s, that is, the Child Sexual Abuse Treatment Program in Santa Clara County, California, which reported virtually no recidivism of father–daughter incest in more than 600 families receiving a minimum of 10 hours of treatment and formally terminated (Giarretto 1976, 1981). Even though a chapter on this program was included in *Sexually Abused Children and Their Families*, the editorial notes on the chapter reflect his doubts (Kempe and Beezley Mrazek 1981).

Dr. Kempe's personal relationship with Anna Freud, daughter of Sigmund Freud, may have affected his thinking about the harm caused by child sexual abuse, particularly incest. When *Sexually Abused Children and Their Families* was ready to go to press, Dr. Kempe asked Ms. Freud if she would consider writing a forward to the book. She asked instead to write a short chapter in which she could express her feelings about the long-term effects of child sexual abuse by parents. Her words, perhaps the most forgotten by biographers of all her writings, have a stinging effect, even today.

> Where the chances of harming a child's normal developmental growth are concerned, it (incest) ranks higher than abandonment, neglect, physical maltreatment or any other form of abuse. It would be a fatal mistake to underrate either the importance or the frequency of its actual occurrence (Freud 1981).

Evidence Today

The Literature

A Medline search of the literature on child sexual abuse reveals a substantial number of publications from studies all over the world with an increasing number of review articles. Currently, there are three journals (*Child Abuse and Neglect: The International Journal, Child Maltreatment, and Journal of Child Sexual Abuse*) specifically devoted to child maltreatment, and there are many others devoted to violence more generally. However, it is clear from the literature that the quality of the research and writing, for the most part, does not allow for most of these publications to be accepted in high-impact academic journals. While there are notable exceptions, most of the articles are in journals that are read by a quite limited group of readers. This may be fine if the only relevant audience were those already in the field, but it is a major obstacle to maintaining standing in the academic world and garnering both research and service dollars.

Incidence and Prevalence

Between 1992 and 2000, the number of sexual abuse cases substantiated by child protective service agencies in the USA dropped by 40% (Finkelhor and Jones 2004). It is extremely difficult to know why this decline occurred, and the explanation is

likely to be complicated. On the positive side, it may be due to years of prevention efforts that focused exclusively on sexual abuse. On the other hand, it may be related to changes in how agencies substantiate abuse, increased incarceration of perpetrators, and exclusion of cases that do not involve caregivers. It is crucial that monitoring of incidence (the rate in one particular year) continues. In 2009, only 9.5% of all child abuse victims were reported to be sexually abused (USDHHS 2010).

Data regarding prevalence have been quite variable due to methodological considerations. New global evidence from Dutch scientists reports two types of (lifetime) prevalence – self-reported and reported by health professionals. The rates were derived from a meta-analysis of 217 published studies between 1980 and 2008, more than 300 samples, and nearly ten million participants from around the world. The self-reported rate was 12.7% (127 per 1,000 children) and the rate reported by health professionals was 0.4% (4 per 1,000 children). The gap in rates, while having many possible explanations, is still significant and may help explain the discrepancy in rates reported over the years since Dr. Kempe's 1977 lecture. The global prevalence was higher for girls than boys and varied by country (Stoltenborgh et al. 2011).

Short- and Long-Term Effects

There was a belief by some mental health professionals in the early 1980s that sexually abused children developed similar reactions to their abuse in what was termed the "child sexual abuse accommodation syndrome" (Summit 1983) and had similar long-term symptoms and mental health difficulties. There was even an unsuccessful attempt to formulate a cluster of such symptoms into a single diagnosis and have it included in the Diagnostic Statistical Manual of the American Psychiatric Association. The current thinking is that each child has his or her own unique reactions that are not predetermined by the type of abuse but rather by a complex set of interactions between other bio-psycho-social risk and protective factors in the child, child's family, and environment.

But that said, the association of childhood adversities, including child sexual abuse, with the early onset of mental health conditions and the adult onset of physical health problems is increasingly well documented. For example, a recent survey of adults in ten countries demonstrated an association of child sexual abuse with subsequent onset of chronic physical conditions in adulthood, including osteoarthritis, chronic spinal pain, frequent or severe headaches, and a considerably strong association with heart disease (Scott et al. 2011). Also, many psychiatric conditions have been correlated with child sexual abuse, with depression being among the most common. It is important to note that while these are important associations between abuse and poor outcomes, the abuse itself may not necessarily be a causative event. Unfortunately, the field lacks a credible large-scale prospective study that might shed more light on these issues. A newer approach to understanding these associations is to try to focus on gene/environment interactions. For example, work by Bradley and colleagues has shown that heritable differences in neurotransmission

may exacerbate or dampen the effects of child abuse on the stress hormone system and thereby affect the risk for the onset of depression (2008).

Evidence Regarding Intervention Effectiveness

Although there are a couple of excellent home-visiting programs that have been shown to prevent child maltreatment, the evidence regarding the prevention of sexual abuse or the effectiveness of treatment for child abuse victims is much less substantiated. A stringent review by Macmillan and colleagues assessed the effectiveness of interventions to prevent child maltreatment, including sexual abuse, and associated impairment (2009). They concluded that it is currently unknown whether school-based educational programs prevent child sexual abuse and that cognitive-behavioral therapy for sexually abused children with symptoms of posttraumatic stress shows the best evidence for reduction in mental health outcomes. Overall, the authors advocated that future research ensures that interventions are assessed in controlled trials, using actual outcomes of maltreatment and associated health measures.

Current Perspectives on Child Sexual Abuse

Thirty-five years have passed since Dr. Kempe shed light on "another hidden pediatric problem." Many of his principles regarding recognition, evaluation, and intervention are still being applied to sexually abused children and their families. But social pendulums swing and problems that garner public attention, political will, and funding in one decade may get displaced by other problems. For example, in the field of child sexual abuse, sexual trafficking of children and sexual abuse of children by religious clergy have dominated the press in recent years.

Dr. Kempe began his 1977 lecture with the fact that although pediatrics had started with the single critical issue of deaths due to diarrhea caused by unsafe milk, it had gone on to include the battered child syndrome; then he asked his colleagues to become aware of child sexual abuse. The scope of the modern pediatrician's practice continues to expand exponentially. Despite new focuses, child sexual abuse continues. Dr. Kempe would admonish all of us not to forget.

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Chapter 23
Sexual Abuse as Another Hidden Problem

David P.H. Jones

This article and the prestigious lecture, on which it was based, were major contributions that drew pediatric attention to the problem of sexual abuse, while at the same time describing the full gamut of contributory causes and effects of sexual abuse succinctly and compellingly. The article is a record of the 1977 C. Anderson Aldrich lecture that was written by C. Henry Kempe for presentation at the annual meeting of the American Academy of Pediatrics in New York in November 1977. While he was unable to present it himself (he was admitted the night before to the Coronary Care Unit of Bellevue Hospital Center in New York City – see Kempe 1979), it was published in *Pediatrics*, the journal of the American Academy of Pediatrics, the following year. He stated his purpose clearly. It had been 15 years since the "Battered Child Syndrome" article (Kempe et al. 1962) had created such a major impact in the pediatric community and beyond, and he wanted an equivalent impact to awaken pediatricians to the problem of sexual abuse of children and adolescents. Henry considered sexual abuse to be just as common as physical abuse and neglect, yet felt that it was receiving insufficient professional and social attention while children and young people were suffering extensively and had been left without care from health-care and other professionals. He wanted to correct this, and did so through this paper.

The occasion, and the nature of the bestowed lecture, of which this article is a transcript, is relevant. C. Anderson Aldrich was a pioneering pediatrician who had been head of pediatrics in Chicago and had died in 1949. He had stressed the importance of the whole child and had drawn together health staff, which incorporated pediatricians, psychologists, psychiatrists, nutritionists, and many others, to provide comprehensive care for children at all stages in development. He, like Henry Kempe, had stressed the importance of resilience as well as harm caused by

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environmental influences on the child and young person. Aldrich realized the importance of communicating with parents and in his famous book, *Babies are Human Beings* (1938) had pointed out that "every human being, as he grows into childhood, must inevitably be hampered and opposed by the restrictions of his environment, and the best we can hope for is to modify somewhat the urgency of this conflict. The degree to which we are considerate of our babies' early needs, however, may be the measure of his later ability to feel secure in a world of change and to adapt himself to the necessities of circumstance." Kempe took forward the spirit of Dr. Aldrich's realism about environmental adversities in this important address in New York. The lecture, and this article, is written within the spirit of concern for the developing child and young person and what environmental impacts might affect him or her and what the pediatric health community might be able to contribute in order to mitigate these effects. But it also, and crucially, includes a concern with how to overcome adversity.

The article itself was read by a much wider audience than the pediatric medical community. It was read and cited by many others from the fields of social work and social policy, psychology, and psychiatry who were at the time wrestling with how best to manage sexually abused children and young people who were by that stage being recognized in much greater numbers than previously across the USA.

In my personal view, it was of great importance that this article was written by a pediatrician. Moreover, this particular pediatrician was Professor and Chair of the Department of Pediatrics at the University of Colorado School of Medicine – a major academic institution in Denver. The fact that the article covered such a wide range of facts about sexual abuse and stressed the whole child, developmentally, shone a beacon for the rest of the field. It is my view that the probable impact of the article would not have been quite as great if the author had a different professional background. Henry was well aware of this and used his influence wisely, just as he had 20 years previously as lead author of the highly influential "Battered Child Syndrome" article. His aim was clear – to raise professional and community awareness of this major health problem faced by children and young people, which impacted their emotional health and development and, at the same time, to encourage appropriate intervention.

The article is a wide-ranging overview of what was known and being discovered about sexual abuse at that time in the USA. It deals with the recognition of sexual abuse, its consequences for the developing human, types of sexual abuse encountered, professional responses to these discoveries, family dynamics, physical findings, and interventions both therapeutic and legal and systemic. Many of the themes addressed in this article were subsequently developed further in two important books – *Child Abuse*, written by Henry Kempe and his wife Ruth (1978), and the edited book by Pat Mrazek and Henry Kempe entitled, *Sexually Abused Children and Their Families* (1981). Henry's 1978 paper covers the protean presentations of sexual abuse vividly, with examples of physical complaints, diseases, mental health presentations, addictions, as well as the disruption of socialization and sexual development.

It is not really possible, and indeed would be a disservice to summarize this article, which needs to be read in full. So selective highlights only have been chosen for this appreciation.

The varied types of presentation of sexual abuse are illustrated throughout Henry's talk. He notes that sexual abuse occurs across all socioeconomic groups, and in that respect contrasts with physical abuse and neglect. The group in Denver was discovering that younger children represented up to a quarter of the total numbers coming to professional attention. Stepchildren were considered to be at increased risk, an observation later confirmed by Finkelhor (1984) and others. Other presentations ranged from pregnancy, prostitution, sexually transmitted diseases, drug and alcohol abuse to antisocial behavior and high rates observed among teenage runaways.

Henry emphasized the child's perspective and predicament. He stressed the need for children's accounts of maltreatment to be heard and responded to. He also elaborated on the dilemma for the adolescent victim of intra-familial sexual abuse when contemplating disclosing the family secret, who feared the breakup of "normality," on the one hand, and the trauma of continuing abuse, on the other. Threat, coercion, and violence are spelled-out in his talk.

Henry drew distinctions between violent rape, pedophilia, and incest, describing the somewhat different dynamics that the Denver group had observed in these situations. In 1977, they felt that effects of sexual abuse by those outside the family would be less serious than those associated with incest or violent rape. Now we see these distinctions as less sharply demarcated.

The response of professionals, and, as Henry vividly illustrates in this paper, the nonresponse of some professionals is insightfully dealt with. Denial, disbelief, and a tendency for staff to blame the victim of long-term sexual abuse for having caused their own victimization are described in detail and these responses remain important to clarify and draw attention to today.

Henry drew attention to complex family dynamics, especially among incest cases. He described the process of apparent family collusion, whereby the abuse of a child victim is tacitly accepted as a price to pay for maintenance of a distorted "normality." He is skeptical about claims by family therapists that intervention in cases of intra-familial incest is possible in the majority of cases and with no recurrence observed. He states quite clearly that this had not been their experience in Denver.

The consequences and effects of sexual abuse are serious and the paper summarizes these at several points during his talk. He stresses the developmental perspective which is necessary in order to appreciate the consequences of such maltreatment. He points out how common a sexual abuse history is in adult mental health settings, addiction services, relationship counseling, and in forensic settings, contrasting this with how infrequently sexual abuse is identified during childhood and adolescence. He points out that we are fearful or reluctant to ask children and adolescents about the possibility of maltreatment and is quite clear that he considers this should be part of normal history taking in children's health settings. This is just as important to stress in 2012 as it was in 1977, for little has changed in this respect.

The article reflects the state of knowledge about sexual abuse in 1978 as well as the nature of the cases coming to public and professional attention at that time. In 2012, some aspects would be seen somewhat differently through a contemporary lens. In the first place, the understanding now about the distortion of attachment that sexual abuse leaves in its wake as well as the markedly severe effects on younger children as a consequence of this at a time when attachment relationships are evolving would be more clear now than then. At that point, Dr. Kempe and the Denver group were considering adolescent abuse to be more severe than that occurring in early childhood. This may have been a distortion based on the nature of cases presenting to professional attention in the 1970s. It is likely, for example, that adolescents coming to professional attention then would have been abused for much of their childhood. Similarly, early accounts of what we would now consider to be grooming and preparation for distorted sexual violence later on in childhood are clearer when we see the younger population of children. In 2012, we would be less certain that single episodes of abuse by a stranger would have little or no effect on the child. Additionally, the extent of coercion and threat inherent in intra-familial sexual abuse is perceived more seriously now than perhaps was the case in the 1970s, where Kempe refers to much incest as nonviolent in nature. While there may be an absence of physical assault in a direct sense, the indirect nature of threat and the induction of fear are reported with clarity by survivors of intra-familial abuse. Similarly also, the classical triangle of abusive father, mother in denial, and child victim forming a collusive triangle described one sort of variety of intra-familial abuse but cannot be said to be typical of all cases.

Nonetheless, this thoughtful talk and article placed sexual abuse firmly on the map as far as health professionals and others were concerned and led the way for innovative attempts to manage and intervene with cases at a much earlier stage. It probably also provided an incentive for preventive approaches because, as Dr. Aldridge had noted many years earlier, repair and intervention after the fact have limited, though important, effects.

It must be stressed that it was out of the ordinary for a head of pediatrics of a major medical school to address the Academy and publish an article which at the time was so hard-hitting. This underlines Henry Kempe's career-long commitment to ensure that child maltreatment in its various forms was taken seriously by pediatricians, the broader medical and health community, and of course by the wider professional and lay society. He did not stop there, however, insisting that there be appropriate social and legal response to maltreatment and, crucially, intervention for affected children and young people and their families. He did not see sexual abuse as the last frontier in this drive, pointing out the central role of emotional maltreatment. However, in this particular article he effectively drew professional attention to the problem of sexual abuse and what might be done about it. Henry Kempe forced a reluctant professional community to acknowledge the problem of sexual abuse of children, and our inadequate response to it to date, forging the way for many of us who followed to make further contributions, and for that we owe a considerable debt to his efforts and his courage as expressed in this address and subsequent paper.

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Chapter 24
Commentary on Kempe C.H. 1978 Sexual Abuse, Another Hidden Pediatric Problem: 1977 C. Anderson Aldrich Lecture

The Legacy of Decisions That Stemmed from This Article/Work: A UK Perspective

Arnon Bentovim

Kempe first introduced the theme of sexual abuse as a form of abuse that needed to be recognized at the International Society for the Prevention of Child Abuse and Neglect conference in London in 1976, the year before the C. Anderson Aldrich Lecture (Kempe 1977). He put this concern in the context of an account of the stages of awareness of different forms of abuse in society.

Stage 1 – Denial that either physical or sexual abuse exists to a significant extent. Abuse that is seen as felt to be due to psychotic, drunken, or drugged parents or foreign guests, and nothing to do with the community as a whole.
Stage 2 – The community pays attention to the more lurid forms of abuse – the battered child, begins to find ways of coping more effectively with severe physical abuse, and, through early recognition and intervention with less severe abuse.
Stage 3 – Physical abuse is better handled and attention is now beginning to be paid to the infant who fails to thrive, and is neglected physically. More subtle forms of abuse, such as poisoning are recognized.
Stage 4 – The community recognizes emotional abuse and neglect and patterns of severe rejection, scapegoating, and emotional deprivation.
Stage 5 – The community pays attention to the serious plight of the sexually abused child.
Stage 6 – Guaranteeing that each child is truly wanted and provided with love and care, decent shelter and food, and first-class preventative curative and health care.

The themes that Kempe described in 1976 and in his 1977 lecture provided a picture of the way in which Stage 5 – the recognition of sexual abuse in the USA – came into the public eye and professionals' practice.

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Developmental Processes in the UK

It is interesting to look at the way in which our own practice in the UK has developed since that seminal paper. There had already been significant response within the USA; there was far less response in the UK. It was in December 1981 that I was able to initiate a Ciba Foundation study group, to assist the professional community in the UK to consider the issue of child sexual abuse (CSA). The study group had key members from the UK, which included the police, adult, and child and adolescent psychiatrists, pediatricians, social workers, and probation and legal representation. We met from December 1981 for several years and published a handbook in 1984 which was a tribute to Henry and Ruth Kempe's contribution to the study and understanding of child abuse, and more recently CSA (Porter 1984).

Through the examination of cases that attracted public attention and had been the subject of government enquiries (DHSS 1982), it was noted that concern had reached Stage 3 in the UK. Physical abuse was better handled and attention was being paid to infants who failed to thrive and more subtle forms of abuse were being recognized. A system of Area Review committees had been established along with extensive guidelines for professionals to deal with physical abuse through case conference, key work support, and interdisciplinary work. The most recent guidelines reviewed (DHSS 1980) stretched toward Stage 4 by indicating that Emotional Abuse and Neglect that required registration should be brought into the child abuse procedures.

When we turned to sexual abuse, Stage 5, we found equivocation and a lack of clarity. A memorandum drafted by the Department of Health noted that sexual abuse should be included in the definition of child abuse, but stated that sexual abuse "should not be registered as a separate category, though some aspects will fall within the criteria of other forms of abuse." There was grave doubt and confusion, yet there was awareness of the work in the USA, for example, Finkelhor's (1979, 1980) research on community samples, which indicated that 19% of women and 9% of men were reporting an experience of sexual abuse that appeared to have had long-term harmful effects on self-image and an ability to make sexual relationships. Russell's (1983) work also indicated high levels of inappropriate sexual experiences. An initial survey of young people in the UK in a teenage magazine (Baker 1983) indicated that a significant number of respondents described sexually abusive episodes. The study conducted by Patricia Mrazek et al. (1981, 1983) showed the lack of multidisciplinary collaboration in the field. Sexual abuse was defined under three categories:

Type 1 – Battered children whose injuries were primarily in the genital area
Type 2 – Children who had experienced attempted or actual intercourse or other inappropriate general contact with an adult (e.g., fondling, mutual masturbation)
Type 3 – Children who had been inappropriately involved with an adult in sexual activities, not covered by 1 or 2, for example, coerced into taking part in pornographic photography

These were children and young people seen between 1977 and 1978 by a selected group of professionals, which included police surgeons, pediatricians, child psychiatrists, general practitioners, and social services department. A total of 1,072 cases were reported – an incidence of 3 per 1,000 children reported during childhood, a far lower proportion than those who responded both to research on community samples in the USA and the preliminary research in the UK. Contrary to popular belief, the children featured in the survey were not "seductive adolescents." Sixty percent of the total group of children were over the age of 11, 27% were aged 6–10, and 13% were under the age of 6. There were 85% girls and 15% boys. An overlap of physical violence of around 10% was noted. The proportion of children who reported sexual abuse by strangers was 26%. In most cases, the perpetrators were members of the immediate family or known and trusted individuals: 43% within the child's family and 31% family acquaintances. One-half of perpetrators of intrafamilial abuse were fathers, one-quarter step-fathers, and the remainder were siblings, grandparents, and a few mothers.

The striking observation was the high level of prosecution in these cases, often unaccompanied by any psychotherapeutic or social work help. There was a low-rate referral (less than 11%) to child psychiatrists, and there were many cases where social work referral had not been made. By default, the sole form of child protection being practiced was the prosecution and imprisonment of the offender. We were therefore able to point out that an anomalous situation existed: children physically injured were being managed by an interdisciplinary conference, which, following the Department of Health guidelines, could exercise discretion over issues such as police investigation and prosecution, with emphasis on protection and therapeutic and social work, whereas a more potentially damaging issue of sexual abuse was dealt with by police investigation and prosecution with little in the way of therapeutic, child-care, or protective work. We felt that the attitudes observed were reminiscent of those seen 15–20 years earlier during the initial stages of the recognition of the physical abuse of children. There was a general high level of secrecy, failure to report, and an uncoordinated punitive response. A response was needed that brought together the work of all professionals to create a climate in which professionals were encouraged to recognize the sexual abuse of the children, to respond to minimal signs in a way that would ensure safety and initiate therapeutic work. It was felt that a nonpunitive climate was essential to enable parents who suspected or were involved in sexual abuse to come forward without the fear that family breakdown meant inevitable incarceration of the abuser. We were concerned about the years of self-sacrificial behavior, suicidal attempts to escape intolerable situations, risk of antisocial activities, prostitution, or drug and alcohol abuse.

This information was conveyed to professionals by the British Association for the Study of Prevention of Child Abuse and Neglect, a member organization of ISPCAN through publication of a pamphlet. This outlined the main features of CSA making suggestions for the development of professional awareness, assessment, and management (BASPCAN 1981). Many thousands of these pamphlets were printed and distributed, provoking a demand for workshops, teaching events,

television and radio productions, and newspaper and journal articles, which drew attention to what had obviously been a difficult area for many individuals. This resulted in an upsurge of interest, both in recognizing sexual abuse, and in clarifying how and when to get help in dealing with the problem. A well-organized, humanistic approach following the model developing at Great Ormond Street Hospital was advocated, which brought together statutory and therapeutic measures that included self-help groups. Increasing numbers of individuals, both children and parents, came forward for help. Television programs or newspaper articles led to individuals describing long-standing painful memories of abuse, a deep sense of guilt and shame, and a traumatic impact on their lives. Sexual abuse occurred in secret, was kept a secret by the family, and was being kept a secret by society's attitudes and taboos.

The Establishment of the Great Ormond Street Hospital Sexual Abuse Program

The program was initiated by Arnon Bentovim, Tillman Furness, Marianne Tranter (now Bentovim), and Liza Miller (now Bingley-Miller) in 1981. Many colleagues joined us to work for varying periods, together with colleagues from North America and wider afield. The team was established in 1981 as a result of referrals, which followed from the Mrazek, Lynch and Bentovim survey. We were influenced by Kempe's account of the functioning of the incestuous family, and called upon the principles emerging from Family Systemic work, which was developing in the UK. There had been a particular development at Great Ormond Street of Focal Family Therapy (Bentovim and Kinston 1991), an approach based on dynamic thinking, focusing on how families dealt with highly traumatic experiences of family members, parents in childhood, or during the childhood of offspring within the family (Mrazek and Bentovim 1981). We also noted the effectiveness of the Giaretto group work approach in the Parents United model (Giaretto 1981) and combined this with a family systemic approach to group work approaches for family members (Bentovim et al. 1988; Monck et al. 1996).

Individual and group therapeutic work for children and young people needed to be adapted to different stages of development. A therapeutic day included new referrals, family meetings, and groups available for young children – for girls between 9 and 11, 12 and 14, and 15 upward, and adolescent boys who were victims, and also boys who were responsible for sexually harmful behavior. There were groups for caretakers, for mothers, and there would be the early beginnings of some groups for male offenders, and couple groups at a later stage when there was the feasibility of rehabilitation.

Extensive involvement with the professional network was essential, particularly, in the initial phases. It was essential to develop approaches to assist children and young people to describe extensive experiences of sexual abuse, despite the context of secrecy and fear, which continued to play a key role in children's and families'

lives. Protocols were developed to interview young children with anatomically correct dolls that were available (Vizard and Tranter 1988), and programs to work with police and social workers to develop teams to assess young children who had been sexually abused. The use of videotape, both to record and for training purposes, was also made available for use within court contexts. The aim was to reduce the need for children to be cross-examined in court, and material could be used within civil proceedings to ensure that children were protected. A parallel development was occurring in Leeds (Hobbs and Wynne 1986) which began the complex process of describing children's developing genital anatomy to interpret complex physical signs.

The aim of both interviews with children and physical examinations was to counter the intense secrecy system within the family, to counter the denial and the Accommodation Syndrome (Summit 1983) when children made allegations that were often tentative and associated with denial subsequently. A variety of different questioning techniques developed within the family therapy field were utilized, including the use of hypothetical questioning such as, "If someone had touched you in a way which upset you, would it be easier to describe this if it was somebody who you did not know, or somebody you knew?"

Following the Family Therapy model, a family meeting was initiated where the facts of abuse could be accepted: responsibility taken appropriately for abusive action or failure to protect; freeing the victim from a sense of responsibility or guilt; accepting the need for a period of family safety, separation. Appropriate therapeutic work was put forward forcefully as an important element of the whole approach. It was felt that an early meeting of this nature could promote the therapeutic work which needed to take place individually, in groups, or with protective parents and children. Potential rehabilitation came later following the successful completion of therapeutic work by children, the mother being in a position of authority within the family, and an abusive parent or step-parent accepting a more peripheral role.

The initial review of the success of this approach in the early reviews (Bentovim et al. 1988; Monck et al. 1996) indicated that although it was feasible for children to be rehabilitated to the care of their mothers if separation had been required at an initial stage, there were fewer children rehabilitated to the care of both parents. The number of abusive individuals who could access and benefit from a therapeutic approach were limited. Mothers found the opportunity of meeting with other carers valuable; children benefitted from contact with their peers. The approach of a therapeutic agency working with statutory services was effective. All children were referred by social workers and the approach was always an open one, with appropriate reporting and close working relationships with other professionals. This ensured that protection and appropriate care of children and young people remained a central concern.

The value of the project was demonstrated through training opportunities and opportunities for research. This is demonstrated by research following boys referred to the service since 1981 into adolescence and adult life to assess factors that resulted in sexually abused boys abusing others. Cross-sectional research confirmed by the longitudinal follow-up indicated that young people who went on to abuse

sexually had been exposed to physical violence within the family had observed their mothers being physically and possibly sexually abused, and they were emotionally rejected or neglected (Skuse et al. 1998; Salter et al. 2003). This gave an indication of the high risk of multiple abuse, polytraumatization, and polyvictimization, which has also been demonstrated in recent research (Finkelhor et al. 2007).

During the 1980s, there were extensive developments in the community, the founding of Childline to provide telephone refuge for those wishing to escape secrecy, National Guidelines recognizing the extensive sexual abuse in rings, child prostitution, institutional abuse, abuse in the Catholic Church, and the recognition of cults and ritual abuse. Therapeutic programs for victims and perpetrators in the community and in prisons developed. Individuals victimized in childhood, claimed at a later stage that they should have a right to bring a prosecution against those who had abused them earlier, whether in the family or within institutions. This resulted in compensation cases, adult children taking their parents to court, and considerable pressure to be able to reopen cases where earlier claims had been found not to be proven at a criminal level.

The Backlash and Current Trends

Inevitably, given the significant denial associated with sexual abuse allegations, despite the Great Ormond Street approach introducing a therapeutic element to the works, there was denial, refusal to accept that abuse had occurred, and extensive criticism against professionals and the diagnostic approaches that were being developed. Interviews with young children were criticized as "leading" and prone to suggesting that abuse had occurred. Physical examinations were felt to give false positives, for example, reflex anal dilatation. The consequences of prosecution or care proceedings led to extensive legal processes – legal and professional challenge. A failure to make out a case that a child had been abused was associated with extensive criticism of professionals for using approaches that had not been scientifically validated and that were open to doubt.

Inevitably, those who felt aggrieved sought public redress, criticizing the professionals. It was alleged that in Cleveland in the north of England, a large number of children had been diagnosed as having been sexually abused on the basis of faulty physical investigations – reflex and dilatation. The extensive publicity-associated criticism of particular professionals created a negative culture and cast doubt on whether the extensive prevalence of sexual abuse described earlier was a real or mythical finding. A public enquiry (The Cleveland Enquiry 1989) helped to establish guidelines for investigation and management.

The False Memory Society claimed that adults who made allegations against their parents were inspired to recall such experiences as a result of the beliefs of therapeutic practitioners. Perhaps practitioners were compensating for the fact that there had been disbelief following Freud's original approach that memories of sexual seduction and abuse in childhood were considered fantasies.

To reverse this situation, therapists believed that memories of sexual abuse were valid, or accounted for dissociative symptoms in adult life. There were also critiques that the claims of ritual abuse were co-created by therapists with vulnerable individuals.

The feminist community mounted a fierce critique of family therapy/systemic approaches and its application to the sexual abuse field (Bograd 1990). They argued that family members were not equal; the social, cultural milieu implied an assumption of male power and hegemony. Women and children were perceived within society as being appropriate figures for blame and scapegoating. There was an extensive critique of the approach described by Henry Kempe, which perceived marital failure and sexual difficulties between adults as justifying a male to behave abusively to a child or family member. They argued that family meetings must inevitably be associated with a disadvantage for children and women, particularly any meeting with a perpetrator. Ceci and Bruck (2006) wrote a powerful critique of failures of professionals to help children to accurately describe and interpret their memories and risking the creation of false memories. These criticisms have resulted in research to establish the reality of these concerns. Research on interviewing, both in the USA and the UK and others, has tested children's capacities to give reliable testimony in relation to their experiences. This has resulted in an extensive program of development of interviews that are open and reliable. The work of the National Institute for Health (Lamb et al. 2008) has also been associated in the UK with Achieving Best Evidence Approaches for use in both criminal and civil proceedings. Children can be supported to make reliable statements, although they are often far briefer and give far less detail than statements that are facilitated and promoted using various approaches, such as the anatomical dolls, diagrams, and imagery. Although it had been hoped that it would not be necessary for young children and vulnerable individuals to have to give evidence apart from an initial video of statements and any necessary cross-questioning, this approach has been resisted by the courts.

The feminist critique has resulted in developing models of intervention that take these issues into account and look in detail at the profile of those responsible for sexually abusive action. Bentovim (1995) introduced the idea of a "Trauma Organized System." The climate of violence induced by an abusive parent, or family member, reinforces the climate of silence, of "seeing, hearing or knowing no evil." A family traumatic pattern that results in abusive action is attributed to the victim rather than acknowledged by the abuser. The perception of potentially protective family members and professionals are distorted by the abusive family member and the victim is both abused and disbelieved – a double form of abuse.

Work on understanding the nature of sexual offenders' behavior has led to extensive knowledge about the way in which offenders groom the environment, enable them to abuse children and young people, and maintain secrecy. The need to make an accurate assessment of the risk of future abusive behavior is now seen as an essential component to any therapeutic endeavor. Treatment programs have been developed for use in prisons in the UK, the USA, and Europe; individuals need to be able to take responsibility for abusive action and show a capacity to respond to therapeutic work. Campaigns such as "Stop it Now" by the Faithfull Foundation in

the UK and USA provide channels for individuals to get help with their own and family members' behavior.

The distinction between those who abuse within a family and those who abuse against children or young people outside the family is now seen as far less clear. There is less justification for a totally different approach to those who are responsible for incestuous abuse and those responsible for abuse outside the family. The approach taken in the original Giaretto program (Giaretto 1981) was that prosecution was a key component to a successful outcome. It holds individuals responsible for having offended against societal rules, but at the same time acknowledges their right to have access to therapeutic help to enable them to live a "Good Life."

There is deep concern about the extensive use of children and young people in prostitution, as part of large-scale national and international criminal activities. There is concern also about those with pedophilic orientation who amass collections of images of children and young people being subject to sexual abuse often associated with violence, and the misuse of social networking sites to groom and entrap children and young people. Punitive response remains significant in the management of sexual offenders in the community. The need for humanistic "circles of support and safety" may be outweighed by concern about protecting the community.

So Where Have We Reached and Where Are We Going?

The journey from Henry Kempe's 1977 lecture has been a long and eventful one. The most telling changes are noted in successive prevalence studies. In the UK, the National Society for the Prevention of Cruelty against Children (Radford and NSPCC 2011) has recently completed a 10-year prevalence study conducted in 2010, which compared the prevalence of sexual abuse to some 10 years earlier. In line with the findings by Finkelhor and others, there has been a significant reduction in the prevalence of sexual abuse perpetrated against children. From an overall rate of approximately 9%, the prevalence rate is now 4%. It is important to recognize that even so, the number of individual children known to authorities is only a proportion of the total number of children abused, perhaps as few as 1 in 10 or 11. There still remain unreported, sexually abusive secret abusive experiences as also physical abuse, neglect, and emotional abuse. Perhaps the extensive public narrative about sexual abuse and its management has led to a reduction of abuse perpetrated against children. The number of parental figures who perpetrate sexual abuse against children has also significantly lessened, and represents a small proportion of overall sexual abuse against children and young people. The most significant source of sexually abusive behavior against children in the UK is abuse by known individuals, either adults or young people in the social environment.

There is a significant level of sexually abusive behavior associated with dating violence, and growing concern about the way in which social networking sites can lead individuals into "cybersex," over the Internet, putting themselves at significant

risk through wide exposure of images to actually meeting with individuals who seem to be appropriate in age and developmental stage, yet turn out to be far older. The change in drinking and drug use patterns among young people and high levels of expectations in relationships put those who have already lived in a context of adversity at significant risk of becoming embroiled in relationships that are harmful. The widespread use of effective programs to prevent sexual violence in school could impact on this growing international problem (Wolfe 2006).

Despite a general decrease of sexual abuse of children, studies in the UK, USA, and Scandinavia demonstrate that there are significant numbers of young people who suffer extensive adversity, sexual and physical abuse at home, and exposure to violence. These young people are prone to further victimization within their social context. They become the individuals involved in dating violence, and are involved in intergenerational patterns of abuse and violence. Research, which has followed young women who have been sexually abused through to their becoming parents, confirms the extensive and harmful impact of sexual abuse in childhood (Trickett et al. 2011). Longitudinal surveys bringing together data from thousands of adults who demonstrate psychotic behavior, or severe depressive states, point to the uniquely harmful impact of physical and sexual abuse on development and the way in which it sensitizes vulnerable individuals to major physical and mental health risks (Nanni et al. 2011).

Henry Kempe's drawing attention to "sexual abuse, another hidden pediatric problem" complemented the original "Battered Child Syndrome" paper. The papers demonstrate to the world that these two scourges of humanity, physical and sexual abuse, can cause untold harm to future generations. The mission to prevent abusive behavior will perhaps help us move toward Henry Kempe's sixth stage – where every child is truly wanted, protected, educated, and cared for to the best level that society can afford.

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Part V
Child Abuse as an International Issue

Chapter 25
Introduction and Commentary: Child Abuse as an International Issue

Jill E. Korbin

This part begins with a brief 1982 editorial in *Pediatrics*, in which Henry Kempe emphasized the importance of culture in understanding and responding to child maltreatment. Henry Kempe's commitment to a truly international effort to address child maltreatment cannot be underestimated. In founding the International Society for Prevention of Child Abuse and Neglect (ISPCAN), and its journal *Child Abuse and Neglect, The International Journal*, Henry Kempe firmly expressed his commitment that child abuse and neglect are not peculiarly American or Western problems, even though first identified in these nations. Rather, child maltreatment, in Henry Kempe's view, was a worldwide issue demanding worldwide attention and solutions.

Prior to the formal establishment of this international body, Henry had made full use of his international network of students, fellows, and colleagues, enlisting them to pursue and promote child abuse prevention and treatment in their home countries. Establishing and sustaining a well-functioning international society, not simply a group held together by name only, but a group of committed individuals who work together, has not been an easy task. Anne Cohn Donnelly's excellent edited history, *An International Movement to End Child Abuse: The Story of ISPCAN* (2002), contains entry after entry that underscores both the commitment and the conflict that ensued trying to bring together a multitude of international voices about child maltreatment, first what it is, and then what to do about it.

The five chapters in this part reflect Henry Kempe's international and global vision and legacy. Jaap Doek, the third president of ISPCAN and a major force in bringing developing countries to ISPCAN through the Developing Countries Committee, considers in his commentary how Henry Kempe's commitment to children worldwide contributed to ongoing international efforts, including the United

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Nations Convention on the Rights of the Child. R. Kim Oates, the sixth president of ISPCAN, explores how child abuse work spread across the globe to areas that had previously not recognized or ignored the issue. Joav Merrick brings his experience in both Scandinavian countries and Israel in child protection in very different contexts. Margaret Lynch, the fifth president of ISPCAN, who had significant influence in drawing in developing countries, with her colleague Philista Onyango, one of the primary movers in establishing the African Network, then offer a comparison and consideration of child maltreatment work in the UK and Kenya. This chapter underlines the conflicts in delineating the problems of concern in very different cultural contexts and circumstances. Finally, the current president of ISPCAN, Irene Intebi and the advisor to the president, Richard Roylance, look at current international efforts to address child abuse and neglect through the still-vibrant organization and network of ISPCAN. Considering the global variability in many aspects of addressing child maltreatment, there is much work to be done.

Chapter 26
Cross-Cultural Perspectives in Child Abuse

C. Henry Kempe

Cross-cultural perspectives in the field of child abuse and neglect are largely lacking. In many countries, not much is published about child rearing and about possible child abuse and neglect. One or two official statistics are not adequate to show a low incidence of these conditions. Thirty years ago child abuse in the industrial world was thought to be uncommon. Only active public and professional concern led to the emergence of a truer picture of all forms of child abuse: physical abuse, sexual abuse, and emotional and nutritional failure to thrive owing to maternal deprivation.

Child rearing is the essential element in the transmission of culture in any group or society. Definitions of child abuse vary from culture to culture and evolve over time, and they may reflect the necessities for survival of the group. Not infrequently, cultural rationalizations for harmful behavior toward children are accepted blindly as proof that the treatment accorded children is neither abusive or harmful.

It has been presumed that Western cultures in recent decades have advanced to the point at which the individual right of each child is not in conflict with those of the group and has come to be protected more fully; but Western cultures continue to show competitive and violent behavior which does not yet give sufficient support to dependent individuals, such as mothers and children. Indeed, mothers are no longer thought of as "dependent" although they do require extra care and concern in order to fulfil their maternal role. In contrast, studies of nonWestern groups may suggest that those cultures see some of the Western child care practices as abusive and neglectful (baby-sitting, toilet training, for example). We may need to reevaluate our own methods as well. What is needed, then, is a careful balance between those who believe that all "progress" is good for children as against those who glorify "simple" societies, which are indeed highly complex and whose child care practices, although traditional, may no longer serve the best interests of their society.

Child-rearing practices transmit many cultural values at a level (nonverbal, for example) so basic as to seem innate. They all tend to favor the development of those characteristics that form character and influence behavior. Some child-rearing

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customs help to develop characteristics in the child that are highly valued by the culture and are suited to perpetuate cultural values (independence or violence or filial piety or obedience to law). Erikson's work clearly shows this interplay among cultural values, child-rearing practices, and behavior characteristics.

All cultures encourage dependence and even total care for the very young for varying periods after birth as a necessity for the babies' survival as well as for attachment and socialization. How early in a child's development a shift toward more self-sufficiency and independence is made (in some groups it is as early as 1 year of age) and *how* it is made (in some groups it is gradual and kindly; in others, abrupt and harsh) have much to do with the kind of character developed in the child.

When circumstances of a nation change rapidly, as in times of sudden urbanization and industrial exploitation, there may be a serious lag and maladaptation of traditional cultural values which are then quickly reflected in difficulties in child rearing. Isolation and loss of support for mothering come through clearly as frequent concomitants of abuse and neglect in many cultures trying to adjust to rapid change brought about by external forces.

Ours is increasingly becoming one world. The recent completion of the international "Year of the Child" brought efforts from all members of the United Nations to address the most urgent needs of their children. Thus, for the first time in human history, has the world, as a whole, addressed the needs of children wherever they are. This shift in attitude should rapidly lead to more understanding of how to prevent and treat child abuse and neglect the world over. Clearly, no nation has a monopoly on superior methods of child rearing; but worldwide attention to the physical and emotional needs of the defenseless child has taken the matter out of the hands of those who regard children as chattel and is gradually identifying those in each culture who are willing to defend the defenseless baby and its often inadequately supported mother. This development is so recent as to become a landmark in the history of child welfare everywhere.

Chapter 27
Henry Kempe's Legacy: National and International Impact

Jaap E. Doek

Introduction

Henry Kempe devoted his time and energy before and after the publication of his 1962 landmark article on the battered child syndrome to promoting awareness of the existence and various aspects of child abuse and neglect among his colleagues and other professionals working with or for children and the public at large in his country. He emphasized the importance of developing policy and practice for the prevention of child abuse and neglect (Kempe 1976), and the necessity of early identification of children suffering from or at risk of child maltreatment (Kempe 2007). With these goals in mind, he campaigned for the introduction of reporting laws, and the imperative of multidisciplinary intervention for and treatment of child victims of abuse and neglect.

During the 1970s, Kempe expanded his activities internationally, using his vast experience in international efforts to eradicate smallpox and other infectious diseases. He received a grant from the Rockefeller Foundation to organize an international meeting at the Foundation's Study and Conference Center in Bellagio, Italy. This meeting, in October 1975, afforded the opportunity for an exchange of experiences, research outcomes, and views relative to child abuse and neglect from a group of international participants. The meeting also marked the starting point of an international movement to end child abuse (Donnelly 2002).

In this contribution, I shall first comment rather briefly on the impact of Henry's work at the national level in other countries, using my country, the Netherlands, as an example. This will be followed by more elaborated observations from a child's rights perspective on the impact of Henry's ideas and activities at the international level.

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Impact at the Dutch National Level

At the end of the 1950s and the beginning of the 1960s, Henry's increasing interest in child abuse and neglect grew out of his experiences as a pediatrician and as Chairman of the Pediatric Department at the University of Colorado in Denver. The publication of the 1962 article with the results of his experiences and a survey was most likely meant to raise national awareness, as is also shown by his many activities thereafter in cooperation with the Federal Children's Bureau (Kempe 2007). There is no explicit indication that Henry wanted to trigger interest in other countries around the world with this article.

However, within 2 years following the publication of Henry's 1962 article, two pediatricians in the Netherlands published the results of a study of 12 cases of abused children under the age of 3 years in the *Dutch Medical Journal* (Kuipers and van Creveld 1964). It was the beginning of a lively discussion on how to address child abuse. A lot of attention was given to the privileged communication between a physician and his patient, and the question of whether this confidentiality could be breached and under which conditions. However, in the discussions there was no reference to the reporting laws that were at that time introduced in the USA as a possible solution for the dilemmas a family doctor faced when he knew or suspected that a child was a victim of abuse: reporting or not and to whom?

In another article in the Netherlands (Abbenhuis 1967), a study of newspaper reports of child abuse cases concluded that around 120 children died per year due to child abuse. With reference to Kempe's 1962 article, with the information that 10% of hospitalized battered children died, the author estimated that 1,200 children per year were so seriously abused that they needed medical treatment, and that the total number of abused children would be 12,000.

In light of these discussions, the Dutch government decided to establish a national interministerial committee to advise on the development of a policy for better identification and treatment of abused children, including responsible physician–patient confidentiality. I was the secretary of that committee (for more information on developments in the Netherlands in the 1960s and 1970s, see van Montfoort (1994)).

In order to facilitate and promote reporting of cases of child abuse, while protecting doctor–patient privileged communication, the committee recommended the introduction of the "confidential doctor." Family doctors, pediatricians, and others bound by confidentiality could contact the confidential doctor for advice on actions they could take or could refer the case to this doctor. Upon referral, the confidential doctor could then collect further information on the referred case. If this information confirmed that the child was indeed a victim of abuse, the confidential doctor should mobilize existing services for the protection and treatment of the child, including if necessary the reporting of the case to the child protective board. This recommendation resulted in the establishment of four Confidential Doctors' Bureaus on January 1, 1972 (Doek 1978, 1986). Thus, in the Netherlands, there were no mandatory reporting laws, but a separate and rather unique service for advice on and

reporting of cases of child abuse. The bureaus' definition of an abused child that could be brought to their attention was the one Henry Kempe used in his 1962 article: "Any child who received non-accidental injury (or injuries) as a result of acts (or omissions) on the part of his parents or guardians."

After some years of experimenting and on the basis of further developments (van Montfoort 1994), the Dutch government decided to establish Confidential Doctors' Bureaus in every province, to regulate by law the activities of the bureaus, to change their name to Advies- en Meldpunt Kindermishandeling (AMK; Centre for Advice and Reporting in Cases of Child Abuse), and to integrate them in provincial bureaus for youth care.

It may be assumed that Henry's article had an impact on the developments in other countries as well. For instance, Alfred White Franklin, a UK pediatrician, and a participant in the Bellagio meeting, took the initiative to involve the special Standing Committee of the British Paediatric Association in drafting a memorandum advising on the management of battered baby cases and published in the *British Medical Journal* (The Standing Committee on Accidents in Childhood 1966).

The Dutch and British examples illustrate the initial impact of Henry's 1962 article. However, an even more important development was the impact of the international and regional congresses and conferences organized by the international organization, ISPCAN (International Society for the Prevention of Child Abuse and Neglect) that Henry established in 1977. These events were important tools both in putting child abuse and neglect on the national social–political agenda and in strengthening or further developing this agenda. These events included several important components and were

- *Learning events*: Participants exchanged experiences, for example, in developing effective reporting systems, prevention, treatment programs, and legislation, and could benefit from learning about good practices presented at these events. The conferences and congresses were a contribution to improving professional knowledge and understanding of the various aspects of child abuse and neglect, and afforded the opportunity to acquire or improve professional skills.
- *Encouraging events*: By sharing their experiences, participants could encourage and support each other via discussions on how to overcome societal and political obstacles in developing activities aimed at raising awareness, prevention, and treatment of child victims of abuse or neglect. Participants could benefit from experiences in other countries in advocating for adequate legislation and services for addressing child abuse and neglect.

It should be noted that the impact of the congresses and conferences of ISPCAN, the international organization established by Henry, was most likely significantly strengthened at the national level in the Netherlands and in other countries after 1989, when the UN Convention on the Rights of the Child became an important force in improving the protection of children from all forms of violence. In conclusion, Henry's 1962 article and his initiatives and leadership in the establishment of ISPCAN had and continue to have a lasting impact at the national level in the Netherlands and in other countries.

Impact at the International Level

Henry's international impact can be seen both through the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) and through the later development of the United Nations Convention on the Rights of the Child (UNCRC).

ISPCAN and The International Journal

To the best of my knowledge, Henry did not organize the Bellagio meeting in October 1975 for the purpose of establishing an international organization or to start the publication of an international journal. He had a clear agenda of topics he wanted to discuss with different professionals from seven European countries and the USA, with a view to get the prevention and treatment of child abuse and neglect on the social–political agenda of their respective countries (Doek 2002). Only at the end of the meeting did Henry express an interest in creating an international organization for the purpose of promoting greater awareness and publishing an international journal (Girodet 2002). The first International Congress on Child Abuse and Neglect took place in Geneva in 1976 (Ferrier 2002). The International Society for Prevention of Child Abuse and Neglect (ISPCAN) was incorporated in Denver on July 7, 1977 (Bross 2002), and in that same year the first volume of *Child Abuse and Neglect. The International Journal* was published (Cherryhomes and Roth 2002).

Since then, many international and regional congresses and conferences were organized under the aegis of ISPCAN. *The International Journal* moved from a quarterly to a monthly publication and became the leading forum for the presentation of national and international developments and outcomes of research in the field of child abuse and neglect. In short, ISPCAN and *The International Journal*, both established by Henry, became important tools of an international movement to end child abuse (Donnelly 2002). From an international perspective, the development of the movement to end child abuse, from the establishment of ISPCAN and the *Journal* in 1977, can be conceptualized in two broad phases: developing a truly global movement to end child abuse and neglect, and expanding from child abuse to other forms of violence against children.

Developing a Truly Global Movement

ISPCAN and *The International Journal* were established by professionals from the developed part of the world (Europe and the USA) and the central theme of their activities was child abuse and neglect in the family setting. However, after the First Congress in 1976 in Geneva, discussions started on the need to involve professionals from developing countries in the activities of ISPCAN. The organizers of the Third Congress in Amsterdam in 1981 undertook targeted actions, including visits to developing

countries and fund-raising, to increase participation from developing countries. These efforts resulted in 35 participants from 15 different developing countries (three from Africa, six from Asia, and six from Latin America). This marked the beginning of a systematic policy to promote the involvement of professionals from developing countries in the efforts to prevent and end child abuse and neglect. A committee for developing countries activities was established within the board of ISPCAN (de Ruiz 2002). Regional organizations were established, such as the Latin American Association for the Prevention of Child Maltreatment in 1982 and the African Network for Prevention and Protection of Child Abuse and Neglect (ANPPCAN) in 1986 (Onyango 2002) with currently national branches in more than 25 African countries. The organization of regional conferences in Africa, Asia, and Latin America (and Europe) was promoted and supported. ISPCAN also organized, with the support of international experts, training seminars in developing countries to increase understanding and knowledge of the various aspects of child abuse and neglect. An ISPCAN scholarship was established for professionals from developing countries that offered free membership in ISPCAN, including a subscription to *The International Journal* for 1 year.

Moving from Child Abuse to Other Forms of Violence Against Children

This globalization process came inevitably with a broadening of the themes discussed at ISPCAN congresses and conferences. At the Third Congress in Amsterdam in 1981, Francois Breton of the ILO delivered a keynote address on child labor. At following congresses, presentations were made on abuse of children in institutional care, on violence against street children, sexual exploitation of children, and violence in the community. It meant that ISPCAN became more and more a movement to end all forms of violence against children. This is reflected in the definition of child abuse adopted in 1999: "Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (WHO 1999).

During the 1970s and 1980s, ISPCAN became the leading international organization of professionals in the field of prevention and treatment of child abuse, broadening its scope of activities and putting child abuse on the international agenda, with increasing cooperation with UN agencies such as UNICEF, WHO, and ILO. A few examples of this impact include the following:

- In 1979, the Parliamentary Assembly of the Council of Europe recommended that Member States develop a charter on the Rights of the Child, which should include a Special Section on Child Abuse (Section II) with provisions on prevention, reporting of suspected cases of child abuse, cooperation between authorities and professionals, and mandatory courses on child abuse prevention and treatment in all professional schools (Recommendation 874 (1979) [1]).

- During the drafting of the Convention on the Rights of the Child in the 1980s, a special article was included in the text for the protection of children from child abuse, including sexual abuse, neglect and negligent treatment, and exploitation in the family and other care settings.

After the adoption of the Convention on the Rights of the Child (CRC) by the General Assembly of the UN on November 20, 1989, and particularly since the beginning of this century, child abuse and all other forms of violence against children, in line with the broader scope of ISPCAN's activities, became a very visible part of the international agenda. At the recommendation of the CRC Committee[1] a UN study on violence against children was carried out. The report of that study was presented to the General Assembly of the UN in the fall of 2006, recommending various actions for the prevention and treatment of all forms of violence against children in the family, the school, care institutions, the work place, and the community to be undertaken by the Member States. To promote, support, and monitor the implementation of these recommendations, the UN Secretary General appointed on May 1, 2009, Marta Santos Pais as his Special Representative on Violence against Children (for more details, see Doek 2009). ISPCAN was involved in the study and is participating in the follow-up to the Report, particularly in the drafting and implementation of General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence.

In the 1970s and 1980s, ISPCAN was the pioneer and initiator in drawing national and international attention to the problems of child abuse and neglect. The success of this role is reflected in the fact that today ISPCAN is a partner in a global network of NGOs and UN agencies with the goal to ensure that the life of all children is free from all forms of violence, a freedom they are entitled to under the UN Convention on the Rights of the Child. I wonder what Henry's comment would have been on these developments. Given his respect for children, his commitment to their protection whenever necessary, and his international ambitions, I assume that he would have welcomed and supported these developments.

Henry's Legacy and the Rights of the Child

Between 1980 and 1989, an open-ended working group established by the UN Human Rights Commission drafted the Convention on the Rights of the Child (Detrick 1992). The CRC was adopted unanimously by the UN General Assembly on November 20, 1989 and entered into force on September 2, 1990. Today, almost all countries in the world (193 out of 196) have committed themselves to the implementation of the rights of the child enshrined in this Convention.

[1] The CRC Committee is a group of 18 international experts elected by the States parties to the CRC (art. 43 CRC) in charge of monitoring the implementation of the rights of the child in the States parties to the CRC. These States have to report regularly on progress made and remaining difficulties in implementing the CRC (art. 44 CRC) to the Committee. After a review of this and other information, the Committee issues Concluding Observations with specific recommendation for further actions by the States concerned (Doek 2011).

Henry died in 1984 and was not directly involved in the drafting process and had no direct impact on the content of the Convention. But there are links between Henry's activities and the rights of children in the CRC. These links are illustrated in the following two observations:

First, one of the main characteristics of the CRC is that it explicitly recognizes the importance of the family for the development of the child and the responsibilities of the parents (preamble, art. 5, 9, 18, and 27) and stipulates that all actions regarding children should be child-sensitive, respecting their rights, for example, to regular contact with their parents and families. Henry's ideas and practice as a pediatrician show that he fully agreed with the importance of the family and the need for a child-sensitive approach. In the 1950s, and thus far before children's rights were explicitly recognized, Henry developed a child-sensitive policy in his pediatric department by making the treatment of children as gentle and painless as possible and by introducing unlimited visiting hours for parents, siblings, and other members of the family such as grandparents. He asked children what they want to eat (see art. 12 CRC on the right of the child to express views) and requested the kitchen to provide whatever food was familiar to the child, paying attention to the child's ethnic background (see art. 20, para. 3 and art. 30 CRC). He later developed residential care programs for parents and children in cases of child abuse and neglect, underscoring the importance of trying to keep the family setting intact for the child (Kempe 2007). In short, Henry was an advocate of children's rights "avant la lettre."

Second, in 1975 Henry prepared an agenda for the meeting in Bellagio with topics which he (I assume) considered to be key elements of addressing child abuse and neglect. These included prediction and prevention; interdisciplinary family diagnosis and development of treatment plans; new treatment modalities; and rights of children and the law.

In 2011, the CRC Committee issued General Comment No. 13 on The Right of the Child to Freedom from All Forms of Violence (UN Doc. CRC/C/GC/13, 18 April 2011).[2] Connecting the Bellagio agenda of 1975 and the General Comment of 2011 shows that Henry's approach to child abuse is still a very valid one and confirmed by the children's rights approach of 2011. In the General Comment, a lot of attention is given to the importance of prevention, with various recommendations for the introduction of preventive programs such as home visitation, already developed by Henry in the 1970s, and financial and social support to families at risk. Various recommendations in the General Comment elaborate the importance of an interdisciplinary approach. For instance: "Professionals working within the child protection system need to be trained in inter-agency cooperation and protocols for collaboration. The process will involve: (a) a participatory, multi-disciplinary

[2] A General Comment is considered to be an authoritative document in which the CRC Committee presents its interpretation of one or more articles of the CRC in relation to a certain theme, e.g., early childhood, adolescent health and development, children with disabilities together with specific recommendations for legislative, social, and other measures the governments of the States parties to the CRC should undertake; for the texts of these General Comments of the CRC Committee, see www2.ohchr.org/bodies/English/comments/. For the need for a General Comment on Violence against Children, see Bennet (2009).

assessment of short- and long-term needs of the child, care givers and family …" (para. 50). However, there are no specific recommendations for the establishment of multidisciplinary teams in hospitals.

Regarding new treatment modalities, the General Comment recommends the introduction of shelter and crisis centers for children and their families who have experienced violence at home (para. 47), which seems to reflect the residential care facilities like the Circle House discussed in Bellagio. The topics discussed in Bellagio within the context of the rights of children, such as access to health care services, the recognition of the child as an individual client with rights, and the right of the child to be heard and to be informed about what is going to happen are, of course, elaborated in details in the General Comment. For instance: "Children's views must be invited and given due weight as a mandatory step at every point in a child protection process. The child's right to be heard has particular relevance in situations of violence" (para. 63). Many other rights are given attention, such as the right to nondiscrimination: "States should address all forms of gender discrimination as part of a comprehensive violence-prevention strategy. This includes addressing gender-based stereotypes, power imbalances, inequalities and discrimination which support and perpetuate the use of violence in the home, in school and educational settings, in communities, in the workplace, in institutions and in society more broadly" (para. 72).

Acknowledging the many developments since 1975 in terms of, for example, an increase of knowledge of the dynamics of child abuse and, more broadly, violence against children and the improvement of prevention and treatment, it can be concluded that there is a continuity in the core issues we have to address and work on in our efforts to prevent and end child abuse and other forms of violence against children. Henry's legacy is still with us.

Let me conclude with Henry's own words from a speech in 1978:

> All of us are united in wanting to give each child the very best in life; our educational programs reflect this wish, as do our research efforts – all are designed to benefit children the world over. But global concerns can overwhelm and immobilize the best of us. It is just not possible to worry about all the needs of all children all the time. There lies frustration and total inaction as well. For each of us there must be only one patient at a time and, generally, one major research theme at a time. Thus one keeps one's sanity and does the very best possible job. At the same time all of us who are devoting our professional lives to the cause of children must engage our minds and our hearts on their behalf, each one of us and wherever we can: by the quality of our work, by being the child's advocate in our towns and in our states, and by influencing national policy to our best ability. Do so with passion! (Kempe 2007, 231).

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Chapter 28
Child Abuse as an International Issue: Cross-Cultural Perspectives

R. Kim Oates

In the 30 years since this paper was published much has happened in understanding the cross-cultural perspectives of child abuse. And although there is a long way to go, good progress has been made.

How much of this change was a result of Henry Kempe's 1982 paper, "Cross-Cultural Perspectives in Child Abuse"?

The paper is short, just over one page. It emphasizes the fact that in 1982, there were very few cross-cultural studies in child abuse and neglect, including few studies of the possible relationship between child-rearing practices and abuse. Kempe pointed out that whereas previously child abuse and neglect had been poorly recognized, by 1982 its scope and its adverse effects were starting to be better understood.

Even so, he pointed out that Western cultures do not support children well. The paper is not judgmental. He noted the crucial role of parents and pointed out that we can learn from the child-rearing practices of other cultures, emphasizing how crucial child rearing is to the development of children. The problems that sudden urbanization may cause for traditional cultures are mentioned and he ends on an optimistic note, that with 1979 United Nations Year of the Child, the world has started to address the needs of children.

None of the views expressed in this paper were particularly new. Cross-cultural issues in abuse had been documented by the anthropologist Jill Korbin in the first volume of *Child Abuse & Neglect* (1977) and in the 1980 edition of Kempe and Helfer's book, "The Battered Child." Jill had spent 6 months in 1978 as a scholar-in-residence working with Henry Kempe at the National Center for the Prevention of Child Abuse and Neglect and undoubtedly would have influenced his thinking about child abuse in other cultures.

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Urbanization in other cultures as a factor contributing to abuse and neglect had been previously described. In 1980, Fraser and Kilbride described how, among the Samia of Kenya, child abuse had begun to appear following increased urban migration, socioeconomic change, and mixed marriages, all factors that eroded the strong clan and extended family structure, which had previously protected against abuse. Similar problems had been reported amongst the Zulus, where child abuse had increased in parallel with increased industrialization and a breakdown of the traditional extended family structure (Leoning 1981). Nathan and Hwang (1981) had suggested that social and cultural restraints prevented adequate identification of abuse in Malaysia, while Haditono (1981) had written about the problems of identifying abuse in Indonesia, where invasion of a family's privacy could lead to litigation.

These four papers all appeared in *Child Abuse & Neglect* while Henry was editor-in-chief. An advantage of editing an international journal is that it expands an editor's horizons and perhaps these papers also influenced Kempe's cross-cultural perspectives. Kempe wisely submitted this paper to a general pediatric journal so that his message could reach not just those who were interested in child abuse, but those who were interested in child health, child development, and international pediatrics.

So why was this paper so important? In 1978, Kempe raised awareness of sex abuse with his paper, "Child sexual abuse, Another hidden pediatric problem." Just as he was not the first to describe the importance of cross-cultural perspectives in child abuse, he was not the first to write about child sex abuse.

But it was not so much the message as the messenger. Kempe's stature was so great that when he wrote about any aspect of child abuse, he could not be ignored. He used that stature to encourage others to take these new areas seriously. This is an important part of Henry Kempe's legacy.

When this paper was published, 20 years had passed since Kempe had alerted the world to the problem of child abuse. In the West, we were by now at the stage where we could discuss the problem openly, lobby for legislative change, and seek funds for services. But this was not the case in many other regions.

In her 2002 edited history of ISPCAN (International Society for the Prevention of Child Abuse and Neglect), Anne Cohn Donnelly recounts how, at a seminar in Switzerland on child abuse, Esin Konanc, a lawyer from Turkey, spoke about the brutality experienced by some children in Turkey at that time. Esin then told Anne that after speaking out in this way about one of her country's dark secrets, she was fearful about returning and that her job could now be in jeopardy. Esin did return to Turkey where she became a prominent leader in raising awareness of the problems of child abuse and in changing government policy. She was elected to the ISPCAN Council and was one of the organizers of the First Turkish Conference on Child Abuse and Neglect in Ankara in 1989. Due to the pioneering action of Esin and others, much has changed.

In 1978, when ISPCAN was just 1 year old, with Henry as its President, a decision was made to encourage the participation of representatives from developing countries in international congresses. This made sense if ISPCAN was to live up to its name as a truly international society, particularly as its Mission Statement included the phrase "to prevent cruelty to children in every nation."

In 1980, Jaap Doek, who became ISPCAN's third president, formed a subcommittee on developing countries for the 1981 Amsterdam Congress. With financial support from Dutch foundations, he visited developing nations in Latin America and Asia to promote the international work of ISPCAN and to encourage participation in the Congress. As a result, 35 delegates from 15 developing countries, including three from Africa, attended the Congress. A plenary session was held on abuse and neglect in developing countries and plans were made for national seminars to be held in Peru, the Dominican Republic, and Indonesia.

Regional conferences or workshops were held in Brazil and Indonesia in 1983. The Nigerian Regional Conference in 1985 led to the establishment of the African Network for the Protection and Prevention of Child Abuse and Neglect, ANPPCAN.

Even before this, in the late 1970s and early 1980s, child abuse initiatives were developing in Hong Kong. Patricia Ip, a pediatrician at United Christian Hospital and Priscilla Lau in 1978 started ACA (Against Child Abuse), an organization which became influential in professional recognition and public awareness of an area that had hitherto been an unspoken problem in Asia. Patricia Ip was presented with the Kempe Award in 2000.

Henry, who died in March 1984, would have been pleased to know that at the 1984 Montréal Congress, the special session for delegates from developing countries, which had commenced in Amsterdam, not only continued but was complemented by a new pre-Congress Seminar for Developing Countries, an innovation that continues to this day.

The first ISPCAN Congress to be held in the southern hemisphere was in Sydney in 1986. It was an opportunity for delegates from Asia to attend and for the first time we had representation from Nepal, China, Korea, and Papua, New Guinea. Henry's vast contribution to the field was recognized by the inaugural Kempe Lecture, given by his friend and colleague Brandt Steele, and the Kempe Award presented by Ruth Kempe to George Brown of Alaska.

The Sydney Congress, like all of the early Congresses, was another example of Henry's vision and the inability of people to refuse his requests. As Pierre Ferrier, one of Henry's early colleagues in this field and the fourth ISPCAN president, said, "Henry Kempe was a man with glorious ideas. When he presented one of those ideas and asked you to take care of it, you had to say 'Yes'." Henry had decided that Sydney would be a good place for a future ISPCAN Congress. When I happened to be standing next to him waiting to enter a reception at the 1982 Paris Congress, Henry told me that I should organize the 1986 Congress in Sydney. This was how things were done in those days. Pierre Ferrier was right. When Henry suggested doing something, you did it. Sadly, Henry did not live to see the Sydney Congress.

Then in 1988, the Seventh ISPCAN Congress was held in Rio de Janeiro, Brazil. This was the most international of the congresses up to that time. It had the broadest program with considerable emphasis on problems in developing countries, such as child labor and street children. Franklin Farinatti, chair of the Congress Program Committee and later an ISPCAN president, described the conference as being hugely significant for Latin American countries, strengthening the emerging new era of children's rights in that region.

Subsequent congresses in emerging nations have been held in Malaysia (Kuala Lumpur 1994), South Africa (Durban 2000), and China (Hong Kong 2008).

The cross-cultural perspectives of child abuse and neglect were now fully established.

In my own region, several outstanding individuals have taken the lead, often as initially isolated professionals who influenced community awareness, worked with their governments to achieve legislative changes, and educated their colleagues.

In 1986, Malaysia held its first conference on abuse and neglect in Kuala Lumpur. One of the main organizers was Mohd. Sham Kasim, a pediatrician. Sham had been influenced by Henry's work. He also knew the value of networking and involved the Malaysian Council of Social Services in the conference's organization, invited keynote speakers from Singapore, Hong Kong, and Australia, ensured that media exposure was provided to increase public awareness, organized a public forum on child abuse, and successfully lobbied for law reform to protect children. Sham asked me to speak at the conference and the public forum. After seeing what an important force he could become in the region I suggested he stand for the ISPCAN Council the next time elections were held. He was successfully elected and later served as ISPCAN's 11th president (1988–2000).

Tufail Mohammed, a pediatrician from the Peshawar area of Pakistan, is an example of a person so influenced by the seriousness of child abuse that his subsequent career changed. In 1991, he was at the Seventh Asian Congress on Pediatrics in Perth, Australia, where he attended a plenary session, "Freedom from Abuse" at which I was privileged to be one of the speakers. This session highlighted the overall global situation regarding child abuse and neglect and challenged professionals about the importance of committing time to work in this area.

The realization of the extent and seriousness of this problem caused Tufail to decide to make a difference in his own country. He became a leader in child abuse awareness and prevention and was elected to the ISPCAN Council in 2006.

It had been difficult to find a child protection leader in the People's Republic of China. When the International Congress on Child Abuse and Neglect was held in Sydney, government funding was obtained to bring a delegate from China. However, we had no influence in who would be chosen and even if we had, there was so little information about child abuse in China that we would not have known who to ask. The Chinese authorities sent, as was their way at that time, a very senior pediatrician from Kunming, so senior that he had passed away 2 years after the Congress. He was presumably chosen as a reward for long and faithful surface to his university. He had very little English and may have found a conference on this topic an example of the decadent lifestyle in Western countries. This theory was reinforced a few years later when I was asked to speak at a Chinese university and chose the topic of child abuse. The response was polite and I was officially told after the lecture "This is a very interesting problem you have in western societies but we only have one child per family, we love them and we would never harm them."

How things changed in the intervening years. In early 1998, Professor Fuyong Jiao, a neurologist from Xian, came to the Children's Hospital at Westmead (Sydney) to spend the year attached to our neurology department. He enjoyed the experience

but had few opportunities to travel beyond Sydney, As I was presenting at the 12th ISPCAN Congress in Auckland in September that year, I thought this could be an opportunity for Jiao to travel and meet other people. Funding was obtained and we traveled to Auckland together. I am still not sure how it happened, but at some point during the Congress something changed in Jiao's view of child health. He became passionate about the problem of child abuse and determined to do something about it on his return to China. He is now the leading figure in China in raising awareness of this problem and in providing training for professionals through the center he established in Xian. He received the Kempe Award in 2006 and was elected to the ISPCAN Council in 2010. His foundation, the Xi'an Philanthropic Child Abuse Prevention and Aid Centre, has received several awards including the 2010 Women's World Summit Foundation first prize in the Children and Youth Section.

Henry's influence in child protection and his interest in promoting cross-cultural awareness spread to Thailand. At the Third Asian Regional Conference on Child Abuse and Neglect in 1993, a Thai lawyer, Sanphasit Koompraphant spoke about child prostitution in the carpet factories in the north of Thailand. It was one of the most moving presentations I had heard. Sanphasit went on to become the leading Thai figure in understanding and preventing child abuse, an ISPCAN councilor from 1998 and president in 2008 until he relinquished the position to be able to devote more time working with the United Nations on the continuing implementation and monitoring of the UN Convention on the Rights of the Child.

I first met Henry Kempe in 1974 and his influence on me was profound. I had completed my pediatric training at Boston Children's Hospital and was flying home to a position at the Children's Hospital in Sydney. I knew this position would involve some work in child abuse, so I arranged to stop over in Denver to meet the legendary Henry Kempe and to see what ideas I could pick up. Henry was very gracious, but very busy. He introduced me to several people including Brandt Steele who kindly took me to lunch.

The next encounter with Henry was in Perth, Australia 1975, where he was keynote speaker at the First Australian Congress on Child Abuse and where Henry asked a helpful question at the end of my presentation. His presence in Australia at that time was very important to those of us who were trying to get some credibility for this relatively new, and not particularly wanted, field.

It is difficult to realize how little was known about child abuse and neglect in the 1960s and 1970s compared with our current level of understanding. Children's rights were not thought of as being particularly important, if they were thought of at all; 1979 had been the International Year of the Child, but it would be another 10 years before the UN Convention on the Rights of the Child was introduced and started to make a difference.

Child abuse was rarely mentioned in Asia. There were few leaders in the field and there was so much to learn. In many ways it was an exciting time. Those of us who became involved from the very early years felt as if we were breaking new, exciting ground. While the work could be frustrating, there was the feeling that we had the potential to make a difference. For many of us, the work was grounded in the fact that Henry Kempe was concerned about and interested in our work, pushing

us toward new frontiers and challenging us. So it was not a total surprise that in 1982, he put out the call to look at this problem more broadly and to consider its cross-cultural perspectives.

Now, 30 years later, what is the situation? The early leaders in this part of the world are still playing important roles but, more importantly, are mentoring others to follow their lead.

Recognition was slower in Japan. Although we were unable to attract Japanese delegates to the 1986 Sydney Congress, awareness occurred a few years later. Now, the Japan Society for the Prevention of Child Abuse and Neglect (JaSPCAN) is a multidisciplinary association, which holds annual conferences, publishes its own journal and was influential in the decision of the Japanese government to introduce the Child Abuse Prevention law in 2000.

To see how far we have come in this part of the world, the 9th edition of the ISPCAN publication, "World Perspectives on Child Abuse" lists a range of important developments as well as key challenges for Australia, Japan, Hong Kong, New Zealand, the Philippines, and Singapore, including government-sponsored national frameworks, new child death review teams, new laws to protect children, home-visiting programs, more emphasis on primary prevention, improved data collection, and legislation against corporal punishment.

There is still a long way to go. Thirty years after Kempe wrote on cross-cultural perspectives and 22 years after the UN Convention on the Rights of the Child, there are still obstacles. These include attitudes of societies and parents to corporal punishment, concerns that acknowledging children's rights might erode parental rights, the need for more widely available primary prevention programs, more secondary and tertiary prevention strategies for high-risk groups and wider education for parents and care givers in effective parenting skills.

Added to these are new challenges, such as improving justice systems for children who are victims of abuse and concerns about budget cutbacks for abuse-prevention programs when national economies are hurting. There is a need to improve work environments and provide career pathways and adequate respite for those working in this field, so that professionals can be attracted to work and remain in this area. And there are more recent concerns about new communication technologies such as the Internet and social media, which could provide new opportunities for abusers but which may also be able to be harnessed for prevention and protection strategies.

But when we look at the potential problems of the future, it can be helpful to seek reassurance from the successes of the past. And there have been many. So much has been achieved since 1982; so many children and families have been helped, awareness has increased enormously, and innovative prevention and treatment programs have been established and evaluated. The world is now a safer place for many children. Our aim is embodied in the words of the 2006 United Nations World Report on Violence against Children: "No violence against children is justifiable and all violence against children is preventable" (Pienheiro 2006). This is where we are heading.

There is certainly a long way to go, but the legacy of Henry Kempe's cross-cultural view gives us the basis for continuing to go forward. Henry would have been pleased.

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Chapter 29
Child Abuse and Neglect: Experiences from Scandinavia and Israel

Joav Merrick

Introduction

Henry Kempe was not the first to describe child abuse and neglect, but he was the first physician who managed to make society and the health and welfare systems aware of the battered child syndrome. With his skills and determined work from 1962 to his death in 1984, he managed to bring the message across. This chapter describes the evolution of events in Scandinavia and Israel, where I have worked and been involved with child health and human development over the past several decades. While much progress has been made, I take the position that our work is still not finished and will require continuing efforts to ensure that every person is born healthy and wanted; that all children have the chance to achieve their full potential for healthy and productive lives, free from disease or disability; and to ensure the health, productivity, independence, and well-being of all people through optimal rehabilitation.

This chapter will not really be a commentary on the commentary (Kempe 1982), but rather describe the influence of the work by Henry Kempe (born Karl Heinz Kempe, 1922–1984) and his collaborators (Kempe et al. 1962) on events in both Scandinavia and Israel, where I have had the pleasure to work and observe events over nearly the past 40 years. I believe the 1962 paper (Kempe et al. 1962) and the subsequent 20 years of traveling, international meetings, establishment of the International Society for Prevention of Child Abuse and Neglect (ISPCAN), and encounters with Henry Kempe had a major impact in Scandinavia.

Although child abuse and neglect have attracted our attention over the past 50 years, violence toward infants, children, and youth has always been part of our

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history (Rodin 1981; Lynch 1985; Heins 1984; Kroll and Bachrach 1986; Knight 1986; Radbill 1987; Aries 1973; Miller 1985).

In international medical literature, intentional injuries to a child were mentioned in the year 900 by a Persian physician working in the harems of Baghdad (Lynch 1985). Greek physicians in the early second century also seemed aware of newborn babies at high risk for later abuse and neglect, and even advocated infanticide in some circumstances (Lynch 1985).

Throughout the sixteenth, seventeenth, and eighteenth centuries, children were raised under the rule of the "Schwarze Paedagogik" (Miller 1985), with parents as the supreme masters of their children. Parents made all decisions, had complete power, and ruled with a firm hand. Tradition and child-rearing instructions cautioned parents to begin "breaking in" their children at a very early stage in order to gain complete control over them. This tradition has unfortunately continued to this very day.

During the eighteenth century, poverty, violence, and alcohol abuse were part of daily life in London and indeed in all of Europe. The English artist William Hogarth (Rodin 1981) made the well-known engraving "Gin Lane" in 1751, showing the total disintegration of society, children with the characteristics of fetal alcohol syndrome, neglect, and even fatal child abuse.

The nineteenth century brought more understanding for children's rights, as well as the acknowledgment of child maltreatment. In Denmark, a fatal case of child abuse was described already in 1827 (Klingberg 1827), while in Paris, Ambrois Tardieu (Lynch 1985; Heins 1984; Knight 1986; Radbill 1987), professor of forensic medicine, reported on 32 cases of child abuse in 1860: nine cases of brutality and ill-treatment, five cases of severe injuries and torture, and 18 cases of fatal child abuse. In New York in 1871, a church worker discovered that 8-year-old Mary-Ellen was beaten and starved by her foster family. Appeals to the police and department of charity were unsuccessful (Heins 1984; Radbill 1987). However, contact with the American Society for Prevention of Cruelty to Animals brought the matter before the Court on the grounds that Mary-Ellen was a member of the animal kingdom and she was subsequently removed and replaced in an orphanage.

The American Society for Prevention of Cruelty to Children was founded in 1875. The first English Society was founded in Liverpool in 1883 and the London chapter, the following year. During the first 3 years, the London Society dealt with 762 cases of assault, starvation, dangerous neglect, desertion, cruel exposure to excite sympathy, other wrongs, and 25 deaths (Lynch 1985).

Since I am limited by space, I will make a brief summary of events concerning child abuse and neglect in both Scandinavia and Israel.

Finland

The first national child welfare organization in Finland was established already in 1870 and in 1937, it expanded to form a national child protection association in order to gather local municipalities and not-for-profit organizations under one umbrella (Merrick 1989a).

In 1981, a poll was conducted of 530 of the Finnish population older than 14 years of age: 3% of respondents had observed physical violence toward small children and 1% toward teenagers; 44% of the respondents were of the opinion that physical punishment of children was needed at least on certain occasions. The majority of Finns (60%), however, was in favor of a special law to ban all child abuse and physical punishment of children, as was done in Sweden in 1979 (Peltoniemi 1983).

A Child Welfare Act was introduced in 1983 (Merrick 1989a), which centered on the needs of the child and abolished physical punishment. In 2008, the New Child Welfare Act was introduced, which is more exact and detailed than its predecessor from 1983. There are several new obligations for the authorities and the Act also introduces new statutory duties, measures, and practices for child protection work. The main principles are effective early intervention; the systematic nature of the work, that is, plans for everything and for every level of the work; a target-oriented way of working; equality for all clients regardless of their sex, age, origin, language, or religion; and the right timing for all interventions and measures. The core values are in accordance with the UN Convention on the Rights of the Child, the best interests of the child, and respect for the responsibilities, duties, and rights of the parents or other legal guardians of the child. Along with the protection of the child, participation is being strongly emphasized. There is one whole chapter and several new sections that define how the child must be heard in child protection procedures and how the child must be allowed to influence matters concerning himself/herself. There is an overall obligation for child protection staff to work directly with the child and to find out his/her views and interests during the whole child protection process.

Sweden

In 1633, King Gustav II Adolf established a Children's House (Allmänna Barnhuset) in Stockholm for poor and orphan children, where they could learn a trade. Mortality was high and eventually more children were placed in foster families (Merrick 1989a). Allmänna Barnhuset is today a government institute involved with teaching, conferences, research, and policy issues concerning child welfare in Sweden.

One of the first case reports of child abuse was described in 1957 (Selander 1957) and later others followed, but the first national survey came in 1969, when information was gathered from 178 hospitals, specialist clinics, and forensic institutes (Merrick 1989a). The survey found 119 abused children during the 1957–1966 period with 15 cases of mortality and the report gave suggestions and recommendations for teaching, intervention, and prevention.

During the 1970s, more cases occurred and several advocacy organizations were established, which together with official reports resulted in a law in 1979 to abolish physical punishment by parents (Merrick 1989a). Sweden's example has inspired passage of similar laws prohibiting parental use of physical punishment in Austria, Denmark, Cyprus, Croatia, Latvia, Israel, Germany, and Iceland. The purpose of these bans is to explicitly recognize children's rights to protection under the law – the same rights that adults take for granted. In addition, Italy's highest court has

ruled that "the use of violence for educational purposes can no longer be considered lawful." In 1993, a governmental Children's Ombudsman Institution was established in Sweden, selected by the government each time for 6 years. She/he is at the disposal for all children until the age of 18 years. The foundation for the work is the UN Convention on the Rights of the Child. The tasks are: to represent the interests and requests from children and youth; to reinforce the carrying out of the UN Convention on the Rights of the Child; to overview the keeping of the UN Convention on the Rights of the Child; and information and formation of opinion, research, and statistics, and international knowledge transfer about the UN Convention on the Rights of the Child.

Iceland

From the 1960s to date, there have been few studies on child abuse and neglect in Iceland (Merrick 1989a), but a larger study has recently been published (Gunnlaugsson et al. 2011). The participants were 3,515 students, 14- and 15-year-olds, in the national compulsory school system in Iceland. As a part of the 2003 ESPAD survey, each pupil was asked about experiences of severe verbal arguments and physical violence at home as well as their background, behaviors, and mental health assessed with the use of tested measurement scales.

About 22% of the participants stated that they had witnessed a severe verbal argument between parents and 34% stated that they had been involved in a severe verbal argument with parents. This rate was slightly higher for girls compared to boys. Altogether, 7% of adolescents had witnessed physical violence at home, where an adult was involved, and 6% of the participants stated that they had experiences of being involved in physical violence at home, where an adult was involved. Witnessing or being involved in severe verbal arguments at home and/or witnessing or being involved in physical violence with an adult was significantly associated with greater levels of depression, anger, and anxiety.

According to the Icelandic Child Protection Act, the main objective of child protection is to ensure that children (defined as individuals under the age of 18 years) are raised in satisfactory conditions. The Ministry of Social Affairs is the ultimate authority in matters of child protection. On behalf of the Ministry, the Government Agency for Child Protection is in charge of day-to-day administration of child protection services. The basic unit for child protection in Iceland is the Child Protection Committee, which is responsible for child protection services at the local level. In Iceland, there exists a mandatory reporting system in which the public and professionals alike are obliged to notify the local Child Protection Committee if a child's welfare is in any way compromised. Child Protection Services on the Local Level, according to the law, requires each local authority to maintain a Child Protection Committee (CPA) composed of five members. CPA deals with more than 8,000 referrals each year.

Iceland has also established the Children's House, a child-friendly, interdisciplinary, and multiagency center wherein different professionals work under one roof in the investigation of child sexual abuse cases. The basic concept behind the Children's House is to prevent subjecting the child to repeated interviews by many agencies in different locations. Research has shown that when this happens it can be very traumatic for the child and may result in "re-victimization," or the amplification of harmful consequences that can be more severe than the abuse itself. In the Children's House, the child is interviewed in a special room by a trained investigative interviewer. The interview is observed in another room by a judge, who is formally in charge of the procedure, a social worker from the child protection authorities, the police, the prosecution, defence attorneys, and the child's advocate. The interview is videotaped and can be used in court at the main proceedings.

The first Ombudsman for children was appointed by the Prime Minister in 1995, a lawyer, who served for two 5-year periods.

Norway

In Norway, the names of Peer Skjælaaen, Per Hågå, Sverre Halvorsen, and Kari Killen Heap come to my mind. Peer Skjælaaen was instrumental in bringing Henry and Ruth Kempe to Norway in 1974 to lecture and inform about child abuse and neglect, and, in the following years, Peer Skjælaaen made an enormous effort to bring awareness not only in Norway, but all over Scandinavia.

Very few studies on the prevalence of child abuse and neglect have been conducted in Norway. For child sexual abuse, two national surveys have been conducted, which reported the prevalence to be from 3% to 16% (Jensen and Backe-Hansen 2010).

The prevalence of physical child abuse in Norway was recently investigated in 7,033 children and adolescents (8–19 years old), where 20% of girls and 14% of boys had experienced at least one violent episode during their lifetime. Approximately, 2% reported being beaten more than ten times during childhood. Furthermore, 10% of the youth reported witnessing at least one violent episode between their parents (Mossige and Stefansen 2007). In another study (Schou et al. 2007), 15,930 youth aged 15–16 years were asked whether they had been physically or sexually abused during the previous year. The results indicated that 4.6% of the girls and 3.3% of the boys had experienced violence from an adult. The rates for sexual abuse were 6.1% for the girls and 1.6% for the boys. In the study, the children were not asked who sexually abused them.

Norway was the first country in the world to introduce a law to protect children against parental rights to punish their children (in 1972), a Child Ombudsman in 1981, and it also established the Norwegian Center for Child Research at the Norwegian University of Science and Technology in Trondheim in 1982.

Denmark

Parental rights to punish their children dates back to 1683 in Denmark (Merrick 1986), when King Christian the Fifth by law provided parents to strike their children or servants with a stick, but a weapon was not allowed and beating could not impair health. In the "good old days," it seems to have been rough going, like the data from the city of Copenhagen death statistics from 1748 can testify. During that year, 3,328 persons died with 987 due to hitting and beating (Merrick 1986) and the clerk who did the statistics also noted that most of these 987 were children.

The first published case I could find was from 1827 (Klingberg) with a classic case of a stepfather-alone home with a 2-year-old child, while the mother was at work. The case report describes the autopsy, interview of family and neighbors, and also a 2-year jail sentence.

Research was conducted by the Copenhagen Forensic Institute (in the 1936–1967 period), a national questionnaire survey was conducted via general practitioners and school physicians for the 1956–1966 period (Merrick 1989a), and a national survey of all pediatric departments, forensic officers, forensic institutes, and forensic councils was conducted for the 1970–1979 period with a total of over 1,000 cases and 38 fatalities (Merrick 1989b).

Later, other surveys and research were conducted and in 1982 Denmark took the initiative to establish the first Scandinavian Congress on Child Abuse and Neglect to gather all professionals for knowledge exchange. The Seventh Congress will take place in Bergen in 2012.

After many years of advocacy, which started in 1905 by Member of Parliament Peter Sabroe and since 1977 via the National Child Welfare Association (Børns Vilkår), Denmark in 1986 finally abolished the right for parental corporal punishment. In 1987, Børns Vilkår established a national Children's Hotline, which has since been very active in helping and promoting children's rights in Denmark.

A National Council for Children's Rights was set up in 1994 for a 3-year trial period as an independent body based in the Ministry of Social Affairs with the first chairman of Børns Vilkår as the chairman of the council. After evaluation, it became a permanent body. Three members including the chairperson are appointed by the Minister, while the remaining four by the coalition of child NGOs.

Israel

Child protection is the responsibility of the Ministry of Social Affairs and Social Services, reflecting a belief in social intervention rather than legal action. This preference is expressed in both the legislation regarding child protection and the organizational structure of the service system. The Social Services Law of 1958 obligates local authorities to develop and provide the majority of the welfare services for needy populations, including services for children who are victims of abuse and neglect. Child protection services are provided by child protection officers. Child

protection officers are social workers with at least a Bachelor's degree in social welfare departments who have undergone specific training and have been appointed by the minister of social affairs (Szabo-Lael and Zemach-Marom 2010).

In Israel, the Association for Child Protection (ELI) was established in 1979, and the National Council for the Child in 1980. The National Council for the Child in 1989 was the driving force in the creation of and advocacy for the groundbreaking child abuse criminal legislation in Israel and mandatory reporting. This legislation was important, not only because it made reporting abuse mandatory but it was also monumental in classifying child abuse in Israeli law. Reports are to be made to the police or to the child protection officer in the welfare services located in every municipality. Data clearly show that the law has greatly increased public awareness about child abuse and show that the rates of reporting since its legislation have risen significantly. In 1990, there were only a few hundred reports of abuse, whereas in 2000, there were 32,120 reports of suspected abuse and in 2008, 44,425 reports to social workers or the police were recorded. It is also important to note that over 97% of those reports were found to be true.

Conclusions

Henry Kempe was not the first physician to describe child abuse and neglect, but he was the first physician who managed to make society and the health and welfare systems aware of the battered child syndrome. With his skills and determined work over about 20 years from 1962 to his death in 1984, he managed to bring the message across.

Our work is not finished and it will never finish, I presume, in order to ensure that every person is born healthy and wanted, that all children have the chance to achieve their full potential for healthy and productive lives, free from disease or disability, and to ensure the health, productivity, independence, and well-being of all people through optimal rehabilitation.

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Chapter 30
Understanding Child Abuse and Neglect Across Cultures: Reflections from Kenya and the UK

Margaret A. Lynch and Philista Onyango

The commentary by Henry Kempe on Cross Cultural Perspectives in Child Abuse focuses on the role of child-rearing practices in both the prevention and origins of child abuse. He is clearly referring to cultures throughout both industrialized and developing countries. However, first impressions of the forms of child abuse, neglect, and exploitation most commonly found in the developing world do not suggest a direct link to a child's experiences of parenting in the early years. This chapter starts, therefore, with an examination of an apparent dichotomy between the way child abuse, neglect, and exploitation are viewed in Western and developing countries (Onyango and Lynch 2002). The paths followed in the second half of the twentieth century by Kenya and the UK in the recognition of different forms of abuse, neglect, and exploitation are explored and compared. In both countries, the influence and legacy of Henry are obvious.

We then present some of the evidence of abuse and neglect occurring within families in developing countries and how this is influenced by environmental conditions. Henry drew attention to the effects of urbanization and we use Kenya as an example of where this has, in his words, led to "maladaptation of traditional cultural values which are then quickly reflected in difficulties in child rearing" (Kempe 1982, p. 497).

Henry highlighted the significance of the International Year of the Child as signaling a worldwide commitment to improving children's lives and protecting them from maltreatment. This was formalized in the Convention on the Rights of the

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Child and references to its effect will be made throughout this chapter, which will conclude with a brief discussion of its impact on the lives of children, especially in the developing world.

An Apparent Dichotomy of Approaches

Kempe linked child abuse and neglect with child rearing and, thus, in the early years, attention in the West at least was focused on abuse and neglect occurring in the home, and multidisciplinary expertise grew in assessing an individual child's needs and the parent's ability to meet those needs. Family dynamics were placed center stage when considering interventions. In an apparent contrast within developing countries, the field was dominated by those who considered child abuse to be a problem of states that do not provide adequately for their citizens. Their focus was on the frequent abuses that occur outside the home, including children on the streets, children exploited at work, at danger from traffickers, and at risk of sexual violence. Such abuses have been seen as predominantly the result of processes and systems that fail children and where the main remedy is to advocate for change and legal protection.

One only has to look at some of the figures frequently presented by UNICEF (2006) to understand why this might be so:

- 126 million children aged 5–17 years are engaged in hazardous work.
- 130 million girls and young women have undergone genital mutilation.
- 1.2 million children are trafficked worldwide each year.
- 250,000 children serve as child soldiers in armed conflicts.

The majority, though not all of the children suffering such abuses or exploitation, live in a developing country.

However, a closer look at this apparent dichotomy shows that the perception of what constitutes child abuse, its root causes and remedies, also depends very much on one's field of work or professional background. Those working in the medical field, like Kempe, were most likely to identify individual cases of physical and sexual abuse or neglect occurring within the family. Hence, the emphasis quickly became treating the child and working with parents to provide good-enough parenting. In the early years, this focused almost exclusively on the mother, but in many countries, work with fathers is now routinely undertaken. The family may be referred to social/family welfare and home visits may be made. Caseworkers may be employed and if there are mental health problems, psychiatric services may be recommended and, at worst, a child may be removed from home and sent for fostering or temporary care. In cases of child sexual abuse, the perpetrator may end up in prison or at a rehabilitation center or both.

In developed countries, the scene is dominated by doctors, psychologists, nurses, and social workers. These multidisciplinary teams are usually well trained and have clear procedures and protocols to follow. In developing countries, this approach is still "a work in progress," and the numbers of professionals with the necessary skills are few. But, advances have been made thanks to the UN Convention on the Rights

of the Child and by the efforts of lawyers and activists who are using it to advocate for the rights of children, even within families, and to push for the development and provision of services.

Yet, it took the UN a long time to acknowledge child abuse and neglect with UNICEF, for example, preferring to refer to "*children in especially difficult circumstances*" in the 1970s and 1980s (Ennew 2003). Yet, these children, in so-called difficult circumstances, were either facing maltreatment within their families or by the society or the state. But, because the priority was given to the current circumstances of the child (e.g., the street, factory, army, or brothel), the failures of parenting or of state provision that had precipitated the child's predicament or suffering, were often overlooked and the focus of programs became "child rescue." Indeed, it is only in recent years that UNICEF has encouraged cooperation between their Child Protection and Early Childhood Development programs (Ulkuer 2010, personal communication. New York: Early Childhood Development Unit/PDO UNICEF).

ISPCAN too tended to follow the example of UNICEF, and although presentations on CAN in developing countries were a constant feature of Congress from the time of the Third Congress in Amsterdam in 1981, the papers usually addressed topics such as child labor, child trafficking, commercial sexual exploitation and were grouped together in designated sessions. The ISPCAN/ANPPCAN Africa-wide conference in Addis Ababa in 2009 was groundbreaking in addressing early childhood development.

Despite this breakthrough, the way in which terminology has evolved continues to perpetuate differences in perceptions of child abuse and neglect between different fields of work and professionals. This is particularly true for the term Child Protection. For example, in a recent UNICEF publication (2009), Child Protection Systems are described as a way of ensuring vulnerable children and families have access to school, health care, social protection, justice, and other essential services. In other words, Child Protection is being seen as a mechanism by which children identified as vulnerable have their rights realized. In contrast, within countries such as the USA and UK, child protection is seen as being about CAN and that which occurs predominantly within households. For example, Child Protection training for doctors will focus on the recognition and management of child abuse and neglect that might present to them in the hospital or clinic.

Two Paths to Recognition of CAN

The way in which the various manifestations of violence against children have come to be recognized in Kenya and UK can be used to compare and contrast the paths taken in Western and developing countries (see Table 30.1).

Within the UK, the issuing of guidance by the relevant ministries on the application of legislation relating to the protection of children from abuse and neglect, now referred to as "safeguarding" can be traced back to the 1950s. Issued to guide multiagency management of cases, initially, the focus was on physical abuse and neglect in family settings. Indeed, the process of recognition in the UK more or less followed the path

Table 30.1 Two paths to recognition

	UK	Kenya
1950	"Children neglected or ill-treated in their own homes"	(Child labor already identified as a problem by colonial government)
		Abandonment, neglect, and truancy recognized
1970	Abuse (mainly physical) and neglect in family settings	Physical and sexual abuse reported by hospitals
1980	Failure to thrive, emotional abuse and sexual abuse	Sexual abuse, resurgence of recognition of child labor
		Street children, children affected by armed conflict
1990	Children in residential settings	Children in residential care and schools
	Organized abuse	Negative cultural practices (FGM, child marriage)
	Abuse by children and young people	Child pregnancies
		Child with deformities
2000–2011	Children in need (prevention)	Child trafficking, sale of children and sexual exploitation, child pornography
	Fabricated and induced illness	Displaced children
	Trafficking, forced marriage, children in detention, asylum-seeking children	Children in detention

described by Henry Kempe in a paper presented at the London Congress in 1978 (Kempe 1978). Starting with the identification of obvious physical abuse perpetrated by deviant parents, by the 1970s, attention began to be paid to less lurid abuse and to the consideration of emotional abuse and neglect and failure to thrive. Then in the early 1980s, we struggled with Henry's support to gain acknowledgment of the extent of sexual abuse within families in the UK. One paper was first rejected by a mainstream UK journal because "*This is not a problem likely to be encountered by family doctors in the UK*" (Mrazek et al. 1983). During the 1990s, the concept of CAN widened to include abuse of children in residential settings, sexual exploitation, and abuse by other children and young people. Only in the guidance of 2000 did we reach Henry's sixth stage and begin to identify vulnerable children and families (called "in need"). That decade also saw child protection expanding to include groups of children who developing countries had identified years before as abused and exploited (sexual exploitation, trafficking, forced marriage, etc.). Some of these groups include a high proportion of children from cultures from outside the UK. Only in very recent years has child protection guidance included children in detention and those who have come to the UK as asylum seekers.

In Kenya, there has been no study tracking the recognition of CAN and the development of a CP system, but as early as 1919, missionaries in the country were concerned about exploitative child labor that reached a peak in 1930s when the British colonial government was challenged to respond and laws and policies were introduced. By 1950, while abuse within the family was not openly acknowledged, the consequences were being addressed with the establishment of approved

schools for children in conflict with the law and institutions for abandoned children. A statutory body, the Child Welfare Society of Kenya, was established and employed social workers to deal with cases of abuse. In the 1970s, isolated cases of mainly physical abuse from within the family were being identified in hospitals, and Kempe's work became known within Faculties of Medicine. The media too began reporting cases. After Independence (1963), the existence and extent of child labor had been denied, and it was not until the 1980s that following research studies (Bwibo and Onyango 1987), it was again acknowledged. This decade also saw the recognition of street children and children affected by armed conflict; child soldiers and refugee children. Sexual abuse too was being sporadically reported. The government attempted to strengthen mechanisms to protect children, but resources were limited and staff not trained.

The 1990s saw concerns extend to abuse in institutional care and violence against children in schools perpetrated by teachers. Cultural practices were also under scrutiny with FGM, child marriage and child pregnancies all being identified as having negative consequences for children. As elsewhere in the developing world, this has presented a particular challenge, because, as identified by Kempe in his cultural perspectives paper, there remain those who continue to provide "cultural rationalization for harmful behaviour towards children" (Kempe 1982, p. 487). The years that have followed have seen the types of abuse recognized in Kenya widen further to include the killing of deformed children, child trafficking, sexual exploitation, child pornography, and treatment of children in conflict with the law. The numbers of children in residential care have increased as have displaced children. The increasing number of parents dying from HIV/AIDS has exposed their orphaned children to a wide range of abuses. At the same time, this has been the decade in which the government has reviewed and amended laws and policies and attempted to build a framework for a national child protection system.

When considering the forms of CAN now acknowledged in the two countries, while there are some differences in the sequence of recognition, the final overall list is remarkably similar with both abuse within the family and within the wider community, demanding attention from policy makers and service providers not just in the UK and Kenya, but worldwide. This can be attributed to the early work of Kempe and colleagues and the effects of the UNCRC.

Much of the pioneering work in child protection in countries like Kenya has been carried out by NGOs. The development of the Regional African Network for the Prevention and Protection of Child Abuse and Neglect (ANPPCAN) demonstrates (see text box) what can be achieved when activists from across a region work together.

Evidence of Child Abuse and Neglect Within Families in Developing Countries

The UN Secretary General's World Report on Violence against children presented much evidence of violence within families in developing countries (Pinheiro 2006). Caning of children is common, as are other forms of severe physical abuse often justified as discipline (UNICEF 2009). Rates of sexual abuse by family members,

The History of ANPPCAN 1986–2011

The African network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) was formed following a conference on child labor in Enugu, Nigeria, in 1986.

With the vision, "A continent where children are free from all forms of maltreatment," the organization quickly made an impact. ANPPCAN was awarded the C. Henry Kempe award at the ISPCAN Congress in 1988, and since then it has received a number of awards.

From the start, ANPPCAN built partnerships, raised awareness, advocated for children's rights, and undertook research across the continent. It has Chapters in 26 countries and focal points in ten others. It is registered as an International NGO in Kenya, where its headquarters are located. It has observer status with the African Union and Human and People's Rights Commission. Its activities in the early years drew attention to the violation of children's rights across Africa and contributed to the formulation and adoption of the African Charter on the Rights and Welfare of Children (1990).

Topics addressed through research, conferences, and discussion forums, include

- Children and armed conflict (1987 – first international conference on the topic)
- Street children (1989, 1992–1993 – led to a national hearing (Kenya) on street children)
- Awareness of CAN by public and children (1993–1994 with a follow-up in 2000)
- Commercial sexual exploitation (2004)
- Child trafficking in East Africa (2006)
- Child sexual abuse (2007 – first Africa-wide conference)
- Family based care as an alternative to institutional care (2009)

In addition, between 1993 and 2009, regional conferences have been held in five countries in collaboration with ISPCAN:

- 1993: Cape Town, South Africa. General
- 1999: Nairobi, Kenya. Ratification of International Treaties on Children
- 2004: Enugu, Nigeria. Trafficking of Children
- 2006: Kampala, Uganda. Impact of HIV/AIDS on Children
- 2009: Addis Ababa, Ethiopia. Early Childhood Development

More information: http://www.anppcan.org/

relatives, and by neighbors are high, and poverty and overcrowding expose children to adult sexual activity. Children may be sold to traffickers by their parents, involved in smuggling stolen goods across borders, or sent at a young age to work as domestic helps. Because of the heavy workload they are expected to undertake, they may end up abusing children in their care.

Abandonment of children by single mothers is common. Countries in sub-Saharan Africa have many AIDS-related orphans leading to so-called child-headed households, where children try to care for younger children without the necessary skills and without the ability to protect themselves or their younger siblings.

However, work with individual cases, in a developing country, quickly becomes overwhelming, and it becomes clear that there is a need to move beyond a consideration of child rearing to an examination of the role of society. A home visit in, for example, a Nairobi slum, undertaken because a child has been identified at the hospital as physically or sexually abused, can lead to a nasty shock! In the same home you may well find children who have never attended school or have dropped out; or a child who has been trafficked into child labor and is working as domestic help with the "care" of younger children; or a mother who will tell you that some of her children are living in the streets and she had not seen them for some time. Families in such places face enormous challenges in rearing their children. They may be unemployed, living in extreme squalid conditions, often in a one-roomed house where everything takes place including procreation, cooking, living, etc.! The neighbors will be suffering the same fate. Children can be left on their own when the parents, often a single mother, goes to look for food, starting at dawn and not returning until nightfall. The parents cannot send their children to safe places, such as day-care centers, because the cost is too high for parents with no or very little income. Looking outside of the home at the immediate environment, one is struck by the disorder and poor environmental conditions like nonexistent sewage systems; no toilets; no running water, electricity, or garbage management; dirt tracks, etc. In the neighborhood, because of unemployment, one finds brewing of illicit liquor and changaa dens. Crime rates are high as criminals hide in such disorganized environments.

Residents living in these slums, which are considered unofficial settlements, do not benefit from most state programs and often the health and welfare services that exist are dysfunctional. In Kenya, for example, children less than 5 years are not supposed to pay for health services, but in reality, such policies are not implemented and parents end up paying for health services. So if a family lives under such circumstances, which can only be remedied by the state, who should be considered to be the perpetrator?

Impact of Urbanization and Industrial Exploitation on Child Rearing

In a city such as Nairobi, as in most major cities across the developing world, the slums are the result of migration by the population into the urban areas, either to seek work or because life as a subsistence farmer has become unsustainable. Children are put at risk not just because of the squalid living conditions described above but also because of the maladaptation of traditional child-rearing values and practices.

All societies have norms and values they aspire to transmit from one generation to the next. In African societies, breast-feeding was expected and women could breast-feed their children openly. The family ensured these mothers were fed well

following delivery. These people produced what they consumed. Even if the mother went to the garden, she took the baby with her and she could breast-feed the child on demand. Until babies reached age 4, there was always someone at home to look after them. All families stayed living close to immediate relatives and at age 4 a child could move from one home to the next and be cared for as he/she grew. A mother who left her children without food was shunned and considered lazy. Often, she was reprimanded to change. So, there were rules and taboos that guided child rearing and which protected children. For example, at age 4 children went to sleep with the grandmother and never slept in their parents' bedroom. So they were not exposed to adult sexual behavior. Children, as they were growing, were taught how to relate to fathers and other relatives, especially the male. With the move from rural to urban areas things changed. Bottle-feeding was introduced to enable mothers to work long hours away from the home. Other traditional practices could not be transferred. With no relatives to reprimand them, parents could do anything to their children. The majority could only afford one-room type of accommodation, and the neighbors were total strangers and often from a different background.

Living in poverty also makes parents send young children to stay with their extended relatives or work for others as domestic help. Some mothers have shifted their parental role to maids, most of whom are children themselves, and children as young as 9 have been found in this role.

The saddest part is that the majority of parents is not educated and rarely has marketable skills, making perpetuation of their unfortunate state inevitable. Because these families know no alternative, bringing about change becomes difficult. Hence, the need for broader community-based approaches to challenge the status quo, such as the approaches adopted by NGOs targeting awareness raising, public education, and advocacy, aimed at changing attitudes and behavior.

Even more disruptive to cultural values and traditional child-rearing practices than economic migrations are the forced migrations due to conflicts and drought (e.g., Somalia, Sudan, and the Democratic Republic of the Congo). Families end up in other countries and above all, in camps, where they have lived for many years without becoming citizens of the host country. There is a lot of abuse that takes place in these camps and rearing children in camps is yet another extreme challenge.

The Effect of UNCRC

Henry Kempe saw the International Year of the Child in 1979 as a sign that for the first time members of the UN were willing to address the needs of children worldwide. It was to be another 10 years before the Convention on the Rights of the Child explicitly gave every child the right to protection from abuse and neglect. The Convention also includes a provision under which the State is charged with supporting parents in the rearing of their children. There is also a mechanism for holding countries accountable through the regular reporting process.

The CRC undoubtedly brought many blessings to children worldwide, and many countries have improved education, health, and other service provision. This can be verified from the many reports which show that indicators such as infant and under-5 mortality rates have improved tremendously. On the other hand, implementing the CRC has led to countries becoming awash with legislation and policies, which often are not effectively enforced or implemented (Onyango and Lynch 2006).

Although lack of implementation of laws and policies, by and large, has been attributed to lack of resources due, at times, to misuse of same and duplication of efforts, salient factors such as governments in developing countries being told or directed on what to do, also contribute. Situations where "expert" groups sitting in Geneva and New York design strategies to be implemented by the developing world in line with, for example, the UNCRC, ILO Convention on Worst Forms of Child Labor, abound. While this may be considered as technical support and strategic partnerships, the processes often end up being donor-driven and not based on needs or locally owned. The efforts end with donor funds.

Similarly, in developing countries, priorities for children's issues may be changed on an annual basis, depending on the interest of those funding them and with international mandate. A good example is the current international efforts to strengthen child protection systems in sub-Saharan Africa. In Kenya, this process was started by the Coalition on Child Rights and Child Protection in 1996 and by 2002 child protection systems had been created in 34 districts and many others strengthened. Unfortunately, these noble efforts were discounted as not a "systems approach" according to the international groups as currently spearheaded by UNICEF (UNICEF Annual Report 2010).

The work of Kempe and colleagues, for example, the 1976 book (Helfer and Kempe 1976), contrasts with this approach by starting at the grassroots, where the families are, and encouraging people to use their creativity in finding ways to prevent abuse, neglect, and exploitation.

Conclusion

Once one explores below the surface of the apparent dichotomy between the origins of child abuse and neglect in different cultures, it becomes apparent that, as described by Henry Kempe, child rearing and cultural values play a pivotal role. Furthermore, while there are some differences in the paths followed by countries, such as Kenya and the UK, in the progressive recognition of the many forms of abuse and neglect that can be experienced by children, the "final" list ends up as surprisingly similar.

The circumstances confronting families in urban slums or refugee camps, as predicted by Kempe, require adaptation to external forces in a way that may severely compromise the care and rearing of children. Holding such families responsible for abuse of their children assumes a control they do not have. Such families are rendered helpless and action is required on behalf of the children not just by NGOs, but

by governments and the international community. Thus, there is a need to work both with individual families and communities and to continue the advocacy battle for universal acknowledgment of children's rights and the provision of services to promote the welfare of children and protect them from abuse. Henry Kempe understood this and his influence can still be found both among those who work with individual families and among those who advocate and lobby at national and international levels for the full realization of children's rights.

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Chapter 31
The Role of ISPCAN: The Uncomfortable Truth of Child Abuse and Neglect Goes Viral

Irene V. Intebi and Richard Roylance

It is both fascinating and humbling to read the musings – written in the "heat-of-battle" as it were – of a person who has been of significant influence at an important moment in history. So it is with C. Henry Kempe and his commentary published almost 30 years ago in *Pediatrics*, entitled "Cross-Cultural Perspectives in Child Abuse" (1982). Kempe condensed within a single page an impressive collection of original thoughts and comments on the subject of child abuse and neglect (CAN) as considered from a global (or "world") perspective.

He noted in his commentary that the predominant focus of writings and research up until that time had been on "Western cultures" (sic). Although terms may have changed in the ensuing decades (i.e., "Western cultures," "Developed World," "Industrial World," "First World," "Northern Hemisphere," etc.), Kempe explored the presumptions inherent in much of the published work up to then, that "all 'progress' was good for children" (Kempe 1982). He questioned whether there might be unexpected adverse side effects from embracing all facets of a "Western cultural" approach. He posed the idea that although some "'simple' societies" (Kempe 1982) had practices that were demonstrably not in the best interests of children, there may, nevertheless, be some cultural wisdoms in those non-Western cultures that would stand the test of objective examination.

In his commentary, as in his work, Kempe paid particular attention to the issue of "dependent persons" (specifically children and mothers), and to the vulnerabilities of such "dependent" persons to the adverse effects of overly rapid socioeconomic change – both in "Western culture" and in the developing world. The amelioration

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of extreme poverty was an undoubted good, reducing mortality and morbidity from causes such as infectious disease, maternal illness, and child labor. Yet, Kempe foresaw that the social isolation and changes in traditional family support structures that arose from rapid urban-drift and socioeconomic upheavals had the potential to undermine that good.

The power of Kempe's foresight was such that over the ensuing decades, the ideas raised in his commentary have become the subject matter of countless papers, books, and conferences and are now core concepts for social policy-makers in all countries of the world.

The international community continues to explore the implications of these ideas within both clinical and academic practice. The International Society for Prevention of Child Abuse and Neglect (ISPCAN), which Kempe was instrumental in establishing in 1977, continues his multicultural work all over the globe – at national, regional, and international levels.

Kempe's commentary articulated the following important concepts and recommendations for practitioners, service organizations, and policy-makers:

1. The importance of accurate data collection about CAN:
   - The collection of child abuse and neglect demographic data is fundamental to purposeful analysis.
   - When data is poorly collected, low "reported numbers" cannot be taken to reflect a "real" low incidence or low prevalence of the problem.
   - The collection of data in Western cultures forced a change in how people in those cultures perceived the issue of child abuse and neglect. This process should be mirrored in the developing world.
2. Cultural rationalization is insufficient reason to excuse harmful practices:
   - Although a particular child-rearing practice may have a long history within a culture (i.e., it is "customary" or "traditional") this is not sufficient proof that the practice is neither harmful nor abusive to children.
3. "Dependant persons" are vulnerable during periods of rapid economic and social change:
   - Although "Western" economic "progress" provides protection to children from death and morbidity directly associated with poverty, the cultural changes associated with economic progress are not always in the best interests of children.
   - During periods of rapid social changes, all members of a culture are vulnerable, but due to their dependence, children are particularly vulnerable.
   - The social isolation of "mothers"[1] (and the loss of support for "mothering"[2]) that can be associated with Western progress may have adverse side effects and can be "concomitants" of child abuse and neglect.

[1] A more contemporary term might be: "carers."

[2] A more contemporary term might be: "parenting."

4. An international approach to child abuse and neglect is required:
   - The development of a global approach to the prevention and treatment of child abuse and neglect is an important (and at that time new) strategy.

Kempe's approach to these issues was undoubtely influenced by his training in basic science, medicine, and, subsequently, in public health. It is no coincidence that he began a commentary on cross-cultural perspectives by arguing that the collection and analysis of reliable data must be the foundation of all subsequent work; and that "belief" and "past cultural practice" are not appropriate or sufficient arbitrators of how children should be treated! Kempe was at his core, a scientist.

We submit that one of Kempe's lasting influences on the field of child protection arises from his underlying philosophy of practice, which can perhaps be paraphrased as: Don't ask me what I think, ask me what the data say.

It was this approach to issues that drove his demand that colleagues, elected officials, and the public accepted the "uncomfortable truth" that children were sometimes the victims of physical, sexual, and emotional abuse and neglect at the hands of parents and caregivers. He demanded this acceptance from his audience, not because he "believed" in what he said, but because that was where the evidence led him.

In his commentary, Kempe argued that the regular collection of demographic data about child abuse and neglect was fundamental to any purposeful analysis. He argued further that collecting data alone is insufficient, if that data were of poor quality.

He pointed out that it was insufficient for any cultural group to argue that child abuse and neglect were not significant issues within that culture if that argument rested on low incidence figures generated from poorly collected data. Kempe argued that "Western cultures" had been forced to alter their perceptions of how children were dealt with by parents and family because of what the data had shown. He expected no less of other cultures!

Importantly, Kempe had identified historical shortfalls in data collection and analysis within his own culture first, before going on to demand that the broader international community adopt better systems to record and analyze child protection data within their individual communities.

More controversially, in his commentary, Kempe laid down a cross-cultural challenge. His observation that "…not infrequently, cultural rationalizations for harmful behavior toward children are accepted blindly as proof that the treatment accorded to children is neither abusive or harmful…" is as relevant today as it was when he wrote it almost 30 years ago (1982). No matter what country or culture is considered, harmful child-rearing practices still persist 30 years after Kempe.

Kempe was evenhanded in demanding that the determination of whether any particular cultural practice is child-friendly should be decided by measurement and not by opinion. He noted that in non-Western cultures, there were "child care practices, [which] although traditional, may no longer serve the best interests of their society" (Kempe 1982). He went on, however, to note that there were Western cultural "traditions" that were accepted as appropriate by Western cultural adherents – and that these practices should also be questioned as being in the best interests of children. The manner in which Western cultures undertook the care of their children

in areas such as toilet training and infant supervision, and particularly practices that lead to parental isolation, were issues of practice that Kempe specifically questioned. Those debates continue today.

What makes Kempe's commentary so powerful is that the author was writing at the time from that very singular bastion of Western culture: middle-America in the 1980s. His declaration that: "We (i.e. Western culture) may need to reevaluate our own methods as well….clearly no nation has a monopoly on superior methods of child rearing" is remarkably humble in the context of the day (Kempe 1982).

Kempe brought the same analytical approach to the question of child protection from the socioeconomic perspective. Although acknowledging the benefits derived to children from economic prosperity, Kempe cautioned us to measure and analyze potential side effects from such progress, for example, in regard to increased isolation and loss of support for carers (sic: "mothering").

Interestingly, Kempe also noted that it was the rate of socioeconomic change, as much as the characteristics of the change itself, which might be a crucial factor in adverse outcomes for children:

> When circumstances of a nation change rapidly, as in times of sudden urbanization and industrial exploitation, there may be a serious lag and maladaptation of traditional cultural values which are then quickly reflected in difficulties in child rearing (Kempe 1982).

In the concluding paragraphs of his commentary, Kempe touched upon a theme that is so important to his legacy – the realization that

> Ours is increasingly becoming one world. …for the first time in human history, the world, as a whole, has addressed the needs of children wherever they are. This shift in attitude should rapidly lead to more understanding of how to prevent and treat child abuse and neglect the world over (Kempe 1982).

Kempe's dream that his work would extend to encompass the world's children has been fulfilled in the ensuing decades. If Kempe's only contribution to the field was to uncover the issue of violence against children and raise professional and public awareness in the USA, we would have regarded him as an exceptional man and clinician. The further great achievement of C. Henry Kempe was to establish the ISPCAN (Donnelly 2002). It is not possible to discuss Kempe's legacy to the field of child abuse and neglect without looking at the goals and achievements of this organization so close to his heart.

In 1977, Henry Kempe founded ISPCAN, the only multidisciplinary international membership organization to bring together a worldwide cross section of committed professionals to work toward the prevention and treatment of child abuse, neglect, and exploitation globally.

Now, 30 years later, ISPCAN remains committed to the task of increasing public awareness of all forms of violence against children, developing activities to prevent such violence, and promoting the rights of children in all regions of the world. ISPCAN's mission is to prevent cruelty to children in every nation, in every form: physical abuse, sexual abuse, neglect, street children, child fatalities, child prostitution, children of war, emotional abuse, and child labor, while supporting individuals and organizations working to protect children from abuse and neglect worldwide.

Thirty-two years after its foundation by Kempe, ISPCAN can proudly claim the following achievements:

- Ongoing Implementation of the Convention on the Rights of the Child (CRC) Article 19 Working Group:
  - CRC Article 19 Working Group: (a joint project with The International Institute for Child Rights and Development).
  - Both organizations were selected by the UN Committee on the Rights of the Child to draft the General Comment for Article 19 of the UN Convention and design implementation support for its further implementation.
- International Child Maltreatment Data Collection (ISPCAN-WGCMD):
  - A joint project with American Humane Association.
  - The purpose is to coordinate organizations and individuals who are actively working with child maltreatment data collection programs directly sponsored by governmental entities which are sustained and intended to be long term.
  - Participants are not only countries that have implemented child maltreatment data systems but also countries that are involved in planning and developing such systems.
- International I-CAST Tools:
  - A joint project with UN High Commissioner for Human Rights, WHO, and UNICEF.
  - With assistance from UNICEF and the Oak Foundation, ISPCAN developed questionnaires and interview guides for collecting generic data on the extent and depth of child abuse and neglect.
  - The project was undertaken in conjunction with the UN Secretary General's Study on Violence against Children and has been conducted with NGOs, governments, and professionals internationally.
  - The first UN study on violence against children. More than 100 professionals from different countries were involved in the project. The questionnaires were field tested in eight countries (Colombia, the Democratic Republic of Congo, Egypt, India, Kyrgyzstan, Lebanon, Malaysia, and Russia).
  - It is envisioned that the availability of a common tool will enable systematic comparison of data across cultures, time, or between research groups, even when such groups operate within the same country or use the same language.
  - It is anticipated the use of these tools will result in policies and programs that promote child protection and in curricula adaptation for general and continuing professional education.
  - At present, the instrument has been translated in Arabic, French, Hindi, Malay, Marathi, Russian, and Spanish. At a later stage, the instruments will be made available in local languages.

- The ISPCAN World Perspectives:
  - A biennial publication that offers a unique view of the state of child maltreatment policy and practice in multiple countries.
- Use of new technologies to disseminate knowledge and expertise and to strengthen regional and international professional networks:
  - *The Link and Special Reports*: allow ISPCAN members to share information on their worldwide efforts to develop educational and training opportunities for fellow professionals in child abuse and neglect prevention. Articles more focused on practical issues and the multicultural challenges of members' work, providing models of international practice with multidisciplinary and international perspectives are published in The Link. There are printed versions in English and in Spanish (La Conexión) and electronic versions in English, Arabic, Chinese, Spanish, French, and Russian.
  - *Virtual Issues Discussions (VID)*: an interactive message board hosting special online focus groups on a variety of different topics.
  - *The Listserv*: enables ISPCAN members to stay up to date with news, trainings, and other ISPCAN announcements. It is also a general professional forum for trading questions and answers among members.
- Dissemination of practices and knowledge from developing countries at every ISPCAN International Congress Developing Countries Forum; the annual Global Institute at the San Diego Conference (USA) and Cultural Institute Workshops at APSAC Annual Colloquium.
- "Medical," "Mental Health," and "Interdisciplinary Practice" curricula development in joint collaboration with professionals from industrialized and developing countries.
- Continued international multidisciplinary trainings in developing countries led by local NGOs – with the goal of training a core group of professionals. Projects have been developed in Africa, Asia, Latin America, and Eastern Europe.[3]
- Specific consultation projects in the Kingdom of Saudi Arabia, Georgia, and China.
- Active involvement and support of regional conferences in the Asian Region and in Arab countries.

Following Kempe's vision, ISPCAN has worked to actively recruit members from diverse cultural backgrounds. ISPCAN went through three evolutionary stages in its goal to represent as many cultures, countries, and regions of the world as possible.

[3] Countries involved in training projects:

African Region: Kenya, South Africa, Cameroon, DR Congo, Benin, Ethiopia, Malawi

Asia-Pacific Region: Malaysia, Thailand, India, Pakistan, Bangladesh, China, Sri Lanka, the Philippines

Latin American Region: Argentina, Brazil, Colombia, Belize

Eastern European Region: Latvia, Bulgaria, Poland, Estonia; Belarus, Georgia, Russia (Nizhniy Novgorod and St. Petersburg)

Arab Region: Egypt, Lebanon, Syria, Yemen, West Bank Territory.

In the first stage (1978–1988), the challenge was to engage developing countries' representatives, with ISPCAN Councilors working to create awareness of the issues of child abuse and neglect in as many countries as possible, and to promote the role that ISPCAN could play to assist.

In its second stage (1988–2000), the challenge was to create a specific space for developing countries within the ISPCAN organization. The Developing Countries Committee of the Executive Council was created and resulted in the election in 1998 of the first developing country president, Franklin Farinatti (from Brazil), and the selection of South Africa as the site for the 2000 ISPCAN International Congress (Alma de Ruiz 2002).

Since 2000, with the contribution of developing countries members, councilors, and the invaluable financial help of funders, ISPCAN entered a third stage, a stage in which the challenge is the consolidation of what was built in the past, while encouraging innovation and creativity. There is an increasing number of ISPCAN presidents from developing countries. There is a growing percentage of developing countries' councilors on the ISPCAN Council in leadership roles (Committee Chairs; Executive Committee members). Potential ISPCAN members can choose to take different types of ISPCAN memberships – reflecting the economic differences among regions, countries, and professions.

As a further strategy to fulfill Kempe's vision, ISPCAN's "Country Partner Program" was launched in 1999 to formalize affiliations with existing national, multidisciplinary organizations working in child abuse and neglect prevention, with a special focus on groups in developing countries. This ongoing collaboration aims to further the common mission, goals, and programs of ISPCAN and its partners, supporting an exchange of materials, information, and membership benefits between ISPCAN and these other societies.

In 2002, Alma de Ruiz wrote a review, highlighting how the tensions Kempe had described between "Western cultures" and the developing world were manifest within the recently created ISPCAN. She wrote:

> … [In the '80s] there was a general excitement about the idea of sharing a common goal: the well being of our children for both industrialized and developing countries, but the issues were so different in different cultures, as were the realities that surrounded them.
>
> For industrialized countries, the central issue was the prevention of intrafamilial child abuse and neglect. This was in accordance with a strong tendency inside the Executive Council to stay clearly away from any political issues. On the other hand, for developing countries the whole concept of child abuse was closely related to poverty and lack of basic health and educational services for millions of children. It was around this time that WHO, as well as other international organizations, were conscious of the need to approach the issue of child abuse as a health problem together with violence in general. Political issues were central to developing countries, where most of us had been through dictatorships and revolutions. (…)
>
> (…) In this context, for developing countries, the central issue was not only intrafamilial child abuse but clearly extrafamilial or community child abuse (Alma de Ruiz 2002).

This analysis by professionals experienced in "developing country" work – emphasizing the importance of the larger social influences on the incidence and prevalence of child abuse and neglect – was one that Kempe (the public health physician) would have applauded. It has taken some considerable time for "Western

cultures" to look beyond the individual child and the individual perpetrator for effective intervention and strategies for prevention.

Children are abused and neglected by individual perpetrators in developing countries (just as they are in developed countries), but child abuse and neglect in developing countries is often a more complex and challenging issue due to issues of severe resource limitation and unpredictable social infrastructure. In developing countries, issues such as unremitting poverty, chronic high unemployment, war, civil strife, movements of refugees, inadequate schooling, health care, and social services combine with system and policy inadequacies to create huge additional stressors impacting upon the incidence and prevalence of child abuse and neglect.

These structural conditions may be so extreme as to do much more than cause an individual parent to harm or neglect an individual child; these conditions can precipitate "systems-level" forms of child abuse and neglect such as child soldiers, street children, child trafficking, child slavery, child prostitution, child rape, refugee children, and children orphaned due to HIV/AIDS (Wallace 2008).

Although children in "Western cultures" should be significantly better protected than children in developing countries, there are groups of "children-at-risk" in "Western cultures" who live under circumstances as difficult as those found in any developing country.

Kempe's hope was that organizations such as ISPCAN would work to share knowledge and experiences internationally – to reveal the similarities and the differences in child-rearing practices among cultures and to acknowledge the importance of the economy, of wealth distribution, and of service provision (health, education, justice) – to allow parents to meet the protective needs of their children.

Kempe is likely to have agreed with Peter Lachman et al. when they state,

> The potential to prevent child abuse [in Asia, South America, Eastern Europe, & Africa] is there if the key issues are addressed.
>
> International child protection strategies cannot address the abuse of children in the Southern hemisphere without looking at issues like the global debt & without considering the struggles of their whole community (Lachman et al. 2002).

Kempe's call to arms for the development of an international cadre of persons willing to "defend the defenseless baby" echoes within, and is amplified by ISPCAN (1982). Thus, directly and indirectly Kempe has contributed to moving the field of child protection forward in all the countries of the world.

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