TREATMENT OF FAMILIES EXHIBITING VIOLENCE TOWARD CHILDREN

A Multidisciplinary Bi-County Child Abuse Treatment and Prevention Program

Lehigh County Children's Bureau

Lehigh County MH/MR

Head Start of the Lehigh Valley

Northampton County Children's Bureau

Northampton County MH/MR

Center for Social Research
Lehigh University

Report prepared by
the staff of the Center for Social Research
Lehigh University

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PREFACE

The document which follows is divided into two parts. Part I describes the service program for treatment of families exhibiting violence toward children, including the research and evaluation. Part II provides information drawn from the formal citations for abuse during the period 1967-1975.

The program described in Part I has several striking characteristics. It is a regional program covering two counties generally known as the Lehigh (River) Valley, which has a population of 486,000. It is an interdisciplinary program including professionals from the fields of medicine, casework, nursing, psychology, and sociology. It is a changing program. Those who have worked in the program since its inception know in detail of all the changes which have been made to date; and the changes continue.

The present document describes a variety of activities which have been developed as part of the program. These should not be viewed as a "package" but as a set of services, some or all of which might be used or adapted for use in other communities. Two considerations will determine which set is selected for use in any community; the needs of the community, and the availability of staff to deliver the services.

Part II is a report drawn from the formal citations for abuse and represents the first stage of the research and evaluation being conducted as part of the two-county program. The information provides a description of the abuse incidents. Further reports of this activity will be forthcoming in the future.

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PART I

SERVICE AND EVALUATION PROGRAM

I. OVERVIEW OF DEMONSTRATION PROGRAM

The Demonstration Program is a two-county program in eastern Pennsylvania, serving clients in Lehigh and Northampton Counties. The unique aspect of the program is its multidisciplinary team approach. Case work services, group therapy, family therapy, individual therapy, parent education, and evaluation of the services provided are offered in both counties. The program's birth was in Lehigh County in late 1969 at the then Allentown General Hospital when a local pediatrician, Dr. John Wheeler, became concerned over the "rash" of abuse cases (six in 1969), which included one of his private patients, being treated on the hospital's pediatric ward. Dr. Wheeler researched the suggested treatment modalities for abusive parents and approached Dr. Raymond Seckinger, specialist in group psychoanalysis at the hospital's Mental Health/Mental Retardation (MH/MR) Base Service Unit, asking him to set up a program for abusive parents. Subsequently, at the direction and agreements of Drs. Wheeler and Seckinger, the hospital, the Base Service Unit, and the Directors of the two counties' Children's Bureaus, a group therapy program for abusive adults was initiated at the Unit in December, 1969.

Early in 1970, the procedure began whereby each Children's Bureau caseworker who was involved with a particular family in the "child abuse group," began participating in the group. This crystallized the concept that although group therapy became the "core" of the treatment for these "abusive families," other supportive services would be provided each family through the caseworker, outside of the group. This structure also nurtured close communication between the group therapy (MH/MR) and the Children's Bureau. This original group was open to clients from Lehigh and Northampton Counties.

The ever-increasing number of referrals on "suspicion of child abuse" (in Lehigh County from 1969 to 1974 inclusive, there was over a 900% increase in referrals!) necessitated the beginning of a second group for "abusive parents." In addition, during the summer of 1973,

success of the group therapy modality with "abusive families" led to the training of a psychologist from the Northampton County Base Service Unit, so that they could establish a similar therapy group in their county, which they did in October 1973.

The developing collaboration between the medical facilities and other referral sources, the Children's Bureau, and MH/MR offered the crucial element needed to deal with the three phases in the handling of child abuse detection, intervention and treatment.

Although group therapy was the original treatment modality and remains an important element, other modalities - individual therapy and counseling, marital counseling, family therapy and psychological testing were needed, added and developed. Other supportive services were offered the "abusive family" through day care, Head Start, public health nurses, etc.

In October, 1974, Lehigh and Northampton Counties entered into contracts with the Department of Public Welfare, whereby DPW authorized a demonstration program to provide for the expansion of the child abuse treatment programs in both counties for three years, with the final objective and agreement being the training of other professionals from different counties in setting up similar treatment programs in their localities.

Under the expansion of the program, an important component called Home Start has been added in which parent-educators, employed and trained by the local Head Start Program, provide supportive and preventive services to parents.

A research and evaluation component has also been added to the program, under the direction of the Social Research Center of Lehigh University.

The demonstration program as it was finally constituted involved two sets of services, one in each county, which were interrelated through the joint advisory group, the activities with both county programs of Head Start, the Lehigh University Center for Social Research, and possibly most importantly through the personal contacts among all staff involved in the program. Figure 1 is an organization chart of the program.

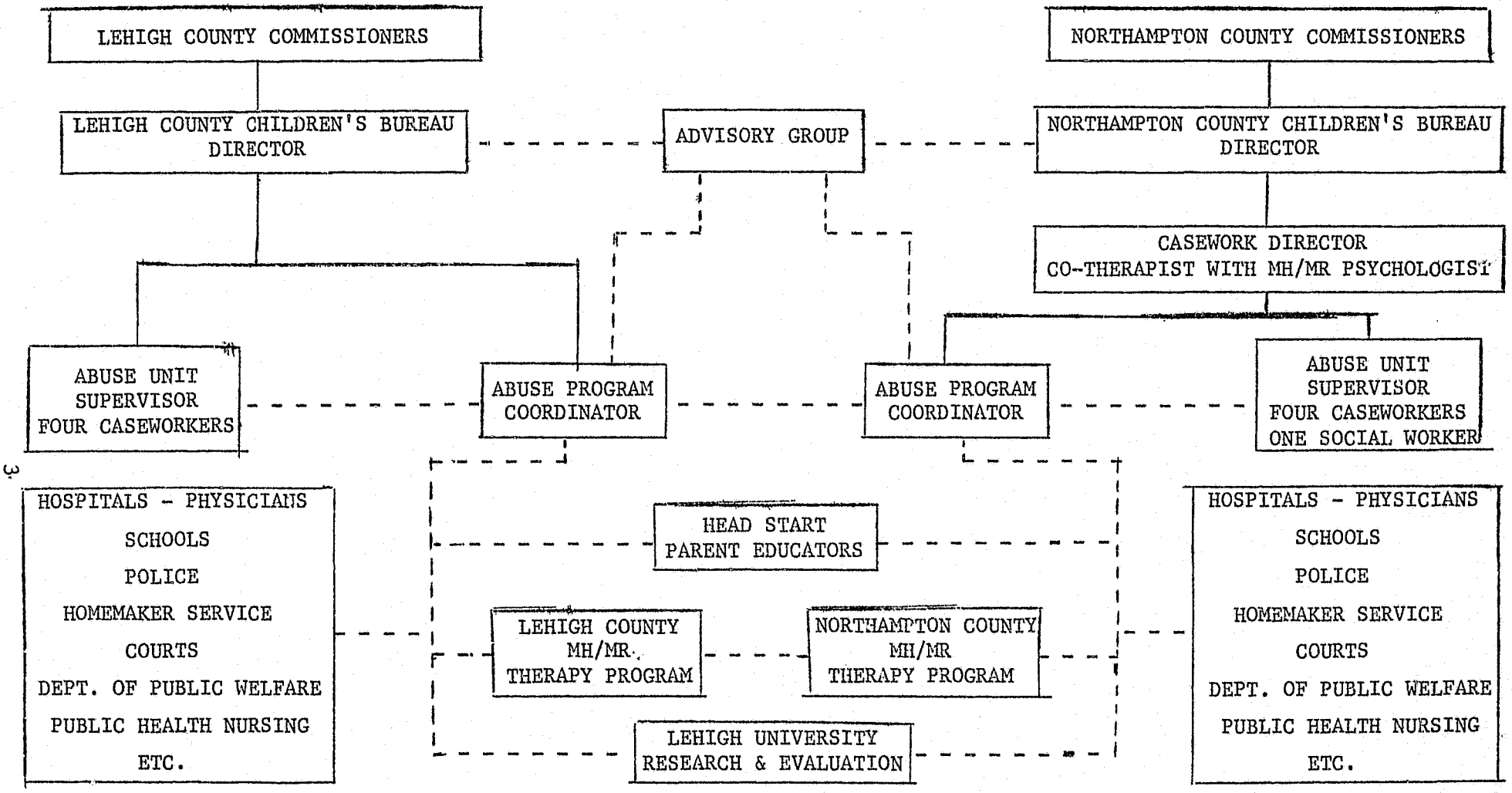

FIGURE 1
ORGANIZATION CHART: COORDINATED CHILD ABUSE PROGRAMS IN LEHIGH AND NORTHAMPTON COUNTIES

While parallel services have been offered in the two counties, there have also been variations in the emphasis on one or another type of therapy, and in job descriptions of certain team members. The description below of the services offered in the two counties will highlight the variations as well as the similarities.

II. FUNCTIONS OF THE SERVICE COMPONENTS

A. Children's Bureaus

1. Services

The two Children's Bureaus provide the intake service for all referrals to the program, and the casework service for all clients through their abuse units. The responsibility for all referrals between the Children's Bureau and the other major components of the program lies with the Children's Bureaus. In addition, the Children's Bureaus of both counties have provided co-therapists for the therapy programs which are run in conjunction with the MH/MR programs in the two counties. In Lehigh County, the co-therapists have been, and continue to be involved in the group therapy program. In Northampton County there has been a shift, perhaps temporary, away from group therapy toward a greater reliance on family therapy. These differences will be explored below in the section on therapy.

2. Intake Process

The intake process begins with a referral of suspected abuse to the Children's Bureau. The referral immediately becomes the responsibility of the intake supervisor, and subsequently of the abuse unit supervisor. If it seems that the case will need follow-up by the abuse unit once the intake study has been completed, then it will be transferred directly to that unit. The abuse unit coordinator is available to other supervisors for clarification of criteria used in judging whether there has been abuse, and for interpretation of the new law and regulations.

3. Job Description

a. Child Abuse Program Coordinator

In both counties, community education is a primary duty of the Coordinator. The person in this position speaks to both lay and professional groups on topics such as causes of child abuse, kinds of injuries cited as abuse-related, stresses related to the occurrence of abuse, services offered by the Children's Bureau and how to utilize the facilities, and the community's role and responsibility in this area. The Coordinator is also involved in helping to tie together the functioning of the various components of the program, in consulting on specific cases, and in proposal writing. In addition, the Coordinator is responsible for such things as procedural guidelines and policy formation, conducting and identifying needs for staffings, and maintaining communications with both the State Department of Public Welfare regional office and the central office in Harrisburg. Any individual circumstances involving attorneys are directed to the Coordinator. He may serve as a witness to summarize the role of the agency and decisions made about a particular family.

b. Casework Supervisor

The Casework Supervisors of both county Children's Bureaus have very similar duties. Both are primarily involved in supervising caseworkers, overseeing direct services to the families, and assigning caseloads. The Casework Supervisor reviews the goals for families with the caseworker and helps him/her work out any problems that might arise with the families. The Supervisor must check to see that the paperwork involved in casework is updated for reports for the research project, and statistics for the agency.

Both Supervisors work closely with the Coordinators; responsibilities overlap and are sometimes shared. An example of this is in-service training. Both positions include some shared responsibilities in this area.

The Supervisor of the Northampton County Children's Bureau is responsible for a weekly unit meeting to review and update the law with

the caseworkers. He also calls in other agencies for a conference on problem cases. The two duties are usually handled by the Coordinator in Lehigh County.

There are some new programs being initiated in Northampton County under the direction of the Supervisor. One of these is the Mothers' Association, which is a social group made up of the mothers in the abuse unit and protective services. In addition, a babysitting co-op is in the planning stages.

c. Caseworker

The caseworkers in both counties work directly with the families. The families are visited in their homes, or meet in the agency. The caseworker's primary function is facilitating the building of positive relationships within the family, and identifying and helping to serve the needs of the family. A basic requirement for successful casework is a relationship of trust between the family and the workers. Openness and honesty on the part of the worker is a necessity to build that trust. Often the caseworker is gradually accepted as the "good parent" by the family, the "caring parent" that the abusive adult may never have felt (s)he had.

Placement of the child in foster care is sometimes felt to be necessary if the child is considered to be in physical or emotional danger in the family setting.

When referrals for additional services are made, it is the responsibility of the caseworker to help the family follow through on the referral and to coordinate the various services.

Transportation of clients is a large responsibility of the caseworkers. This involves transportation to clinics, group or family therapy, other agencies, etc. Sometimes the occasion may be a lunch out in a restaurant for the mother with the caseworker, or a family visit to the library. Records on all contacts with the family are kept.

An emergency must take priority whenever it occurs. As long as the family sees it as a crisis, it needs attention by the caseworker immediately. If the emergency comes in by phone, it is first handled over the phone if possible. The caseworker may then visit the family, or the family may come to the office. The Supervisor may become involved through an emergency conference. A 24-48 hour plan is set up, and other agencies are contacted to determine who is responsible for each part of the plan.

On occasion, a team approach is used to deal with a family. This often happens with a caseworker new to the abuse unit and a more experienced caseworker. During a crisis, caseworkers help each other out by picking up a client, running errands, etc., to free the main caseworker to deal with the emergency. In Northampton County, the initial evaluation of a family is routinely made by a person other than the worker to whom that case is ultimately assigned.

B. Therapy Program

Group therapy for abusive parents was begun in Lehigh County and is still an ongoing program in that county. In Northampton County a group therapy program was begun as part of the Demonstration Program. Presently, however, family therapy has supplanted group therapy in that county. Because of the practical and some theoretical differences in the two counties' approaches to therapy, they will be treated separately in this section.

1. Lehigh County Group Therapy Program

The main focus of this program for the abusive parent follows the theory of group therapy for the borderline personality with severe problems of an inadequately developed ego. This type of person exhibits a low tolerance for anxiety, impoverished feelings, and lack of impulse control. The primary function of group therapy is a reconstruction or repair of the ego which has been ineffective in coping with reality since childhood. The group provides the support to allow the client to become a more self-sufficient person within the family and within the community.

Success of group therapy depends on teamwork and is only effective when the team members function as a well coordinated unit and are complemented or supplemented by the other modalities. A massive support system set up with the community is a requirement of a group therapy program. Individual and family therapy sessions must be integrated into this system as well. If the organization is fragmented, the team members will be fragmented, and therefore the client will experience repetition of earlier disintegrated family relationships, and a perpetuation of the child abuse/neglect problem.

All referrals to group therapy go through the Lehigh County Children's Bureau. The caseworker refers the prospective member to the MH/MR group co-therapist, who then describes the program to the client, including the variety of psychological and neurological services offered. The client is asked for permission to be observed while participating in the group. This observation is a part of staff training. The psychiatrist co-leader also sees the clients for an evaluation, and may recommend other testing.

Each co-leader in the group is representative of a different discipline, and performs a different but complementary function. There must be more than one leader, and there can be as many as three and sometimes four. Rapport between the mental health professionals and the other therapeutic team members is essential to the successful working of the program. This rapport can be established only if there is appropriate education of the staff, including case conferences with all team members, teaching programs, student programs, and an integral sharing among those involved with that particular individual client.

Role definition, communications, and territorial considerations are of the essence in the coordination among the team members. The rapport is only the beginning to the ultimate goal of setting up a working relationship with the individual and the family in treatment.

The therapist, who is psychoanalytically oriented, directs the group process to repair the ego. This person should have a background

of experience and training in a psychotherapeutic group and personal analysis, as well as experience in leading groups.

The social worker co-therapist provides support, guidance, and counseling skills to the group. In addition, he/she serves as a coordinator of therapy with casework service, and supervises the caseworkers (who serve as co-leaders) in the group process.

The caseworker co-leader has a major responsibility for getting the parents into the program and motivating the clients to continue to attend by supporting them through emotional trauma, encouraging clients to bring up problems in the group setting, and helping the clients to see the long-range benefits of participation.

As a co-therapist in group therapy, the caseworker has the position of bringing information about the family to the group or encouraging the client to bring it up himself/herself. The caseworker has the greatest amount of contact with the family, and gives a quality of integration to the two program components. The caseworker can continue work on a particular issue outside the group and, while transporting the client home, can deal with any immediate reactions to the group sessions that might occur.

During the group process, the client goes through two phases. Phase one is a phase of high resistance, when the client is anti-authority and mistrustful of the group. This phase lasts approximately three months, during which there is "acting out" in the form of missing group, coming late, or even dropping out. The client projects the mistrust that originated with his/her parents onto the group leaders. There is also a certain amount of relief gained by the client during the beginning sessions, as (s)he learns that there are others with similar problems. Setting up a working relationship necessitates dealing with the resistances in the treatment process from the beginning to the end. How well the resistance will be dealt with depends on the degree of coordination among the team members.

During phase two, the client is more trusting but may still be cautious. The purpose of the group at this point is to help the participant toward an improved integration of intellect and feelings.

The main issue which is managed within the group therapy program is differentiation of self from: first, the spouse or partner; second, the extended family; and third, the child. "Fusion" and "incorporation" tend to blur the territorial boundaries of partners in a relationship. This automatically disturbs communication and, since parenting involves teaching the child to differentiate from the adults, parenting skills are likewise disturbed. The goals of the group therapy process may require from 36 to 60 months to be achieved. The final result is prevention of generations of violent family responses that cost despair and money much beyond that invested in the thirty-six to sixty months' treatment process.

The "exit/entry" system of these adults is definitely disordered and out of context with reality since the entry occurs without preparation, and exit without grieving. Therefore, in the group process, entering the group offers an opportunity to learn about entering relationships and separation from the group is a chance to learn about processes involved in ending interpersonal relationships.

Another issue dealt with by the group is the aggressive-assertive system. This involves a remodeling of aggression. Clients' language and behavior are often filled with violence. The goal is to sublimate this aggression into assertiveness.

There is often a lack of awareness of one's own stress tolerance. Individual levels of stress tolerance must be taught, as well as use of support systems when that level has been reached.

Other issues covered in the group include parenting skills, self-care, and prevention of pregnancy. A physician is available because there is a high rate of psychosomatic problems and poor bodily care which must be dealt with. Family planning must be stressed in order to prevent

the families from having too many children too close together, thus increasing their stresses before they have learned to cope with the current ones.

These goals are accomplished through consistency, repetition, and reinforcement. Consistency is a major necessity for success in the group. Clients must know the co-leaders will be there, that the group will begin on time, and will meet no matter how many people show up. Individual and family therapy sessions are often used in conjunction with (or instead of) group therapy.

The group is a good context in which to determine when a child should be returned to the home. Positive indications include improved self-differentiation and the establishment of an adequate community support system. The final decision about returning children to their homes from foster care (if there has been placement) is made by the Children's Bureau.

Those clients who are extremely resistant or those with acute emotional conditions are not likely to do well in this type of group therapy. In the case of high resistance, more individual sessions are needed with the caseworker to motivate the client to attend.

Two elements which would be helpful and which would add to the support system for the program are: first, a children's group which would meet at the same time and second, a medical care facility immediately available for acute physical problems and for complete physical examinations on an annual basis.

2. Northampton County Group Therapy Program

Clients who are selected for the group therapy program should have the potential for at least average intelligence, a strong enough ego to withstand confrontation in a group setting, and a willingness to at least review their interpersonal relationships. On occasion there have been clients who participated in the group as a result of a court order requiring their attendance; however, this is not the optimal situation for involvement in the program.

The group focuses on the relationship between the family partners, the family members' expectations of each other, the sharing of their needs and feelings with one another, discipline practices, and less formal, more fun and social ways of relating to their children.

Some issues are more comfortably dealt with in individual and marital therapy sessions. These may include sexual problems, marital discord problems, and sometimes even financial issues. Individual sessions are coordinated with the group sessions and enhance the clients' ability to participate in the group by increasing their trust in and comfort with the therapist, and their self-confidence.

The cohesiveness of the group grows as members discover the commonalities among themselves, grow more hopeful about being able to improve their situations, and learn that others will try to be helpful to them in the group. A sign of growing cohesiveness is the increase in contact members begin to have outside the group, calling on each other for help. Cohesiveness is helped by introducing social hours periodically into the group meetings through celebrations of birthdays and holidays. At these times, members become less defensive and closer to others in the group.

The group therapists themselves had to cope with their own ambivalence about group members having relationships with each other outside the group, as this is in opposition to the traditional approach to group therapy. There are definite benefits to the members, as such contacts provide a social support system otherwise lacking in their lives. On the other hand, there is the danger of inappropriate closeness developing and negative reinforcement. This was used as the basis for a learning experience in the group setting, an opportunity for the members to learn to be more realistic about interpersonal relationships.

Obstacles to participation in the group therapy program on the part of the clients stem from realistic problems (e.g. transportation problems, conflict with work, schedules), psychological resistance when

group probing gets "too close" to conflict areas in the client, and expectations of the clients for benefits from the group which differ from those of the therapist. That is, clients often persist in the group only as long as there is a crisis situation in their lives and no longer see a need for participation once the crisis is over, unlike the therapist who has longer range goals of personality reconstruction. These obstacles might be minimized by having therapists and clients actually spell out their expectations in a written contract at the beginning of group participation. In addition, transportation for the clients may be a realistic problem. Sometimes it is necessary to reach out to the clients by going to the home for therapy sessions.

In summary, no one mode works best with all abusive parents. Coordination of individual, marital group therapy, didactic sessions, and sometimes medication is necessary to achieve therapeutic goals.

3. Northampton County Family Therapy

In Northampton County there is a growing emphasis on family therapy. The "family" includes all members living in the same household. Here too, motivation to participate is a necessity for growth to take place. The caseworker transports the family to and from sessions at times convenient to the family's schedule.

The family therapy model employed uses the therapy session to redirect the family patterns and relationships. It is an action-oriented therapy so that re-alignments and changes take place during the therapy session. Tasks are assigned to the family to be followed up at home.

Currently a worker trained in doing family therapy is supervising other caseworkers in the Children's Bureau who are in training to be family therapists. The supervisor watches the therapy session behind a one-way mirror and may intervene during the session by calling the caseworker-therapist out for suggestions.

While family members engaged in family therapy do not have the benefit of hearing group-therapy members describe problems similar to

their own, such an opportunity is afforded by the Mothers' Association which includes all mothers in the abuse unit as well as mothers from the protective service unit. During monthly meetings there is an opportunity for socialization and discussing mutual problems. A joint baby-sitting service is in the planning stages.

C. Lehigh Valley Home Start - Parent Education

The Children's Bureaus of Lehigh and Northampton Counties have contracted with Head Start of the Lehigh Valley. This contract agrees to purchase the services of the Home Start Program, the home-based component of Head Start, to supplement the services provided by the Children's Bureaus to the families in their Child Abuse Program.

Home Start is a parent/child education program which endeavors to: give parents simple skills with an understanding of how to encourage growth of their child in their environment; place the reins firmly in the hands of the mother and father, building their image of themselves as competent enhancers of development in their own children; and strengthen the parents' investments in the healthy development and growth of their own child (children).

Home visitors help parents understand the needs of their children by providing general knowledge of early childhood development. In order to do this, home visitors assess the children's developmental age and the parent/child interaction. Home visitors then assist parents in developing skills in observing their child's growth and development, especially in those areas assessed to be needs of the children; assist parents in setting realistic individual goals for each child; and assist parents in planning activities and methods to work toward these goals.

Home visitors employ one to one relationships with the parent and child, which is generally considered the most effective way to teach and to learn. The programs planned are individualized for each particular family in ways that group approaches cannot attain. The program can be adapted to "parenting figures" as well as natural mothers.

Home visitors point out ways to implement the home environment to become a natural learning center for its family members. The use of household materials, furnishings and routine household activities are encouraged. The developmental activities available through household activity where child participation is possible are defined and demonstrated.

Home visitors have access to a toy lending library equipped with the types of developmental toys recommended for educating young children through exploration and discovery. These toys are taken into the homes and demonstrated by the home visitor with the child. If the parents are willing, the toy is left in the home until the next home visit when it can be exchanged for another toy. This kind of borrowing is encouraged to begin teaching the families responsibility; young children are experiencing sharing, borrowing and lending. Parents are encouraged to construct toys for the child with ordinary household materials which provide similar learning experiences and develop the same processes. Home visitors recommend that parent and child construct these homemade toys as a joint venture. Along with the instructions for construction, the home visitor discusses limits for control that need to be set and consistently enforced by the parents to keep the child safe and the activity constructive. Positive conversation between adult and child is modeled by the home visitor and strongly recommended for use in the household.

Home visits are one to two hour sessions weekly at the onset of the program. As the parent begins to feel better about her/himself visits are re-scheduled, once every two weeks.

A typical home visit plans for the parent figure and child interaction with the home visitor. This time block includes a planned activity which lasts approximately 1/2 hour. The home visitor then encourages the child to play independently while she and the parent evaluate the experience they have just completed. The home visitor points out the methods that were particularly effective and why; also the signs of growth the child exhibited. The parent is encouraged to express her/his

observations, ask questions and comment. At this time, parents seeking ways to deal with common childhood problems such as eating, sleep habits, discipline and appropriate punishment can be brought to the home visitor's attention for suggestions to be considered by the parent. This is the most important time block (evaluation) of the home visit - the time when the home visitor supports the parent as the child's most valuable teacher.

The educational activities are structured to teach parents to teach their children good health habits, nutritional values, sanitation methods, appropriate developmental skills and safety measures, to help ward against accidents and illness which increase family stress. Home visitors provide the necessary materials and procedures to assist parents to teach these very important matters. Home visitors are trained to model positive approaches to clarify the points they are trying to make when working with the parent and/or child. These procedures are planned with each individual family's circumstances the prime consideration.

Parents are encouraged to seek interests for themselves. Home Start parent meetings are much the same as Head Start's Center Committees where parents as a group can discuss their problems, make program suggestions and committee decisions. This is the parents' own group with officers elected by them. Meetings are scheduled for the program year on a once monthly pattern. Candidates for special interests are discovered through a parent questionnaire. Home Start also provides group experiences such as workshops, child management clinics and continuing education.

For those problems requiring professional services, the home visitor works with the caseworker and encourages parents to make contacts and appointments and to support the caseworker on follow-through. On the spot attempts to project his/her opinion or solution to most stress problems is not recommended; for delivery of such services referral through the caseworker is necessary.

Home Start uses the services of volunteers for parent meetings, health screenings, providing material needs and transportation. Volunteers with special skills such as sign language, Spanish translators, nutritionists and others are very valuable to the Home Start program.

The success of a program such as Home Start depends on the Home Start staff having the ability to adapt to the needs of its families. They must recognize that progress in small amounts is a giant step for the families. Staff must see this kind of minuscule progress as valuable for achieving the next step necessary to reach a goal. Training must be provided to strengthen the assessed needs of the staff, and communication with other agencies involved with the families must be maintained.

D. Research and Evaluation

1. Overview

There are two broad objectives of the research and evaluation effort. One is to develop evaluation procedures for the program and to provide training in the implementation and utilization of these procedures to the multi-disciplinary service team. The other is to develop research on the causes of child abuse and the effectiveness of treatment in preventing its recurrence. The State funded demonstration provided the means by which the former activity is being carried out. Grants from the DHEW Office of Child Development and the DHEW National Institute of Mental Health provide the funds by which the latter effort is being carried out.

Central to the research and evaluation activities is the work of the research advisory group. This group is made up of a representative of each agency involved in the multi-disciplinary service team. The function of this group is to review all proposed steps in the research prior to implementation, and to serve as a liaison from the group to their agency.

2. Activities with the Multi-disciplinary Team

a. The evaluation system

(1) Purpose

The evaluation system was proposed as an activity for the Demonstration Program because of the growing emphasis on evaluation in all service-related programs. From the outset of the program, plans were developed for a system which would make it possible to monitor the progress of families being served and to examine the effect that the services have on this progress.

(2) Elements of the system

The evaluation system is in large measure a systematic set of information on each family. The information is the following:

Personal characteristics of family and family members
This information covers basic demographic characteristics of family and family members. It is needed for keeping the program informed on the characteristics of those being served and for external reporting to governmental and funding agencies.

Types of problems families and family members have
This information focuses on presumed causes of child abuse. Since the exact cause is not known, each family is assessed to identify the presence of any of a variety of problems and the degree of their seriousness. The intention is to determine which problems occur most frequently. The information will be used to assist the service providers in identifying where service is needed and the pace and degree to which progress can be achieved.

Objectives set for a family or its members
The key to the evaluation system is in the setting of objectives for each family or relevant family member, and assessing the degree of progress made toward these objectives. The method used is to rate the degree of difficulty a family or its members are having in each of

several possible problem areas. The list is then rated a second time, this time to indicate the degree to which it is felt each problem can be alleviated. This then becomes the objective. After several months have elapsed, the problem areas are rerated. The change from the first rating to the second represents the degree of progress.

Types of services provided to reduce or remove problems

This information accounts for all of the services provided to a family or family members. It is to be kept both in terms of which services are provided and how much (in hours) of each is provided. The purpose of this information is to make it possible to determine the services that are most effective in solving the problems specified in (2) above and in achieving the objectives specified in (4) below.

(3) Implementation of the system

The implementation phase of the system began with an examination of the literature to determine which family characteristics and family problems were important to identify, and which dimensions were relevant as objectives. A preliminary list of these was developed and reviewed by the Research Advisory group. Out of these discussions came a draft document which was revised several times before actually being put into use. It was then discussed with the relevant staff, changes were made where necessary, and then its use in the relevant aspects of the program were begun.

The procedure initiated for use of the evaluation system was for each Children's Bureau caseworker to complete the background form on each family. This is done during the first few weeks a family is served by the Children's Bureau. At the same time, the set of ratings is prepared indicating a family's current status on each of the progress evaluation dimensions and also setting the goal (or level) to be achieved on each dimension. Each six months these ratings are repeated.

The service accounting procedures are begun at the time services are initiated. Development of the procedure involved construction of a list of all services and activities related to those services that were provided by the treatment program. As these are provided to a family, they are recorded by the service delivery personnel.

(4) Current status

The current status of the evaluation is that 110 families from the two counties are now included in the system. Families are being added both as the inclusion of all families in the current caseload is completed and as new families are added to the caseload.

Currently, a major goal is preparation of reports based on information in the system.

b. Staff in-service training

A major benefit of an evaluation procedure is the opportunity it provides for sharpening skills related to service delivery. The development of the background form provided an opportunity to discuss the problems child abusing families manifest and examine the types of goals that can be set.

The context in which much of this work has been done is monthly meetings with the casework staff of the two Children's Bureaus and periodic meetings with the home visitor staffs from Head Start. More formal seminars are also held, led by speakers brought in under the auspices of the Center for Social Research.

Another resource is a bibliography and library provided by the research staff which is made available to all the members of the service delivery team.

The importance of the Research Advisory Group to the functioning of the evaluation portion of the project cannot be emphasized too strongly. This was the context in which a wide variety of issues were discussed prior to implementation. As a result many difficulties were ironed out prior to implementation.

3. Research Activities

Based on participation in the multi-disciplinary service team, the staff of the Center for Social Research during the first year of the demonstration program prepared two proposals for submission, one to the HEW Office of Child Development and one to the HEW National Institute of Mental Health. Both were funded and were initiated in June, 1975. The resources provided by these projects have added considerably to the scope of the demonstration and to its national visibility.

a. Study of recurrence of child abuse

One of the research projects is entitled, "An Investigation of the Effects of a Multi-Dimensional Service Program on Recidivism/Discontinuation of Child Abuse and Neglect" and is supported by the Office of Child Development. This project will run until May 31, 1977.

The objective of the study is the identification over a two year period of recidivism or discontinuation of abuse or gross neglect in approximately 380 families who have received varying types and amounts of intervention services. Through extensive interviewing and review of case records, data are being collected on the internal dynamics of the family and the perceived effects of services on the life of the family. For a certain proportion of the families, further information on personality and attitudinal factors will be available via periodic ratings by therapists and other service-related personnel. The variety of services which may have been received by any one family following referral to the Children's Bureau for abuse or gross neglect include: casework services, group therapy, family or individual therapy, parent education and training in "parenting" skills, and child-related services. Recidivism will be defined by further legal citations of abuse following the initial citation. In addition, parents will be questioned in the interview about their current discipline methods (and those of their spouse or partner) as an additional source of data on severity or harshness of treatment of the child.

The hypotheses being tested are:

Discontinuation of abuse is associated with reduction of tension arising from situational stress. The areas of possible stress to be assessed include family conflict, the many possible sources of environmental stress, and child-produced stress.

Discontinuation of abuse is associated with a change in personality and attitudinal dimensions of formerly abusing parents. The areas to be assessed include the self-image of the parent, the degree of autonomy attained by the parent, the degree of insight attained by the parent, the degree of impulse control attained by the parent, child-rearing attitudes, parenting skills, and ability to verbalize needs and feelings.

Discontinuation of abuse is associated with differences in the early socialization experiences of individual parents, i.e., the early experience of some parents contributes to chronic abuse/neglect while that of others is associated with discontinuation after the first citation. The areas to be assessed include childhood experiences of abuse, neglect, role models of violence, and early separation from natural parents.

b. Study of family dynamics and child abuse

The second project is entitled "Family Style and Coping Behavior in Child Abusing Families" and is supported by the National Institute of Mental Health. This project will run until December 31, 1977.

In this project, families cited for child abuse are being compared to control families of low and middle socio-economic status in order to identify distinctive family styles in abusing families, and the relationships between family styles and children's coping behaviors. Family style is conceptualized as the pattern of attitudes and interpersonal relations within the family along particular dimensions. Coping behaviors are defined as strategies for achieving mastery and self- gratification.

The hypotheses being tested specify distinctive qualities of parent-child interaction in abusing as opposed to non-abusing families; distinctive attitudes in abusing parents toward their children, toward themselves, and toward the world in general; and distinctive patterns of stress on abusing families as compared to control families.

All families in the study will have at least one child between the ages of 2 and 5. Approximately 550 families will be studied. Of these, approximately 160 will be families cited for child abuse and currently on the case loads of the local child welfare agencies, 120 families from the protective service caseload of these agencies, 110 families from the Head Start Program of the area, 80 families from the local day care program, and 80 families from middle class Nursery School or Day Care programs.

The methods of data collection include structured interviews of the parents, structured parent-child interactions (using a variety of play-tasks), observations of the child in free play in his/her peer-group (nursery school) setting, individual testing of the children, teacher ratings of the child in the classroom setting, and assessment of birth record data. Preliminary data analysis is currently underway.

III. THE IMPACT OF MULTI-DISCIPLINARY SERVICES ON CLIENTS AND SERVICE DELIVERERS

A question that is being addressed from several perspectives concerns the impact of multi-disciplinary services on clients and service deliverers. The different perspectives can be described for the different parties to the program;

Client: What is the effect of the overall program on clients? What combination of services is most effective? Is involvement with different service delivery agencies effective?

Service Deliverers: Is the effect of a specific service enhanced by the presence of other service components?

Agency Administration: Is the impact of the coordinated program such that the additional administrative burden is worth it?

Community: Does the community perceive the problem of child abuse as sufficiently large and serious to warrant the amount of community resources being expended to alleviate the problem?

Answers to these questions are not readily available. The research and evaluation component is working directly on some of these questions, particularly those associated with the client's perspective. There has been considerable discussion of the questions associated with the service deliverer's perspective and the agency administrations' perspective although there are as yet no definitive answers. Answers to the questions from the perspective of the community are beginning to be addressed.

Overall, these are the questions being posed and to which answers are being sought. The hope is to develop at least partial answers during the next 15 months.

PART II

ANALYSIS OF CHILD ABUSE CITATIONS: 1967 - 1975

Following are analyses of 365 citations (referred to in Pennsylvania as CY 47's) for child abuse in two counties of Eastern Pennsylvania for the period 1967 - 1975. The use of citations was begun in 1967 and continues. The reporting regulations were changed, however, effective the end of November 1975. The data included in the tables go up to the change in the regulations.

When the total number of citations is analyzed in terms of the proportion which were validated, it is seen that over half the citations in each county were classified as validated; that is, there was clear evidence of abuse. Approximately one-fourth were found to be "indeterminable"; that is, there was some evidence suggesting abuse, but the evidence was not clear. The remainder (less than one-fifth) were found to be invalidated or not indicated. The findings were similar for the two counties. See Table 1.

Taking the total number of abuse citations, a relatively small number (about 6% or 7%) received brief service; that is, there was little service provided between the case being opened and its being closed. The remainder are almost equally divided between cases which are still open, and cases which have been closed after service has been provided. These findings are similar for the two counties. See Table 2.

The number of abuse referrals in each of the two counties has grown steadily since 1968. During 1974 and 1975 taken together, there were ten times as many suspected abuse referrals in each county as there had been during 1968 and 1969 taken together.

Lehigh County, up through 1975, has had about 80% more referrals than Northampton County (182 cases in Lehigh County vs. 109 cases in Northampton County). See Table 3.

Many of the abuse referrals were of families who were already on the open case load of the Children's Bureaus or who had been served by the Children's Bureaus at some time since 1961. See Table 5.

About one-half of the total number of abuse cases are now on the open case loads, and currently receiving service from the Children's Bureaus (101 cases in Lehigh County; 71 cases in Northampton County). Lehigh County has about 20% more open cases than Northampton County. See Table 6.

Target children are almost equally divided between males and females. See Table 7.

In both counties, approximately half the total number of citations involve children who are between newborn and 3 years of age at the time of citation. Children 4 through 7 years of age account for another 22% of the cases. There is a smaller proportion of cases involving 12 to 15 year olds. Children 8 through 11 and 16 through 17 are about equally vulnerable, though less so than the very young children. The two counties are similar in this respect. See Table 8.

Taken as a total group, 14% of the target children are known to have been previously abused. See Table 9.

Half the target children were living with both natural parents at the time of abuse; 30% were living with just the natural mother. Another 12% were living with the natural mother and her partner (husband or paramour). A smaller percentage lived with just the father (2.7%), or father and father's partner (3%). See Table 10.

The above figures do not indicate, however, who was the abusing adult. Of the 360 instances in which the sex of the abuser was listed, 60% (217 cases) were males and 40% (143 cases) were females. See Tables 14a and 14b.

About equal numbers of mothers and fathers are cited as abusers (see Table 18a); together they represent by far the largest proportion of the abusers (70.6%). Considering caretakers who are not natural parents of the child, more males than females are cited as abusers (13.7% vs. 3.3%). See Tables 18a and 18b.

The greatest proportion of reports of suspected abuse are made by physicians (50%) and hospital and school nurses (29%). Another 10% of the reports are made by medical administrators and school personnel. The police account for a very small proportion of the reports (2.2%). See Table 11.

Bruises are involved in the majority of injuries referred because of suspected abuse (60%). Of the remaining 40% of referrals, 34% are somewhat equally divided among severe neglect, bone fractures, burns, internal injuries, wounds, and abrasions. The remaining types of injuries (including concussions, poison, gunshot wounds, sexual abuse) account for a relatively small proportion of referrals. See Table 12a.

In most of the cases, only one injury is reported (66.4%). In 15% of the cases, bruises and abrasions are reported as secondary injuries. About 10% of the cases list three injuries.

Wounds, abrasions, burns and neglect are most often cited as the third type of injury in such cases. See Tables 12b and 12c.

The number of fatal injuries is small (1.4%). See Table 13.

Cited perpetrators range in age from 1 to 60 years. Child perpetrators (below 16 years of age) account for only 2% of the citations. The bulk of the perpetrators are in their 20's (38%); about 10% are teenagers (ages 16 to 20); 10% are in their early 30's. See Table 15a.

Most cases involve only one cited perpetrator (84%). About 5.4% of the cases are definitely known to involve two perpetrators. Where the relationship is known between two identified perpetrators, most are husband and wife, with both being natural parents of the child (90% of the 5.4% of the cases known to have two perpetrators). See Tables 15b and 16.

Sixteen percent of the perpetrators are known to have been involved in previous abuse incidents. See Tables 17a and 17b.

Most of the citations represent single instances in which one child is abused, and no further citations are made on that family (243 of the 365 citations). Seventeen families have simultaneous citations of abuse on more than one child in the family at the time of citation (these include 2, 4, and 5 children at one time). Forty families have repeated citations at different points in time; 35 families have a second subsequent citation; five families have a second and then a third subsequent citation. See Table 19.

TABLE I: Citation classification

Citation Classification	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Validated	127	59.0	85	56.7	212	58.1
Indeterminable	46	21.4	41	27.3	87	23.8
Invalidated	41	19.1	22	14.7	63	17.3
Not indicated	1	0.5	2	1.3	3	0.8
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 2: Case status at time of citation

Case Status	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Open	98	45.6	69	46.0	167	45.8
Closed	102	47.4	72	48.0	174	47.7
Brief service	15	7.0	9	6.0	24	6.5
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 3: Year of citation (CY47)

Year - CY-47	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
1968	5	2.3	1	0.7	6	1.7
1969	6	2.7	5	3.3	11	3.0
1970	6	2.7	5	3.3	11	3.0
1971	11	5.1	7	4.7	18	4.9
1972	22	10.2	5	3.3	27	7.4
1973	49	22.8	25	16.7	74	20.3
1974	40	18.6	29	19.3	69	18.9
1975	53	24.8	32	21.3	85	23.3
Not indicated	23	10.8	41	27.3	64	17.5
TOTAL	215	100.	150	100.	365	100.
Percent by County	--	(59.0)	--	(41.0)		

TABLE 4: Year of citation (CY48)

Year - CY-48	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
1967	3	1.4	4	2.7	7	1.9
1968	6	2.8	1	0.7	7	1.9
1969	12	5.6	9	6.0	21	5.8
1970	8	3.7	14	9.3	22	6.0
1971	13	6.0	9	6.0	22	6.0
1972	27	12.6	22	14.7	49	13.4
1973	45	20.9	20	13.3	65	17.8
1974	40	18.6	33	22.0	73	20.0
1975	55	25.6	34	22.7	89	24.4
Not indicated	6	2.8	4	2.7	10	2.7
TOTAL	215	100.	150	100.	365	100.
Percent by County	--	(59.0)	--	(41.0)		

TABLE 5: Year case was opened

Year case was opened	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
1961	0	0.0	1	0.7	1	0.3
1962	2	0.9	0	0.0	2	0.5
1963	0	0.0	0	0.0	0	0.0
1964	1	0.5	0	0.0	1	0.3
1965	2	0.9	3	2.0	5	1.4
1966	3	1.4	3	2.0	6	1.6
1967	3	1.4	6	4.0	9	2.5
1968	14	6.5	9	6.0	23	6.3
1969	26	12.1	16	10.7	42	11.5
1970	14	6.5	13	8.7	27	7.4
1971	20	9.3	12	8.0	32	8.8
1972	17	7.9	20	13.3	37	10.1
1973	38	17.7	20	13.3	58	15.9
1974	31	14.4	24	16.0	55	15.1
1975	43	20.0	18	12.0	61	16.7
1976	0	0.0	3	2.0	3	0.8
Not indicated	1	0.5	2	1.3	3	0.8
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 6: Year case was closed

Closing date (year)	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
1967	0	0.0	2	1.3	2	0.5
1968	0	0.0	1	0.7	1	0.3
1969	6	2.8	1	0.7	7	1.9
1970	7	3.3	1	0.7	8	2.2
1971	7	3.3	4	2.7	11	3.0
1972	6	2.8	8	5.3	14	3.8
1973	17	7.9	18	12.0	35	9.6
1974	26	12.1	17	11.3	43	11.8
1975	36	16.7	24	16.0	60	16.5
1976	9	4.2	3	2.0	12	3.3
Still open	101	47.0	71	47.3	172	47.1
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 7: Sex of target child

Sex of target child	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Male	102	47.4	83	55.3	185	50.7
Female	113	52.6	67	44.7	180	49.3
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 8: Target child's age at time of citation

Child's Age at Time of Citation	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
0 - 1	55	25.6	35	23.3	90	24.6
2 - 3	52	24.1	31	20.7	83	22.7
4 - 5	23	10.7	23	15.3	46	12.6
6 - 7	22	10.2	14	9.3	36	9.9
8 - 9	14	6.5	17	11.3	31	8.5
10 - 11	15	7.0	7	4.7	22	6.0
12 - 13	5	2.3	5	3.3	10	2.7
14 - 15	12	5.6	6	4.0	18	5.0
16 - 17	17	7.9	12	8.0	29	7.9
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 9: Was child involved in previous abuse incident

Child involved in previous abuse?	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	112	52.1	73	48.7	185	50.7
Yes	25	11.6	27	18.0	52	14.2
No	76	35.3	45	30.0	121	33.2
Blank	2.0	0.5	5	3.3	7	1.9
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 10: Person(s) with whom child lived at time of abuse incident

Person(s) with whom child lived at time of abuse incident	LEHIGH COUNTY		NORTHAMPTON CNTY		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Both natural parents	99	46.0	82	54.7	181	50.0
Natural mother	70	32.6	42	28.0	112	30.7
Natural father	4	1.9	6	4.0	10	2.7
Mother and stepfather	19	8.8	7	4.7	26	7.1
Father and stepmother	2	0.9	5	3.3	7	1.9
Mother and paramour	15	7.0	3	2.0	18	4.9
Father and paramour	4	1.9	0	0.0	4	1.1
Grandparents	0	0.0	0	0.0	0	0.0
Foster parents	2	0.9	4	2.7	6	1.6
Adoptive parents	0	0.0	0	0.0	0	0.0
Relatives	0	0.0	0	0.0	0	0.0
Others	0	0.0	1	0.7	1.0	0.2
TOTAL	125	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 11: Source of suspected abuse report

Suspected abuse reported by whom	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	0	0.0	1	0.7	1	0.3
Physician	104	48.4	78	52.0	182	50.0
Medical facility administrator	15	7.0	3	2.0	18	4.9
Parent	1	0.5	3	2.0	4	1.0
Relative	2	0.9	3	2.0	5	1.4
Neighbor	0	0.0	0	0.0	0	0.0
Police	4	1.9	4	2.7	8	2.2
Nurse	47	21.9	12	8.0	59	16.2
School Personnel	11	5.1	7	4.7	18	4.9
Social worker	1	0.5	7	4.7	8	2.2
School nurse	26	12.1	22	14.7	48	13.2
Pre-school personnel	2	0.9	2	1.3	4	1.0
Probation officer (parole)	0	0.0	2	1.3	2	0.5
Babysitter	1	0.5	0	0.0	1	0.3
Other	0	0.0	2	1.3	2	0.5
No answer	1	0.5	4	2.7	5	1.4
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 12a: Nature of child's injury (1st injury reported)

Nature of injury	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	0	0.0	1	0.7	1	0.3
No injury	1	0.5	3	2.0	4	1.1
Swelling, bruises, welts, etc.	127	59.0	93	62.0	220	60.3
Malnutrition	1	0.5	0	0.0	1	0.3
Neglect	17	7.9	11	7.3	28	7.7
Burns	14	6.5	8	5.3	22	6.0
Abrasions	4	1.9	7	4.7	11	3.0
Wounds	10	4.6	5	3.3	15	4.1
Bone fractures	17	7.9	6	4.0	23	6.3
Skull fracture	5	2.3	4	2.7	9	2.5
Internal injuries	12	5.6	4	2.7	16	4.4
Drug abuse	0	0.0	0	0.0	0	0.0
Hair loss	1	0.5	1	0.7	2	0.5
Poison	0	0.0	1	0.7	1	0.3
Gunshot wound	0	0.0	2	1.3	2	0.5
Sexual abuse	4	1.9	1	0.7	5	1.4
Bites	0	0.0	0	0.0	0	0.0
Concussion	1	0.5	0	0.0	1	0.3
Other	1	0.5	1	0.7	2	0.5
Not indicated	0	0.0	2	1.3	2	0.5
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 12b: Nature of child's injury (2nd injury reported)

Nature of injury No. 2	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	0	0.0	1	0.7	1	0.3
No injury	0	0.0	0	0.0	0	0.0
Swelling, bruises, welts, etc.	20	9.3	7	4.7	27	7.4
Malnutrition	2	0.9	1	0.7	3	0.8
Neglect	9	4.2	4	2.7	13	3.6
Burns	5	2.3	2	1.3	7	1.9
Abrasions	18	8.4	9	6.0	27	7.5
Wounds	5	2.3	5	3.3	10	2.7
Bone fractures	7	3.2	2	1.3	9	2.5
Skull fracture	2	0.9	0	0.0	2	0.5
Internal injuries	12	5.6	3	2.0	15	4.1
Drug abuse	0	0.0	0	0.0	0	0.0
Hair loss	1	0.5	1	0.7	2	0.5
Poison	0	0.0	0	0.0	0	0.0
Gunshot wound	1	0.5	0	0.0	1	0.3
Sexual abuse	1	0.5	1	0.7	2	0.5
Bites	0	0.0	2	1.3	2	0.5
Concussion	1	0.5	0	0.0	1	0.3
Other	0	0.0	0	0.0	0	0.0
Not indicated	131	60.6	112	74.7	243	66.4
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 12c: Nature of child's injury (3rd injury reported)

Nature of injury No. 3	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	0	0.0	1	0.7	1	0.3
No injury	0	0.0	0	0.0	0	0.0
Swelling, bruises, welts, etc.	2	0.9	1	0.7	3	0.8
Malnutrition	1	0.5	0	0.0	1	0.3
Neglect	1	0.5	3	2.0	4	1.1
Burns	3	1.4	1	0.7	4	1.1
Abrasions	4	1.9	1	0.7	5	1.4
Wounds	6	2.8	0	0.0	6	1.6
Bone fractures	2	0.9	1	0.7	3	0.8
Skull fracture	2	0.9	0	0.0	2	0.5
Internal injuries	1	0.5	0	0.0	1	0.3
Drug abuse	1	0.5	0	0.0	1	0.3
Hair loss	1	0.5	0	0.0	1	0.3
Poison	0	0.0	0	0.0	0	0.0
Gunshot wound	0	0.0	0	0.0	0	0.0
Sexual abuse	1	0.5	0	0.0	1	0.3
Bites	1	0.5	0	0.0	1	0.3
Concussion	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0
Not indicated	189	87.6	142	94.7	331	90.7
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 13: Severity of child's injury

Severity of injury	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	0	0.0	3	2.0	3	0.8
None	1	0.5	4	2.7	5	1.4
Non-fatal	212	98.6	140	93.3	352	96.4
Fatal	2	0.9	3	2.0	5	1.4
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 14a: Sex of perpetrator listed first

Sex of perpetrator listed first	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	20	9.3	15	10.0	35	9.6
Male	120	55.8	86	57.3	206	56.4
Female	75	34.9	49	32.7	124	34.0
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 14b: Sex of perpetrator listed second

Sex of perpetrator listed second	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	17	7.9	11	7.3	28	7.7
Male	5	2.3	6	4.0	11	3.0
Female	8	3.7	11	7.3	19	5.2
No second perpetrator	185	86.0	122	81.3	307	84.1
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 15a: Age of perpetrator listed first

Age of perpetrator listed first	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
1-5	3	1.4	0	0.0	3	0.8
6-10	2	0.9	0	0.0	2	0.5
11-15	1	0.5	2	1.3	3	0.8
16-20	28	13.0	10	6.7	38	10.4
21-25	41	19.1	32	21.3	73	20.0
26-30	35	16.3	30	20.0	65	17.8
31-35	22	10.2	12	8.0	34	9.3
35-40	14	6.5	5	3.3	19	5.2
41-45	18	8.4	3	2.0	21	5.8
46-50	3	1.4	2	1.3	5	1.4
51-55	3	1.4	2	1.3	5	1.4
56-60	2	0.9	2	1.3	4	1.1
Not given	43	20.0	50	33.3	93	25.5
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 15b: Age of perpetrator listed second

Age of perpetrator listed second	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Not given	19	8.8	19	12.7	38	10.4
3	1	0.5	0	0.0	1	0.3
19	1	0.5	0	0.0	1	0.3
20	2	0.9	0	0.0	2	0.5
21	1	0.5	1	0.7	2	0.5
24	1	0.5	2	1.3	3	0.8
25	0	0.0	2	1.3	2	0.5
26	1	0.5	0	0.0	1	0.3
29	3	1.4	0	0.0	3	0.8
30	1	0.5	0	0.0	1	0.3
31	0	0.0	3	2.0	3	0.8
52	0	0.0	1	0.7	1	0.3
No second perpetrator	185	86.0	122	81.3	307	84.1
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 16: Relationship of first perpetrator to second

Relationship of first perpetrator to second	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	16	7.4	12	8.0	28	7.6
Wife and fellow natural parent	0	0.0	2	1.3	2	0.5
Husband and fellow natural parent	8	3.7	8	5.3	16	4.3
Wife but not parent	0	0.0	0	0.0	0	0.0
Husband but not parent	0	0.0	2	1.3	2	0.5
Female paramour and parent	2	0.9	3	2.0	5	1.4
Male paramour and parent	0	0.0	0	0.0	0	0.0
Female paramour but not parent	1	0.5	0	0.0	1	0.3
Male paramour but not parent	0	0.0	0	0.0	0	0.0
Parent	0	0.0	1	0.7	1	0.3
Child	0	0.0	0	0.0	0	0.0
Sibling	1	0.5	1	0.7	2	0.5
Other relative	1	0.5	1	0.7	2	0.5
Neighbor	1	0.5	1	0.7	2	0.5
Friend	0	0.0	0	0.0	0	0.0
No second perpetrator	185	86.0	122	81.3	307	84.1
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 17a: First perpetrator involved in previous abuse

First perpetrator involved in previous incident?	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	120	55.8	90	60.0	210	57.5
Yes	32	14.9	24	16.0	56	15.4
No	63	29.3	36	24.0	99	27.1
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 17b: Second perpetrator involved in previous abuse

2nd perpetrator involved in previous incident?	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	23	10.7	22	14.7	45	12.3
Yes	2	0.9	2	1.3	4	1.1
No	5	2.3	4	2.7	9	2.5
No second perpetrator	185	86.0	122	81.3	307	84.1
TOTAL	215	100.00	150	100.00	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 18a: Relationship of first perpetrator to target child

Relationship of first perpetrator to target child	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	19	8.8	14	9.3	33	9.0
Mother	70	32.9	47	31.3	117	32.2
Father	62	28.7	61	40.7	123	33.6
Stepmother	4	1.9	2	1.3	6	1.6
Stepfather	16	7.4	7	4.7	23	6.3
Father's paramour	3	1.4	0	0.0	3	0.8
Mother's paramour	19	8.8	6	4.0	25	6.8
Grandparent	1	0.5	0	0.0	1	0.3
Sibling	2	0.9	0	0.0	2	0.5
Relative	6	2.8	6	4.0	12	3.3
Foster mother	1	0.5	2	1.3	3	0.8
Foster father	0	0.0	2	1.3	2	0.5
Babysitter (daycare mother)	4	1.9	0	0.0	4	1.1
Friend of family	1	0.5	1	0.7	2	0.5
Friend of child	1	0.5	0	0.0	1	0.3
Self	3	1.4	0	0.0	3	0.8
Teacher	0	0.0	2	1.3	2	0.5
Other	3	1.4	0	0.0	3	0.8
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 18b: Relationship of second perpetrator to target child

Relationship of 2nd perpetrator to target child	LEHIGH COUNTY		NORTHAMPTON CNTY.		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Unknown	16	7.4	12	8.0	28	7.7
Mother	8	3.7	9	6.0	17	4.7
Father	0	0.0	1	0.7	1	0.3
Stepmother	0	0.0	1	0.7	1	0.3
Mother's paramour	3	1.4	3	2.0	6	1.6
Grandparent	1	0.5	0	0.0	1	0.3
Sibling	1	0.5	1	0.7	2	0.5
Foster mother	0	0.0	1	0.7	1	0.3
Babysitter (daycare mother)	1	0.5	0	0.0	1	0.3
No second perpetrator	185	86.0	122	81.3	307	84.1
TOTAL	215	100.0	150	100.0	365	100.0
Percent by county		(59.0)		(41.0)		

TABLE 19: Families with repeated citations for two counties together

Citations	Families with 1 citation		Families with 2 citations		Families with 3 citations		Families with 4 citations		Families with 5 citations	
	Fam.	Cit.	Fam.	Cit.	Fam.	Cit.	Fam.	Cit.	Fam.	Cit.
1 citation only	243	243	-	-	-	-	-	-	-	-
2 citations at one time	-	-	13	26	-	-	-	-	-	-
2 citations at different times	-	-	33	66	-	-	-	-	-	-
2 citations at one time and 1 repeated citation	-	-	-	-	2	6	-	-	-	-
3 citations at three different times	-	-	-	-	5	15	-	-	-	-
4 citations at once	-	-	-	-	-	-	1	4	-	-
5 citations at once	-	-	-	-	-	-	-	-	1	5
TOTALS	243	243	46	92	7	21	1	4	1	5

Total families 298

Total citations 365

END