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Punish or Treat: The Case for Multidisciplinary Treatment of Abused Children and their Families

James T. Kent, Ph.D.

Dr. Kent is a psychologist and the director of treatment in child abuse and neglect of the Family Development Program at Children's Hospital of Los Angeles. He received his B.A. and M.A. at the University of Michigan, as well as his Ph.D. in child clinical psychology, and interned at the Children's Psychiatric Hospital and Psychological Clinic at the University of Michigan Medical Center. He has wide teaching experience in the field, having instructed at the University of Michigan, USC's School of Medicine, Loyola University and elsewhere. He is a local and national consultant and advisor to many groups dealing with child abuse and other related problems, and is an examining psychologist with the Los Angeles Juvenile Court. Dr. Kent is also an internationally recognized author and expert on the subject.

James S. Apthorp, M.D.

Dr. Apthorp is a pediatrician and head of Children's Hospital's Division of General Pediatrics, as well as the director of the Family Development Program—the child abuse and neglect program at Children's Hospital of Los Angeles. He received his B.S. from Harvard in 1945 and his M.D. from Columbia University College of Physicians and Surgeons in 1950. He is an Associate Clinical Professor of Pediatrics with USC's School of Medicine at Children's Hospital. Dr. Apthorp is an internationally recognized expert and author, having written for a wide variety of professional publications, published teaching presentations, and a manuscript currently in progress. He is a professional consultant to many child-abuse related treatment programs, and others; and serves as a member and advisor to a variety of local and national organizations and councils related to medicine and the protection of children.

Stan J. Katz, Ph.D.

Dr. Katz is a clinical psychologist, and supervising psychologist in the Family Development Program at Children's Hospital of Los Angeles. He received his B.A. in psychology at California State University, Northridge; his M.A. in counseling psychology at Boston University; and in 1977 completed his Ph.D. in counseling psychology at UCLA. He is a lecturer and instructor at UCLA, and has been involved in counseling training and research across the country. Some of his prior experience has included counseling for youth offenders in probation facilities, pregnancy counseling, parent effectiveness and drug abuse. Like Drs. Kent and Apthorp, Dr. Katz' experience in consultation, speaking and writing is broad and extensive.

Children's Hospital of Los Angeles (CHLA) has been identifying and reporting cases of child abuse since 1959. At that time, only three major

hospitals in the country (the other two in Denver and Pittsburgh) were much concerned or aware of the possible implications of unexplained trauma to infants and children. The situation began to change early in 1960 following a Children's Bureau Conference in Washington, D.C. during which the term "the battered child syndrome" was used by a pediatrician, Dr. Henry Kempe, to describe such trauma and to make explicit its probable etiology—physical damage inflicted on children by their parents or caretakers.

The term and its implications caught the attention of a segment of the professional community who in turn reached legislators. The result was that by the mid-1960's every state in the country had passed laws which required that injuries of suspicious or unexplained origin in children be reported to some public agency such as the police, children's protective services, or public health agencies. The main intent of these laws was (1) to afford more protection to children than was possible under existing criminal statutes, and (2) to encourage certain professional groups to be more aware of the possibility of inflicted trauma when seeing signs of physical injury in children.

These laws and subsequent efforts to educate professionals and lay groups about child abuse have been extremely successful with respect to case finding. Reporting rates of validated cases have increased about fifty-fold in the last ten years, reaching well in excess of half a million cases annually, and the rate is still increasing rapidly.

The remainder of the problem is what is to be done with the children and their families once abuse is identified and reported. This part of the problem has been less successfully addressed, and there has been considerably less agreement among people in the area concerning the relative roles of law enforcement, the courts, children's protective services agencies, professional treatment groups, and lay and self-help groups.

In some areas of the country, removal of the child from his parents and placement in foster care has become the major intervention strategy. One consequence of this strategy is that we now have about a half million children in foster care in this country for reasons of abuse or neglect, about triple the number that were there when "the battered child syndrome" was first discussed at the 1960 Children's Bureau Conference. The median length of time in placement for these children is almost three years.

In other areas of the country, the courts and foster care sysem are strenuously avoided except in extreme circumstances: voluntary compliance with treatment recommendations on the part of the parents and monitoring by protective services workers are relied upon to keep children safe. A recent survey of the effectiveness of this strategy suggests that it continues to put an unacceptably large percentage of the children at risk for serious reabuse.[1]

This article will describe a child abuse and neglect treatment program at Children's Hospital of Los Angeles which has opted for a blend of services while working closely with police, the courts, and children's services work-

[1] *A Summary of Findings from the Evaluation of the Joint OCD/SRS National Demonstration Program in Child Abuse and Neglect*, Berkeley Planning Associates, September 1977.

ers of the Los Angeles County Department of Public Social Services—DPSS. The project has avoided the use of foster care in nearly half of its cases and has been able to accomplish the return home of about 80% of the children within a two year period. Most of the children are returned within the first twelve months after the abuse is identified. The rate of reabuse in project children is about 5%.

The project was formally established in 1974 with primary assistance from the National Institute of Mental Health with the aim of providing longitudinal data on the course of abused children.[2] Approximately one hundred children were included in the project for formal study and follow-up services. Nearly twice that number of additional families have also received services since establishment of the project.

The hospital identified about 350 children annually who are diagnosed as having suffered physical effects of inflicted trauma, neglect, or endangering environments (e.g., lack of supervision), but only a portion of these can be followed at the hospital for continuing services because of its large catchment area.

One of the basic assumptions of this project is that any child diagnosed as a victim of inflicted trauma or deprivation should be placed under the jurisdiction of the juvenile court. While we recognize that some families would participate in treatment programs without police and court intervention, it is our experience that reliably differentiating the probable compliers from the non-compliers at the time of identification is virtually impossible. When faced with the possibility of legal intervention into family affairs, almost all parents "volunteer" for treatment services. When the threat of legal intervention is removed, a disturbing number of parents soon find it inconvenient to keep their appointments or make the changes they promised. We find it safest for the children to seek court jurisdiction routinely.

Case finding usually begins in the emergency room with a child brought for treatment of some injury. As a rule, the child is brought by his parents. Admission of inflicted trauma is rarely given to explain the injury in the history given to the physician. Identification, or suspicion of inflicted trauma, results from an inconsistency between the injury that is observed and the cause of the injury as given by the parents. Fractures, burns, and soft tissue injury in infants are of particular concern.

Whenever the emergency room physician suspects that the cause of the trauma is not sufficiently explained by the history given by the parents, or anytime the parents are not able to provide a history, the child is routinely admitted to the hospital for further study. Radiologic studies for evidence of old or healing fractures and blood studies for unusual clotting times are performed at that time. The Pediatric Trauma Coordinator at CHLA (Dr. James Apthorp) examines the child, reviews the findings, and then makes a final determination of inflicted vs. accidental trauma.

This portion of the process, diagnosis of inflicted injury, is regarded as purely a medical question. The social circumstances and psychological characteristics of the parents are given very little weight. We do not view these

[2] "A Longitudinal Study of Physically Abused Children", R01 MH#247241, a research and intervention study funded by the National Institute of Mental Health from 1973 through 1978.

as relevant to the actual diagnosis of inflicted injury. They are, however, considered as highly relevant to the recommended disposition once the diagnosis has been made.

Once the diagnosis of inflicted trauma is made, the parents are informed and then told that a report of the findings must be made to the police as a matter of law. The parents are also offered the opportunity to participate in the evaluation and treatment program offered by the hospital. No promises are made with respect to the recommendations we would be making to the court, but it is stressed that we would provide them with every opportunity to ensure the earliest possible return of the child to their care should placement out of the home occur.

The informing interview by the team's social worker is difficult and highly important to their introduction to the treatment program. The points to be conveyed are that we consider the safety and welfare of the child to be of paramount importance, that we assume they have the same concern, and that we are willing to work with them to accomplish this end. That the parents' intentions toward their children are good should be assumed unless or until subsequent observations bring their intentions into question.

Admissions of guilt at this or any other time in the treatment process are not customary and should not be regarded as necessary for a safe and successful reintroduction of the child into the family. We assume that the parents are responsible for the injury once the diagnosis of inflicted trauma is made. They are told so at the outset and then the matter is dropped unless they bring it up themselves. The treatment is based on our estimates of the likely sources of risk to the child in the environment, not on parents' admissions of guilt.

The next stage in the process is to inform the police that we have a case of suspected inflicted trauma. Arrangements are made for law enforcement personnel to interview the parents and the parents are informed of the time and place of the interview. In general, this is arranged in a manner that will least expose the parents to public knowledge that they are being investigated for possible child abuse. This is desirable whether or not the suspicions should prove to be unfounded. Most parents are already overwhelmed with concern for the fate of themselves and their children. Public shame contributes nothing to the treatment process and may in fact operate to increase defensiveness and denial.

Following the telephone call to the law enforcement agency the child is put on a "police hold", i.e. detained for further investigation. The children are usually detained at the hospital. This permits us an opportunity to observe parent interaction with the child as part of our evaluation and also to spare the child the trauma of placement in yet another environment strange to him and one in which the parents are unable to visit except for brief periods (usually an hour and then only once a week). Since most of our children are under two years of age, we regard the continuation of parent contact as absolutely essential if the child is to be returned to their care at some later time.

The evaluation of the family is accomplished by interviews with the parents together and individually, developmental examination of the child, and occassionally psychological testing of the parents. The latter is done

only when we suspect a psychotic process in a parent or intellectual deficits of a nature that might impair judgment in child rearing. The specific form of the evaluation is less important than the fact that several people are involved in conducting it. One of the basic tenets of the program is that decision-making is best done by a group process that utilizes observations from several people. We feel that this is the best way to balance out the biases and concerns that naturally arise when difficult decisions need to be made on the basis of data that is largely subjective and that often entails substantial risk to the patients.

The risk of returning a child prematurely to a family where he may again be seriously or fatally injured is already well-known to the courts, law enforcement, children's protective services, and treatment agencies. An equally important risk in child abuse is *not* returning children, especially very young children, in a timely manner.

The latter risk can result in a serious—sometimes irreversible—disruption of the parent/child relationship. The consequences to the child of prolonged or indefinite foster care can be as emotionally debilitating as the consequences of a serious physical injury. Withholding a child from his parents unnecessarily can also result in a significant diminution in parent motivation to seek treatment or comply with treatment recommendations.

"Losing" the parents while "saving" the child in such a process may represent no long term gain at all. Besides the emotional consequences to the child, there are possible consequences to future children. Most of the parents are in their prime child-bearing/rearing years. They are likely to parent still more children and, if the problems are not confronted now, the subsequent offspring may suffer from dysfunctional parent/child relationships also. Psycho-social factors which result in child abuse cannot be remedied by simply removing each child from the family as he or she comes to our attention.

It is for that reason that our program rarely recommends criminal prosecution of abusive parents. Jail time may satisfy the requirements of the law and the sensibilities of the community, but it does little or nothing to solve the problem of child abuse, in our experience. In fact, it tends to work against a solution by removing the parents from a treatment program and promoting a belief that once they have paid their time in jail they should not be further "punished" by participation in an emotionally difficult treatment process. We have yet to engage a parent successfully in the treatment program who first spent time in jail or prison for the child abuse. We have, however, been able to use the leverage gained by sentences of probation with a stipulation for counselling to considerable advantage. If there were a deferred sentencing program for convicted child abusers, we would likely feel quite differently about criminal prosecution for parents identified as abusive to their children.

To return to the general problem of risk to children in child abuse cases, we will usually advocate placement of the child out of home in the following circumstances: (1) where one or both parents is disabled by a psychiatric disorder which seriously impairs perception of reality or impulse control, (2) where one or both parents is disabled by a substance abuse problem, (3) where there is a history of abuse to other children under the care of these

parents, (4) where there is a history of parent refusal to attend counselling sessions for problems in child care or management, (5) where the abuse is triggered by an acute situational problem, e.g., loss of housing, employment, divorce—which can be remedied more easily and quickly if the child is not in the home, or (6) when the parents request some time away from the child.

In general, we are slow to recommend placement outside the home for children under the age of two years. The physical risk to the child must be substantial, or approaching "a reasonable medical certainty," before we would advocate such action. The emotional risk to the child of disrupting parent attachment appears to be more significant in that age range, and the usual foster care arrangements for visiting (one hour per week) are not adequate to sustain even a minimal parent/child bond at such a young age.

A safer alternative in cases of young children, in our view, would be an infant/child day care program which allowed the children to remain in the care of their parents evenings and weekends. Unfortunately, such day care programs are rare and, even where available, it is even more rare that the parents can afford them or that public funds are available to offset the cost sufficiently. We are currently developing such a day care program to be conducted at the Colleagues Infant Care Center to evaluate its effectiveness and to explore alternative methods of funding.

The treatment program that is offered at CHLA includes the following components: (1) individual or couple counselling, (2) group therapy (parents and children separately), (3) child management group (parents and children together), (4) parent aide, and (5) pediatric care.

The individual/couple counselling is largely traditional in conduct with the addition that the therapists are expected to provide assistance with such reality problems as transportation, job training, education, and housing. The group therapy component is built around the idea that abusive parents need more adequate social contacts and "life lines," as well as needing to learn to trust others. The groups usually begin with dinner at the hospital to provide this social exchange and then break up into the various parent and child groups. We have found this to be a highly effective method.

The children's groups provide more than just child care while the parents meet in their groups. They also give us the opportunity to provide stimulation for the children and an evaluation of their developmental status. The children's groups are conducted by a psychologist, a developmental specialist, psychology interns, and student nurses.

The child management group is offered for parents who need skillbuilding and information in basic child rearing techniques. Most of these parents are either very young, inexperienced, or intellectually limited. The latter group, sometimes termed "mildly mentally retarded", constitute about a quarter of our patient populations. It is our belief that the connection between intellectual impairment and child abuse has not been sufficiently recognized as one of the major causes of child abuse—the attention, rather, has been on normal functioning parents who represent the majority of abusers, and for whom the most services are usually available.

The parent aide program was developed in response to a need for lay assistance and parent advocacy that could not be provided within the rest

of the treatment program. The parent aides are recruited, trained and supported by a professional person, but their purpose is not "professional." They are assigned to families where social isolation is an especially pressing problem and are asked to function as "good neighbors." They are available for telephone calls, coffee, occasional transportation, babysitting, advice and, mainly, companionship. One of our parent aides, La Maze trained, recently provided La Maze coaching for an abusive mother in the birth of her fourth child. The results of this were so encouraging—e.g., relief of the medical staff who had dealt with her before and the fact that this was the first child she could successfully nurse and hopefully achieve more positive bonding—that we are considering development of a corps of La Maze trainers for our abusive parents.

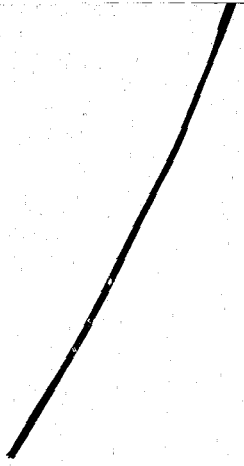
The pediatric care program is provided through a once-a-week clinic which includes developmental and nutritional consultation. Appointments are also provided outside clinic hours. Availability of pediatric care is considered essential to the program. It provides an opportunity to monitor the growth and developmental status of the children and to offer advice to parents in a context which often is less threatening than the formal psychotherapy components of the program.

The components of the program are offered in various combinations depending on our estimate of the family needs. Most parents receive a combination of counseling and pediatric care. No special formula is followed. Whatever works in enabling parents to improve their ability to nurture their children is employed.

One last word about the therapists in the program. They are advised to inform families they treat that we will not withhold any information from the court that is relevant to the physical safety or general well-being of their children. Whatever credibility we have with the court, and to whatever extent we can function as parent advocates in court, depends absolutely on our open relationship with the court so that the information upon which our opinions and recommendations are based is available for court examination.

In other words, no privilege in communication is guaranteed. The only guarantee is that we will inform the parents prior to a court hearing as to the substance of our testimony or allow them to read any written communication before it is sent. This works. It is not the standard therapeutic contract, and it contravenes traditional patient-therapist contracts, but it seems to work to the best interest of the child in these cases.

The last point to be made here is that to maximize the effectiveness of a child abuse team, it is absolutely necessary for the team members to work together, respect each other's judgment (even when there are strong disagreements in particular cases), and provide emotional support for each other. The treatment process is often difficult and frustrating. If one looks continuously to expected changes in the families for a sense of satisfaction, he would "burn out" rapidly. Changes are slow, hard won, and usually rather small by comparison to changes one ordinarily expects in psychotherapy. Cumulatively, the changes become vital to ensure the safety of the child. Before that becomes apparent, however, the therapists and other team members must function to sustain each other.



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