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THE MALTREATED CHILDREN OF OUR TIMES

VINCENT J. FONTANA, M.D.‡

I. INTRODUCTION

THE MALTREATED CHILD for too long has been hidden in a corner of a dark closet among our national skeletons — now his plight is out in the open. Efforts to enlighten the medical profession in the past decade have brought this problem out of its virtual blackout. The picture is an ugly one. It is extensive and it is increasing. We can ask ourselves, “Who are the maltreated children?” They are the children who are being pushed around, thrown down stairs, dropped out of windows, burned with cigarette butts, fried on stove tops, scalded in boiling water, manhandled, beaten, tortured, victims of bizarre accidents, battered to death, starved and sexually abused. They are also life starved and love starved, insidiously neglected, growing up without a sense of self-esteem and becoming future child abusers themselves. Dr. C. Henry Kempe of the University of Colorado at the Colorado General Hospital in Denver reported the results of a nationwide survey of hospitals and law enforcement agencies in 1962 indicating the high incidence of battered children within a one year period.¹ Up to this time, the syndrome of the “battered child” had for the most part been unsuspected and unrecognized by the medical profession. There was little or no information on the subject available in the standard pediatric text books. A new term was coined, namely “The Battered Child” syndrome. The battered child syndrome derived its descriptive name from the nature of the child’s injuries which commonly included abrasions, bruises, lacerations, bites, hematomas, brain injury, deep body injury, fractures, dislocations, injury to the liver or kidneys, burns, scalds, and all other injuries generally resulting from battering a child.

The following year, my colleagues and I reported our observations of a large number of children who were seen at the New York Foundling Hospital Center for Parent and Child Development with no obvious signs of being “battered” but who had multiple, minor physical evidences of parental neglect and abuse. We suggested the

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1. See Radbill, *A History of Child Abuse and Infanticide in THE BATTERED CHILD* 16 (R. Helfer & C. Kempe eds. 1968) [hereinafter cited as *THE BATTERED CHILD*].

term the "maltreatment syndrome" be applied to describe this greater whole picture of child abuse, ranging from the simple — the undernourished infant categorized as a "failure to thrive" — to the battered child, oftentimes the last phase of the spectrum. In these cases, the diagnostic ability of the physician, coupled with the community treatment and preventive programs, can bring about the protection of the child from the more serious injuries resulting from inflicted battering by parents — injuries that have become significant causes of childhood deaths.²

II. THE MALTREATED CHILD

A. *Symptoms of Abuse*

The maltreated child is often taken to the hospital or private physician with a history of failure to thrive, poor skin hygiene, malnutrition, irritability, a repressed personality and other signs of obvious parental neglect. The more severely abused children are seen in the emergency room of hospitals with external evidences of battering. Some are seen with an unexplained ruptured stomach, bowel or liver. Some are seen with extreme symptoms of maternal deprivation syndrome where the mother allows the child to suffer the effects of deprivations that lead to physical and mental retardation. This condition is oftentimes reversible if the children are admitted to a hospital and appropriate diagnostic measures taken. Some children are seen with inability to move certain extremities because of dislocations and fractures associated with neurological signs of intracranial damage. And of course, those with the more severe maltreatment injuries arrive at the hospital's emergency room in coma, in convulsions, or dead. Actual cases of murder, battering, torture, starvation, sexual abuse and life-ruining neglect are recorded in the medical literature. The parents' accounts of how these injuries occurred range from "accidents" to "discipline."

B. *The Source of the Abuse*³

The maltreating parents come from all strata of society. For example, there is the drug addicted mother who was living without a

2. For additional reading on the subject matter of this section, see generally THE BATTERED CHILD, *supra* note 1; V. FONTANA, SOMEWHERE A CHILD IS CRYING (1973); V. FONTANA, THE MALTREATED CHILD (3d ed. 1977); N.Y. STATE ASSEMBLY SELECT COMM. ON CHILD ABUSE, Report (1972) [hereinafter cited as N.Y. SELECT COMM. REP.]; Fontana, *Child Abuse: Tomorrow's Problems Begin Today*, 22 CATH. LAW. 297 (1976).

3. For additional reading, see Gil, *Incidence of Child Abuse and Demographic Characteristics of Persons Involved in THE BATTERED CHILD*, *supra* note 1, at 19-39; Steele & Pollock, *A Psychiatric Study of Parents Who Abuse Infants and Small Children in THE BATTERED CHILD*, *supra* note 1, at 103-45. See generally authorities cited note 2 *supra*.

husband in a ghetto basement apartment with nine children ranging from three to twelve years of age. The mother sold drugs as well as being addicted. Her twelve-year old son was also on drugs and the eleven-year old daughter was prostituting to help with the finances of the house. Another example is that of the unmarried mother who signed out of the hospital after the premature birth of a child, leaving a false address. In three days, the infant had begun to twitch, have convulsions, clutch at its face, scream and regurgitate — all symptoms of drug withdrawal. Subsequently the child was fortunately brought to the emergency room and treated for withdrawal symptoms. Maltreatment of neonatals resulting from parental addiction is becoming more common as the epidemic of drug addiction continues to grow. From another social level we see financially comfortable parents living in a pleasant, clean house in a friendly neighborhood who are without friends. They have four teenagers who have never had visitors. One day, the oldest girl, age seventeen, went to the police and told them that she is the mother of a baby living at home and that her own father is the father of the baby; that he had been having sexual relations with her for more than four years and was now doing the same with her younger sisters. The mother, when questioned, admitted knowing about the situation for years, but had not reported it to the authorities for fear of losing her husband. Yet another example is of a family living in a low income housing project with five children. The family had been reported to the Society for the Prevention of Cruelty to Children and had a lengthy record of child abuse and neglect. The society alleged that the mother beat her children so violently that one little girl had probably died from beatings; that another was brought into the emergency room of a hospital in serious condition with a skull fracture; that another child had been brought to the emergency room, though not hospitalized, on five different occasions — once for a fracture, another time for an abscess, and on the sixth occasion she was dead on arrival from internal hemorrhages.

Maltreatment by parents may involve children of any age with a noticeably greater incidence of abuse of children under three; a large percentage of abused children are under six months of age. One parent more than the other is usually the active batterer and the other parent passively accepts the battering. The average age of the mother who inflicts the abuse on her children has been reported to be about twenty-six years. The average age of the father is thirty years.

The lives of these parents are usually marked with divorce, paramour relationships, alcoholism, financial stress, poor housing conditions, recurring mental illness, mental retardation, and drug

addiction. These stress factors all play leading roles that cause the potentially abusing parent to strike out at a child during a time of crisis. As previously mentioned the problem of child abuse is not limited to any particular economical, social, or intellectual level, or to any race or religion. However, the battering parents' behavior appears to have had roots in their own childhood experiences. The parents often recall that their own childhoods lacked love, support, and protection — rendering them unable to give love, affection and the necessary “mothering” to their own children.

Unfortunately, neglectful and abusive parents with low incomes are under a somewhat greater environmental stress and usually have fewer resources and supports in coping with these stresses and strains than parents with an adequate income. Current situational stress and strain and the deleterious effects likely to result therefrom, are common among neglectful parents. The inability to cope makes them unable to care adequately for their children. This reaction to stress will probably vary with many other aspects of their lives, their circumstances and their environment.

C. *The Perpetuation of Abuse*

There is evidence to indicate that a large number of abused and neglected children will grow into adolescence and adulthood with tendencies towards committing crimes of violence. Persons who engage in violence tend to have been victims of violence.⁴ This generation's battered children, if they survive, will in most cases be the next generation's battering parents. Child abuse, then, is not simply a time-limited phenomenon to be seen as an age-specific, social-medical problem, but as a dynamic phenomenon with a cyclical pattern of violence from one generation to another. In the last decade, child maltreatment has been recognized by the medical profession. However, a reluctance on the part of the physician, traditional yielding to parental authority by the courts, overlapping of investigation by the social service agencies, inadequate training of the social workers and allied personnel in the field of child abuse, and very poor communications among the various disciplines responsible for protecting the abused child have resulted in insufficient protection for the abused and neglected child. These breakdowns in the system give battering parents the opportunity to continue their abusive behavior which can lead to the death of an innocent child.⁵

4. See Steele & Pollock, *supra* note 3, at 111.

5. See N.Y. SELECT COMM. REP., *supra* note 2; Besharov, *The Legal Aspect of Reporting Known and Suspected Child Abuse and Neglect*, 23 VILL. L. REV. 458

III. THE ROLE OF THE PHYSICIAN

The physician is usually the first professional asked to intervene in cases of child maltreatment and he has the most difficult role to play in dealing with a case of a maltreated child. His first and foremost responsibility should be to the child and his family. All of us who have handled battered children over the years have seen rather unfortunate situations where the family physician is unable to recognize his role and oftentimes is unwilling to ask for help. It is the child who suffers.

The physician's suspicions should be aroused when an infant or child is taken to him or to a hospital and the history related by the parents is at variance with the acute clinical picture and the physical findings noted on examination. The parents in these cases often take the child to a number of different hospitals and doctors in an effort to negate any suspicion of parental abuse. The physician will often encounter difficulties in obtaining any type of history from the parents. Making the diagnosis of maltreatment is totally dependent on physical examination, x-ray findings, social service investigation, and a high degree of suspicion on the part of the physician when eliciting the medical history.

Every medical center should have a child abuse committee providing a readily available team of consultants, headed by a senior pediatrician to assist the house staff, a psychiatrist, a social worker and hospital administrator. This team must also assume the responsibility of educating the medical staff as well as other members of allied fields in the community.

Once the injury has occurred, the physician's first and immediate responsibility is to the child. When the parents bring their abused or neglected child to the physician, early diagnosis and treatment is essential. The main reason for admitting the child to the hospital, other than for assessing the degree of injury, is to protect him. It should be a straightforward admission for the purpose of evaluation. The medical and physical evaluation of the child must be handled thoroughly and expeditiously; emergency care is often required if the child is acutely ill.

Every child who has a serious unexplained injury should have x-rays taken of the long bones, ribs and skull. This is the physician's most important diagnostic tool. The x-ray findings often speak for the child.

(1978); Helfer, *The Responsibility and Role of the Physician in THE BATTERED CHILD*, *supra* note 1, at 44; Kempe, *Some Problems Encountered by Welfare Departments in the Management of the Battered Child Syndrome in THE BATTERED CHILD*, *supra* note 1, at 169-74; Redeker, *The Right of an Abused Child to Independent Counsel and the Role of the Child Advocate in Child Abuse Cases*, 23 VILL. L. REV. 521 (1978).

X-rays of the patient's fractures may show various stages of reparative changes. On the other hand, if no fractures or dislocations are apparent on examination, the reason may be that bone injury may remain obscure during the first few days of inflicted trauma. In these cases, bone repair changes may become evident days after the specific bone trauma. For this reason, x-rays should be repeated approximately five to seven days after the suspected inflicted trauma in order to evaluate the presence of special diagnostic radiologic findings related to inflicted trauma to the bones. These unusual bone changes seen on x-rays include metaphyseal fragmentation, "squaring" of the long bones, periosteal hemorrhages, periosteal calcification, presence of bone fragments, epiphyseal separations, and periosteal shearing.

It is also most important for the physician to take photographs of the body injuries at the time of admission to the hospital. Colored photographs are most helpful in documenting findings to various law enforcement agencies and the courts after definitive diagnosis. When the medical and surgical evaluation has been completed the physician is confronted with the difficult task of gathering all the data together and making a differential diagnosis.

The physician should talk with the parents and work with the house staff. The social worker can enter the picture after the immediate medical evaluation has begun and assist in communicating with the appropriate child caring agencies. The pediatrician on the team should be responsible for completing in detail the necessary child abuse reports mandated under the state child abuse law.⁶ Care must be taken not to eliminate the house staff from the care of the child. Court testimony should be given by the staff physician, not the resident, since experience in this area is essential. With this type of appropriate intervention, physicians can protect children's lives, identifying the parent or family responsible for child abuse and thereby assist in breaking the chain of abuse which is frequently perpetrated from generation to generation.

In summary, the physician's responsibility in suspected cases of child abuse and neglect should include:

1. *Making a suspected diagnosis of maltreatment.*
2. *Intervention and admission of the child to the hospital.*
3. *Assessment* — including a history, physical examination, skeletal survey, and photographs.
4. *Reporting of a case to the appropriate department of social service and child protective unit or central registry.*

6. See Besharov, *supra* note 5, at 464-69.

5. *Requesting of a social worker report* and appropriate surgical and medical consultations.

6. *Conference* within seventy-two hours with members of the medical center's child abuse committee.

7. *Arranging a program* of care for child and parent.

8. *Social service follow-up*.

Efforts have been made throughout the country to protect the abused or battered child by the enactment of child abuse laws in every state of the nation.⁷ Fundamentally these child abuse laws are only the first step in the protection of the abused and neglected child. It is what happens after the reporting that is of the utmost importance. A multidisciplinary network of protection needs to be developed in each community to implement the good intention of these child abuse laws. It is the physician's duty not only to report suspected cases of child abuse but also to initiate the necessary steps to prevent further maltreatment of the patient and other siblings in the family unit. The purposes of the child abuse laws are usually threefold: 1) to protect the parents when presented with invalid evidence; 2) to protect the child by making it mandatory for physicians to report suspected cases of maltreatment; and 3) to protect the physician involved by legislation that prevents possible damage suits by the parties involved.⁸

Treating a maltreated child is totally inadequate unless it is coupled with a simultaneous concern for the parents. They must be given the benefit of therapeutic programs directed towards rehabilitation and preventive measures that will help eliminate the psychological and social environmental factors that foster the battering parent syndrome. If these parents are to be given any help they must be made to recognize their own intrinsic worth and potential as human beings. This can only be accomplished by recognition of the parents' needs and the cooperative effort by all child caring professionals and paraprofessionals.

Referrals to self-help groups, such as Parents Anonymous, group therapy programs, specialized homemaker facilities, preschool therapeutic day care centers, and foster grandparent programs assist in protecting the abused and neglected child as well as securing help for the battering parents.⁹

7. *Id.* at 459.

8. Concerning protection for the parents, *see* Besharov, *supra* note 5, at 505-09, 514-15. Physicians are mandated to report suspected cases of child abuse in at least 45 states. *Id.* at 465 & n.36. Immunity for those persons who are required to report is provided by all 50 states. *Id.* at 475.

9. For additional reading on the subject matter of this section, *see* Besharov, *supra* note 5; Fontana, *supra* note 2; Helfer, *supra* note 5, at 43-56; Silverman,

IV. A MULTIDISCIPLINARY INPATIENT AND OUTPATIENT PROGRAM

While other communities are doing some excellent initial work in child protection, the New York Foundling Hospital Center for Parent and Child Development Program will be described here because it is the program with which I am most closely involved and also because it may well serve as a model to be shared with other communities.

While our hospital's multidisciplinary program has only been in operation for approximately five years, I would like to point out several important positive gains already achieved. First, the families are now under supervision and the team is learning constructive ways in which to help them cope with their child and their problems. We believe that a good deal of prevention has been achieved. Second, the program has developed a community awareness that there are available alternative methods of treatment as opposed to a strictly punitive approach. These gains are especially rewarding when it is realized that the clients currently being served by the Abusing Parent and Child Unit represent the most oppressed segment of the New York City population. Living in the most depressed areas of the city, they are, for the most part, isolated, lonely, poverty stricken people from completely deteriorated family situations.

Based upon our experiences, it can be concluded at this point that a multidisciplinary approach to child protection and family therapy can work to the benefit of both families and professionals involved with them. This program represents an innovative approach to the problem by combining psychiatric, medical and social approaches in the treatment of the mother (family, wherever possible) and the child. Reputed to be the only comprehensive in- and outpatient child abuse and neglect program in the United States, it opened in September 1972, with the following objectives:

- 1) To prevent separation of parents and child, whenever possible.
- 2) To prevent the placement of children in institutions.
- 3) To encourage the attainment of self-care status on the part of the parents.
- 4) To stimulate the attainment of self-sufficiency for the family unit.
- 5) To prevent further abuse or neglect by removing children from families who show an unwillingness or inability to profit from the treatment programs.

Radiologic Aspects of the Battered Child Syndrome in THE BATTERED CHILD, *supra* note 1, at 59-74.

There are four components of the program: 1) The multidisciplinary team approach; 2) engagement of the surrogate mothers; 3) hotline service;¹⁰ 4) inresident facility.

The *multidisciplinary* team provides comprehensive medical, psychiatric, and social services to both parents and child(ren). The psychiatrist, psychologist, psychiatric social worker, pediatrician, nurse, child care worker, house mothers and paraprofessionals (social work assistants) coordinate their skills and expertise in providing treatment, rehabilitation, and preventive measures through the actual demonstration of how to "mother" while "being mothered" at the same time.

The paraprofessionals who live in the patients' community serve as the *surrogate mothers* to the parent-patients. They "mother" them to fill that very deprived need to experience how to be mothered while helping them learn mothering skills.

As an integral element of the "surrogate mother" service, a "hotline" is provided between these patients and the surrogate mothers, so that they are available to them via telephone or a home visit when the patients need someone to talk to, to ventilate their feelings, or simply someone to listen. The desired effect is achieved when, instead of projecting onto their children and taking it out on them in the form of abuse, the patients turn to the "surrogate mothers."

On a wider scale, there is a hotline at the agency manned by treatment personnel on a twenty-four hour coverage. Anybody can call directly or on behalf of a parent, and these calls are carefully monitored in order to provide instant service, which may include referral to another type of facility, or a follow-up intake interview for admission of the parent and child to the program, as outpatients or inpatients.

The *inpatient component*, as well as the outpatient, is located on the fifth floor of the New York Foundling Hospital. The patients for the inhouse facility are chosen on a very highly selective basis, as it is not our aim to uproot or break up a family unit for placement. Mothers with two to three children are able to enter the inresident program since the agency has nurseries on the seventh, eighth and ninth floors for the other children. Day care and family day care programs are also available in the agency should they be necessary. The child who has been abused remains with the mother, but provisions are made for the other children placed on the nursery to

10. For a discussion of the mechanics and legal considerations in setting up a hotline, see Besharov, *supra* note 5, at 489-90.

interact with them and receive appropriate services. In rare cases where a father is involved,¹¹ although he doesn't enter the inpatient facility, he receives services as well. It is the hospital's projected goal to develop a more comprehensive program for the fathers as outpatients.

During the course of the year the program is equipped to care for forty inpatients and one hundred and twenty outpatients. Inpatients, numbering eight mothers and eight children at a time, live in the residence for at least three months. Outpatients receive services in the hospital as outpatients part of the week as well as services in their home during the remainder of the week.

The Abusing Parent and Child Unit accepts referrals from all public and private social, medical, law enforcement agencies and educational institutions in two boroughs of New York City. All cases are channelled through Protective Services of the Bureau of Child Welfare, the local child protective agency to which all cases of child abuse or neglect must be reported as mandated by New York State law.¹² In addition, the unit accepts self-referrals seven days a week, twenty-four hours a day to enable it to intervene during a crisis situation.

V. CONCLUSION

In summary, the innovative approach of the multifaceted program described above to the treatment and prevention of child maltreatment attempts to break the generational cycle of the battered child syndrome by a technique of behavior modification through corrective child care experiences, education in homeworking skills, environmental assistance and psychotherapy. This broad based concept of treating both parents and child has proven effective in providing crisis management services that not only protect the maltreated child but also simultaneously allow preventive rehabilitative treatment for the maltreated child and his family.

The results of our study with abusing and neglectful mothers clearly indicates that, because of the nature of the problem and the variety of parents involved, a coordinated effort by all disciplines is essential if we are to interrupt the generational cycle by which child abuse and neglect are perpetuated.¹³

11. See Steele & Pollock, *supra* note 3, at 108.

12. N.Y. SOC. SERV. LAW § 415 (McKinney 1976).

13. For additional reading for this section, see *generally* authorities cited notes 2, 3 & 9 *supra*.