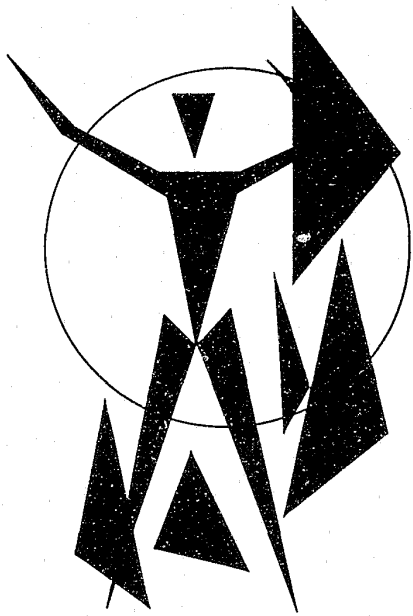
PROCEEDINGS

"Family Violence: Public Health Social Work's Role in Prevention"



An Institute Sponsored by the Bureau of
Maternal and Child Health and Resources Development,
Health Resources and Services Administration,
Public Health Service, Department of
Health and Human Services and the
University of Pittsburgh, Graduate School of
Public Health, Department of Health Services Administration
Public Health Social Work Program

PROCEEEDINGS

"FAMILY VIOLENCE: PUBLIC HEALTH SOCIAL WORK'S ROLE IN PREVENTION"

April 24 - April 27, 1988
University Inn
Pittsburgh, PA

SPONSORED BY:

Bureau of Maternal and Child Health
and
Resources Development
Health Resources and Services Administration
Public Health Service
Department of Health and Human Services

AND

University of Pittsburgh
Graduate School of Public Health
Department of Health Services Administration
Public Health Social Work Program

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Grant Number: MCJ-000114-30

Library of Congress
Catalog Card Number

90-70092

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FAMILY VIOLENCE: PUBLIC HEALTH SOCIAL WORK'S ROLE IN PREVENTION

April 24 - April 27, 1988

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1988 PUBLIC HEALTH SOCIAL WORK INSTITUTE

Introduction

As we proceed toward the end of the decade of the 80's, public health social work is faced with many challenges, not the least of which is reducing the level of violence and abuse in families.

In recent years, health and social service professionals have become acutely aware of a serious and growing problem of family violence in the United States. Cases of child abuse, spouse abuse and even elder abuse are being frequently referred to law enforcement and health/social service agencies. The public has also gained more awareness through more aggressive, and often sensationalized, reporting of such incidents by the media. Reported cases, however, may represent only the tip of the iceberg. The bulk of incidents are never reported and in many families, even if overt violence is not present, members may live with constant fear, threats and intimidation. Not only does family violence take an obvious physical toll on many infants, children and adults, but the emotional impact on individuals and on the family as a whole is immeasurable. We are only beginning to understand the long-range impact. In any case, this has emerged as a serious public health problem, and was the topic of the Surgeon General's Workshop (Violence and Public Health) held in October of 1985. The magnitude of this problem of family violence demands effective and aggressive treatment and prevention interventions.

The topic of the 1988 Public Health Social Work Institute is "Family Violence: Public Health Social Work's Role in Prevention." The keynote address by Alicia Fairley set the tone for the Institute by not only indicating the prevalence and type of family violence, but also discussing various social factors contributing to the problem. Later, Robert ten Bensel focused in his address on the child abuse problem from a national perspective. To put the issue of violence and abuse in a historical perspective, Jack Smey reviewed the past and continuing role of child protective services in dealing with family stress and disorganization. Although these presentations highlighted the seriousness of the problem of family violence and the challenges facing public health social work professionals, the speakers optimistically acknowledged a growing recognition of the issue by policymakers, and the emergence of a variety of creative programs and initiatives to directly address the problem. The

address by Debbie Stokes and the eight workshops described existing (or planned) policies and programs, and provided a forum for participants to discuss the success of these efforts, the adaptability of these programs to other settings, and the potential for development of alternative strategies.

Hopefully, the Institute participants left with not only a better understanding of the scope and the etiology of the phenomenon of violence, but also equipped with new ideas for developing and promoting successful treatment and prevention strategies. As always, it is also the hope of the organizers and sponsors that the Institute has promoted communication and collaboration and esprit de corps among committed public health social work professionals.

Our thanks to the Planning Committee for the Institute format, and to Barbara Montgomery for assistance in compiling the Proceedings.

And to Juanita Evans, our ongoing gratitude for her continued support and sponsorship.

Gerald C. St. Denis

Kenneth J. Jaros

PROGRAM

1988 PUBLIC HEALTH SOCIAL WORK INSTITUTE

FAMILY VIOLENCE: PUBLIC HEALTH SOCIAL WORK'S ROLE IN PREVENTION

April 24 - April 27, 1988
UNIVERSITY INN
Pittsburgh, Pennsylvania

SUNDAY, April 24, 1988

4:00 - 6:00 p.m.	REGISTRATION	LOBBY
6:00 P.M.	INFORMAL RECEPTION AND SOCIAL HOUR	

MONDAY, April 25

8:00 - 9:00 a.m.	REGISTRATION	LOBBY
9:00 - 9:15 a.m.	INSTITUTE OVERVIEW Gerald C. St. Denis, Ph.D., M.P.H. Associate Professor and Director Public Health Social Work Program Graduate School of Public Health	Oakland West
9:15 - 9:30 a.m.	WELCOME Karen S. Peterson, M.P.H. Assistant Dean for Student Affairs Graduate School of Public Health	
9:30 - 10:15 a.m.	KEYNOTE ADDRESS "Family Violence: A Contemporary Social Phenomenon" Alicia Fairley, M.S.W. Special Assistant to the Commissioner of Public Health, Government of the District of Columbia	
10:15 - 10:30 a.m.	Break	
10:30 - 12:00	WORKSHOPS*	Conference Room
	I. "DOMESTIC VIOLENCE DURING PREGNANCY" Mary Rizk, M.S.W., Perinatal Social Work Educator, Cleveland Regional Perinatal Network	#5
	II. "HELPING COMMUNITIES BUILD EFFECTIVE CHILD ABUSE PREVENTION PROGRAMS--THE ARKANSAS MODEL" Becky Williams, M.S.W., Director Medical Social Services, Arkansas Department of Health	#7
	III. "PUBLIC HEALTH SOCIAL WORK AND CHILD WELFARE SOCIAL WORK: A TEAM APPROACH TO CHILD ABUSE INTERVENTION"	#8

*Coffee available in Workshop Rooms.

MONDAY, April 25 (con't)

	Rhonda R. Brode, M.S.W. Director of Resource Development Montgomery County (Ohio) Children Services	Conference Room #8
	IV. "AIDS: PUBLIC HEALTH SOCIAL WORK'S ROLE IN PREVENTION" Ruth Messinger Rockowitz, M.S.W. Clinical Manager -Social Work in Pediatrics Rochester Medical Center Rochester, New York	#9
12:15 - 2:00 p.m.	LUNCH	Oakland East
	"An Historical Overview of Child Protective Services" Jack Smey, M.S.W., Regional Admin. Mass. Society for the Prevention of Cruelty to Children	
2:00 - 4:30 p.m.	WORKSHOPS I, II, III, and IV Repeated.*	
6:00 - 10:00 p.m.	[CAPTAIN'S DINNER CRUISE ON THE THREE RIVERS] RESERVATIONS REQUIRED.	

TUESDAY, April 26

9:00 - 10:00 a.m.	"Child Maltreatment. A Joint Prevention Project Between Public Health and Child Welfare" Deborah J. Stokes, M.S.S.A. Social Work Consultant Ohio Department of Health	Oakland West
10:00 - 10:15 a.m.	Break	
10:15 - 12:00	WORKSHOPS*	Conference Room
	V. "Parenting for Peaceful Families" Barbara Oehlberg. Family Life Educator. Cleveland, Ohio.	#5
	VI. "The Development and Application of a Psychosocial Assessment Instrument" Howard Kroll, Ph.D., Social Work Consultant, Division of Primary Care, Bureau of MCH and RD, Rockville, MD.	#7

*Refreshments in Workshop Rooms.

TUESDAY, April 26 (con't)

	VII. "The Impact of Non-Family Environments on the Social Learning and Attribution of Batterers and Non-Batters-- Do we Promote or Prevent? Oliver Williams, Ph.D., M.P.H., A.C.S.W. Assistant Professor, School of Social Work University of West Virginia, Morgantown	Conference Room #8
	VIII. "STARS - Services to Teen Agers at Risk for Suicide - A Project of the Western Psychiatric Institute and Clinic" James Bozigar, M.S.W., A.C.S.W.	#9
12:15 - 2:00 p.m.	LUNCH "Child Abuse: A National Perspective" Robert ten Bensel, M.D., M.P.H. Professor of Maternal and Child Health University of Minnesota	Oakland East
2:00 - 2:15 p.m.	Break	
2:15 - 4:30	WORKSHOPS V, VI, VII, VIII, Repeated*	

WEDNESDAY, April 27

9:00 - 10:00 a.m.	WORKSHOP SUMMARY Dennis Rubino, M.S.W., M.P.H. Chief Medical Social Consultant, State of Delaware Dept. of Health and Social Services	Oakland East
	NEWS FROM THE FIELD Participants	
10:00 - 11:30	BRUNCH Juanita C. Evans, M.S.W., L.C.S.W. Acting Chief, Child and Adolescent Health Branch, and Chief, Public Health Social Work, Bureau of MCH and RD.	
	UPDATE AND CLOSING REMARKS	

* * * *

WELCOME TO ASTPHSW MEMBERS

* * * *

*Refreshments available in Workshop Rooms.

FAMILY VIOLENCE: A CONTEMPORARY SOCIAL PHENOMENON

Alicia L. Fairley, M.S.W., L.C.S.W.

"Save the Children" is the cry in our urban cities, for sad scenes are unfolding in America today. Our streets are rife with unprecedented shootings, drug wars and killings. The very texture of this new urban violence is often grisly and obscene. It has moved from endemic to epidemic. As a result, the quality of life for all of us has certainly been diminished by the rising tide of violence in our families and our communities.

Family violence has been receiving a great deal of attention these days, however, it is an old problem that has not been well documented and in the past it has been handled very secretively. One of the difficulties is in the development of an accurate data base as there is a great deal of disagreement about what is to be measured.(1) However, I am certain public health social workers and other human service workers can contribute much to this effort, as you have a wealth of information in your files on the psychosocial aspects of violence.

Webster defines violence as "1. physical force used so as to injure, damage or destroy; extreme roughness of action, 2. unjust or callous use of force or power, as in violating another's rights, sensibilities, etc., the harm done by this..."(2) in light of this definition, we must conclude that violence has been with us since time immemorial and we are certainly a country with a history of violence. Historically, in the United States, violence injury has been one of the leading causes of early or premature death.(3) Infectious disease is the other leading cause of loss of productive years for Americans. Until very recently, violence has been predominantly in the domain of law enforcement, transportation and public welfare.

Since 1979, The Center for Disease Control (CDC) has been looking at morbidity and mortality in this country. As a result, they established a program of violence epidemiology. Also in 1979, the surgeon general published "Healthy People", a report in which priority areas requiring national attention in prevention were outlined. In concert with this, public health people from all over the country met and developed objectives for the 1990's. Included in this plan are violence strategies, which have specific objectives related to homicide, child abuse and suicide rates. This was a landmark in public health.

In 1985, The National Academy of Sciences and the Institute of Medicine published "Injury in America - A Continuing Public Health Problem", underscoring the fact that both intentional and unintentional injury remain the major unaddressed public health problems in our day.(4)

In October, 1985, C. Everett Koop, M.D., Surgeon General, United States Public Health Service, convened a major workshop on violence and public health in Leesburg, Virginia and accolades are accorded Dr. Koop for giving violence a very high priority on the public health agenda.(5)

Traditionally, the American Family was considered to be the most important social unit in our society. It was critical to the development of the mental, social and spiritual health of its members. It fostered a sense of belonging and family members were bound together by common bonds and blood. It also served as a source of strength and stability for its members.

Today, something has happened to some of our families, for some of them are becoming extremely weak and unstable. Many are dysfunctional and no longer able to perform their most basic family functions. The manifestations of violent behavior in some of these families, who are incapable of managing their basic family functions, are becoming too big for us to ignore.

People from all walks of life are often shattered by family violence. In the past, many of these incidents were viewed as merely "family spats." Today, we have come to recognize these spats as violent crimes and the stark reality that many of these victims lives are frequently terminated, or people are left with long suffering physical or psychological scars.

Many unsettling and startling changes are already occurring among this new underclass - within these poor, black and other minority families there seem to be; more children having children; more single-parent households; more spouse battering; more child abuse; more incest; more abuse of parents by children; more sibling abuse; more elder abuse and even outside of the family there is evidence of all types of violent acts against other persons who are not a part of the intimate family situation.

The causes of all of these horrible overt and covert acts are complex and multifaceted and often extend into the social and cultural fabric of our society. For many of you in this audience, this phenomenon of violence in the family is outside of your personal experience and it is also probably very difficult for you to comprehend the impact of many of the precursors to this violence such as: life at the "bottom of the barrel" where poverty, hunger, illiteracy, unemployment, poor housing, inadequate education, lack of adequate role models, low self-esteem, lack of access, lack of funds, drug/alcohol abuse and a multitude of other inequities abound.

On the other side of the coin, there are also middle and upperclass families who are affected by this phenomenon of violence, but it seems to be to a much lesser degree and usually it is in concert with drug or alcohol involvement. The problems of the middle and upper classes may be related to a different set of familial and environmental precursors. However, this smaller group of people should also be studied or we may pay a high price for not doing so in future years.

Both the President's Task Force on victims of crime and the Attorney General's Task Force on Family Violence recognized that family violence is much more complex in causes and solutions than crimes committed by unknown assailants.(6) If our society is to survive, we must develop and/or endorse public health policies and research that support the family. For if the family institution is to thrive, it is imperative that we address this very life threatening problem of family violence.

Facts about domestic violence are quite alarming. Activists first succeeded in drawing attention to the problem in 1970.(7) In cases of spouse abuse, in the majority of cases, violence is perpetuated by men against women.(8)

A well known survey conducted in 1975 forever shattered our beliefs that "battering" was rare and of no consequence in our society.(9) In 1985, the FBI reported that 30 percent of all female murder victims were killed by their husbands or boyfriends.(10)

Domestic violence is rarely a single isolated event and the problem seems to escalate over time. Therefore, the victim faces a higher risk of being victimized again.(11) This is frequently passed on from generation to generation, because the children who witness this violence get a very graphic picture and believe that "this is how families behave." There is also evidence to support that these children suffer immediate and serious psychological harm.(12)

Public health's official entry into the arena of violence prevention may seem strange, but violence is a critical problem that demands our immediate attention. Our initial attention is directed primrily at interpersonal violence within the family and its implications for public health social work.

"Each year more than 140,000 americans die from injuries; approximately 10,000 of these fatalities occur on the job and 50,000 deaths are intentional injuries...suicide and homicide."(13) "Homicide is the leading cause of death for black males 15 to 34 years of age and will cause the death of one black male in 28 during his lifetime."(14)

"The suicide rate for 15 to 24 year olds has more than doubled since 1950 and exceeds the rate for persons age 45 and older. Suicide is the third leading cause of death in the 15 to 24 age group."(15)

"For persons 15 to 24 the suicide rate was higher for males than females for both whites and persons of black and other races."(16) However, white males had a clear upward trend from 1970 - 1980.(17)

On the other hand, "when the elderly are touched by crime, they appear to be relatively more susceptible to crime that is motivated by economic gain."(18)

"About half of all violent crimes against the elderly were assaults" (physical attacks including attempts and threats, with or without a weapon) this translates into 4 victimizations per 1000 elderly persons.(19)

In "promoting health/preventing disease: objectives for the nation" (1980), the following facts were noted: "it is estimated that 200,000 to 4 million cases of child abuse occur each year and that 2000 children die each year in circumstances suggesting abuse and neglect."(20)

Through a technique that was really designed to measure crimes such as burglary, robbery, larceny and aggravated assault, the national crime survey uncovers about 450,.000 cases of family violence yearly.(21) However, these figures are not representative of the true level of family violence in the United States, because they are only estimates of the amount of family violence that the victims chose to report.

The FBI compiles uniform crime reports (UCR), however, this report is also limited because not all crimes are reported to the police. Additionally, the police may not classify certain types of family violence as serious offenses. Therefore, they would not be reported to the FBI.

Table I

Table 1. Percent of homicides reported to UCR, by victim's relationship to offender, 1982

Victim's relationship to offender	Percent
Husband	3.4%
Wife	4.8
Mother	0.6
Father	0.7
Daughter	1.0
Son	1.7
Brother	1.1
Sister	0.2
Other Family	3.3
Acquaintances	29.7
Friend	3.4
Boyfriend	1.4
Girlfriend	1.9
Neighbor	1.8
Stranger	16.9
Unknown relationship	28.1
Total	100.0

NOTE: Because of rounding, percentages may not add to total.

Source: Federal Bureau of Investigation, *Uniform Crime Reports, 1982.*

Table I shows crime data on the percent of homicides reported to UCR by victim's relationship to the offender, 1982. It illustrates that approximately 60 percent of all homicides are committed by people who are known to each other, i.e., husbands, wives, mothers, fathers, daughters, sons, brothers, sisters, ither family, acquaintances, friends, boyfriends and girlfriends.(22) This is quite paradoxical, for often the same family member who provides nurturing relationships, too frequently, is also violent toward family members.

Table 2

Table 2. Estimated family violence reported to NCS, by relationship of offender to victim

Relationship	1973-1981 total	Yearly average
Total by all relatives	4,106,000	456,000
Spouses or ex-spouses	2,333,000	259,000
Parents	263,000	29,9000
Children	173,000	19,000
Brothers or sisters	351,000	39,000
Other relatives	988,000	110,000

NOTE: All estimates rounded to nearest thousand.

Table 2 shows the estimated family violence reported to NCS by relationship of offender to victim," a relative of the victim was identified as the offender in 7 percent of all violent victimizations measured by the NCS from 1973 - 1981. This translates into 4.1 million violent victimizations by relatives during the 9 year period."(23)

Table 3

Table 3. Relationship of victim and offender in NCS crimes of violence, 1973-1981

Relationship	Percent of all violent crimes	Percent of violent crimes by relatives
TOTAL	100.0%	
Total by relative	7.2	100.0%
Spouse/ex-spouse	4.1	56.8
Parent	0.5	6.4
Child	0.3	4.2
Brother/Sister	0.6	8.5
Other relatives	1.7	24.1
Acquaintance	32.7	—
Stranger	58.2	—
Don't know relationship	1.9	—

NOTE: In victimizations in which there was more than one offender (7% of all victimizations by related persons), the victimization was classified as committed by the closest relative involved with spouse or ex-spouse being the closest followed by parent, child, brother or sister, other relatives and nonrelatives. Any group of offenders that included at least one related person was included in the analysis. For example, if three people assaulted the victim (e.g., a brother, a cousin, and an unrelated person), the relationship to the victim was classified under the "brother or sister" category.

Overall, the National crime survey in Table 3 shows: crimes by spouse or ex-spouse make up the majority - 5 percent - of all crimes committed by relatives measured by the survey."(24) About 25 percent of the victims of spousal attacks reported previous attacks during the preceding six months. This serial victimization seems to also occur at the hands of other relatives; i.e., parents, siblings, etc... but to a lesser degree.

TABLE 4

Table 4. Percent of violent victimizations not reported to the police, by reasons for not reporting

Reasons for nonreporting	Related offenders	Unrelated offenders
Private or personal matter	59%	23%
Fear of reprisal	13	5
Nothing could be done, lack of proof	8	19
Police would not want to be bothered	8	6
Not important enough	7	28
Reported to someone else	5	15
Did not want to get involved	1	3
Too inconvenient or time-consuming	1	3
Other reasons	18	21

NOTE: Because some respondents gave more than one answer, the totals are greater than 100%.

Table 4 shows the percent of violent victimizations not reported to the police by reasons for not reporting - in other words, these victims did not report the victimization to the police, but responded to the survey. In 59 percent of the cases, the belief that the crime was a private or personal matter was the reason given for not reporting the crime and in 13 percent of the cases, the next most common reason was fear of reprisal.(25)

The NCS also shows that 91 percent of all spousal violent crimes reported, were victimization of women by their husbands or ex-husbands, who acted alone; 5 percent were victimized by wives or ex-wives who acted alone; and the rest were by spouse or ex-spouse in concert with someone else.(26) Seventy-five percent of the spousal violence reported in the survey involved people who were separated or divorced.(27)

TABLE 5

Table 5. Family violence by spouse or ex-spouse by victim characteristics, 1973-1981

Characteristic	1973-81 total	Average yearly rate per 1,000 population
TOTAL	2,333,000	1.5
Sex		
Male	155,000	0.2
Female	2,177,000	2.7
Income		
Less than $7,500	988,000	2.6
$7,500-14,999	650,000	1.4
$15,000-24,999	335,000	0.9
$25,000 or more	155,000	0.7
Age		
Under 16	*	*
16-19	165,000	1.1
20-34	1,528,000	3.2
35-49	496,000	1.6
50-64	110,000	0.4
65 and over	28,000	0.1
Marital status		
Married	554,000	0.6
Widowed	*	*
Divorced/separated	1,746,000	16.8
Race		
White	2,030,000	1.5
Black	277,000	1.6
Other	26,000	1.1

NOTE: Detail does not add to total shown because of rounding and/or missing data. Estimates are rounded to nearest thousand.

*Estimate based on about 10 or fewer sample cases, too few cases to obtain statistically reliable data.

Table 5(28) depicts family violence by spouse or ex-spouse, by victim characteristics, 1973 - 1981. It appears that people of lower income and persons between 20 - 30 years of age are victims of family violence. No differences were detected in the victimization rates of blacks and whites by spouses and ex-spouses.

TABLE 6

Table 6. Percent of reported family violence victimizations, by weapons used

Type of weapon	All family violence	Spousal violence
Weapon	31%	26%
Gun	11	9
Knife	9	8
Other	10	8
Not Known	3	2
No weapon or don't know	69	74

NOTE: In 1% of victimizations, offenders had more than one type of weapon.

Table 6(29) indicates that in about 30 percent of all violent crimes by relatives, weapons were used. Crimes between spouses and ex-spouses have a slightly lower rate of 26 percent.

TABLE 7

Table 7. Percent of family violence victimizations in which victims were injured, by type of injury

Type of injury	All family violence	Spousal violence
Any injury	49%	58%
Knife or gunshot wounds	2	1
Broken bones or teeth knocked out	3	4
Internal injuries, knocked unconscious	3	4
Bruise, black eye, cuts, scratches, swelling	43	52
Other	8	9

NOTE: Detail adds to more than total because many victims reported more than one type of injury.

In Table 7(30), we note the percent of family violence victimizations in which victimes were injured, by type of injury. Note that 49 percent or half of the victims of family violence reported being injured in an attack.

TABLE 8

Table 8. Percent distribution of self-protective measures employed by victims of family violence, by type of measure

Type of measure	All family violence	Spousal violence
Some resistance	73%	75%
Active	23	22
Passive	46	49
Other	4	4
No resistance	27	25

Table 8(31) illustrates the percent distribution of self-protective measures employed by victims of family violence by type of measure. In 73 percent of the attacks by relatives, the victims resisted, but usually it was in a passive manner (i.e., by reason, trying to get away or seeking assistance). In 23 percent of the cases, there was active resistance by physical force or weapon.

From 1973 - 1981, 4.1 million victimizations committed by relatives were reported to a government agency (either the police, bureau of justice statistics or both) and a substantial number of these occurred at least three times during a six month period. It is apparent that family violence is a significant problem of large and currently ill-understood, proportions. Knowledge of the incidence of family violence, like other crimes about which individuals are silent, may never be complete.(32) These statistics are but "the tip of the iceberg" on family violence. For they only underscore our urgent need to study the data, gain new insights, identify the etiologies and seek workable solutions.

What, then, are the psychosocial dynamics that we should consider as we begin to examine some of the etiological factors of this phenomenon of violence? Is there a high correlation between control and violence and/or between strength and violence? Are the perpetrators sick? or are they ignorant? or are they addicted to drugs and alcohol? or are they under intense stress? or does their environment simple drive them to it?

On the other side of the coin, why do the victims tolerate the violence? Are they economically dependent? or do they believe this is how they should be treated? or are they fearful? or are they manipulated? or do they feel powerless? and/or do they have certain religious beliefs that keep them in these situations?

The answers to these questions may seem very simplistic, but there are no simple answers. Furthermore, many professionals have difficulty believing the stories of the victims...especially since they usually meet the perpetrators when they are calm, articulate and very convincing. Additionally, it is difficult for some of us to accept family violence as criminal...because it "hits too close to home."

Many people who attended the violence conference at Lessburg, Virginia have suggested that we have to look at the multi-dimensional nature of the causal risk factors, as well as the interaction between those factors in order to gain some understanding of the problem.

They have also suggested that we should look at the previously known causes/risks that contribute to violence such as the biological, psychological and cultural factors as well as give more consideration or weight to the broadscale social/structural and interactional factors.

Additionally, we should pay particular attention to the issues of conflict resolution, the role of self esteem, positiveimages and the changes that have occurred since 1950 in the major institutions of the home, the school and the church.

In an effort to determine some of the major influences on children, the University of Michigan reported in a survey conducted in 1950 and repeated in 1980, the following findings:(33) Listed below are their findings:

Major Influences on Children

1950	1980
(1) Home	(1) Home
(2) School	(2) Peers
(3) Church	(3) Television
(4) Peers	(4) School
(5) Television	(5) Church

Since 1950, these institutions have changed dramatically in their ability to influence children, however, the home has remained constant. On the other hand, there is some indication that families are now having some difficulty in controlling the influence of peers and the media on their children.

The institution of the family has moved from extended to nuclear to single parenting. Many of these single parents have no real concept about the importance of child-rearing, marriage, appropriate values and stability. Television sets, "squawk boxes" and videos have become the babysitters of the young and adolescents are being educated by their peers, movies, music, TV, entertainment and the drug culture. The family seems to have moved from total involvement with their children in 1950 to little or no involvement with them in 1988. The lack of respect for life, property, household responsibilities, and authority seems to be running rampant. This same lack of respect seems to have spilled over into the institution of the school and discipline appears to be passe. Children are growing up too fast, with inappropriate values and goals and the street is becoming the most powerful institution that influences them.

The schools in many instances are very chaotic and today survival means more than just doing well in class. It means escaping from the criminals who terrorize the hallways, the playgrounds and the teachers.(34) The crimes of theft, violence and disruption are on the rise in schools. In light of this, some children may find it safer to remain at home or in the streets.

The church no longer plays the important role it once played in supplementing the teachings of the home. Very few churches offer action programs that appeal to young people. Seemingly, many churches are becoming bastions for senior citizens only.

Let us take a look at the possible dynamics in the family life cycle in some of our troubled families in particular. Many of them are:

a. Single parented (usually female)
b. The parent is usually a teenager
c. Unmarried
d. Usually no male role model in the home
e. The parent is usually unemployed and on welfare
f. The parent has few if any marketable skills
g. The parent probably did not go beyond 8th grade
h. The family support systems are inadequate
i. The parent probably grew up in a situation similar to her own
j. The parent probably has low-self esteem
k. The parent may have from 1-5 young children
l. They live in poverty and lack proper food and clothing
m. They lack opportunities in many areas

Then, what might be the atmosphere in such a home? It might one that:

a. Has very little nurturance
b. Limited intellectual stimulation
c. Limited rewards
d. Lots of labeling of children rather than labeling behavior
e. Poor communication skills
f. Mental and/or physical abuse
g. Poor supervision
h. Violent behavior
i. Lacking in affection
j. Lacking physical love expressions
k. Lacking in food, clothing and shelter

What is the most likely outcome for children growing up in this type of atmosphere?...We can speculate that the children will probably be limited in their intellectural, social and emotional growth, lacking in appropriate emotional responses, will appear dull and unresponsive and may eventually become very angry, hostile and/or violent to any authority.

This is but one part of the issue. Let us now examine some of the issues raised by our collegues at the Leesburg conference, namely the biological, psychological, cultural, social/structural, and interactional factors.

Take our same model family and consider the following scenario. Namely:

a. the 6 children are male
b. they are 8, 9. 10, 11. 12, 15
c. the 15 and 12 year old are borderline mental retardates
d. the 15 year old is a physically abused child
e. the 15 year old sells drugs
f. the 11 and 12 year old siblings believe in physical prowess and action and try to follow in footsteps of the 15 year old
g. all of the children have watched violent programs on TV throughout their liftimes
h. they live in poverty
i. their father is streetwise and physically powerful. He comes by infrequently, but physically abuses one of the children and their mother. He has a history of using drugs and sometimes carries a weapon.
j. the family has few if any known options for conflict resolution.

The stage has been set for the definite possibility of violent behavior to occur. We have several young males who are biologically at risk because of sex, age and mental limitations. They are psychologically at risk because of the history of violent behavior between their parents and the physical abuse of one of the children. They are socially/structurally at risk because of their poverty; there is a lack of opportunity and male dominance over females prevails; they are culturally at risk because their males believe in physical prowess and action and the media have also validatel their violent behavior; and these factor are further compounded by drugs and weapons in the home.

They have no access to positive roles(i.e., a student, track star, etc), they have been the victims of negative labeling in terms of their I.Q. and their family situation and therefore they feel useless, incompetent and on the outside of "mainstream" society. Where do they turn except to violence within the family or to those "mean streets" outside of the home where violence is common place and life isn't worth a nickel. Youth are often grappling with two opposing thought structures, both of which are determined by their beliefs, alues and norms.

These thoughts are supported by feelings, attitudes and behaviors which imply feelings of deprivation on the one hand and push and pull on the other. Therefore, youth often have difficulty conforming to the requirements of traditional institutions.

During their early development, youth are often hit by trouble because of lack of access to desirable roles, negative labeling and alienation, but in reality, they may have done nothing to precipitate this situation. The processes which produce this type of trouble are usually institutional and are built into the policies and customs of the organization which they come in contact with.

"Youth may be able to hustle occasional jobs, but they cannot control most of the forces which make desirable roles available to them. Nor do young people exercise much control over the processes which produce negative labeling. Access to desirable roles and negative labeling are characteristics or attributes of social institutions, notable schools, work, family and the juvenile justice system."(35)

In light of the data on family violence and its psychosocial indices, what are some of the implications for public health social work? In the area of public policy we should:

*encourage or support the eradication of all public health policies that encourage interpersonal violence
*develop policies monitoring the enforcement of reporting the abuse of children or the victimization of other family members by public health social workers.
*develop policies for including males in the whole spectrum of health care (especially young minority males)

In the area of research we should:

*support improvements in the collection of data about direct and indirect victims of assault/homicide
*pursue research on:

a. how do victims of violence utilize social services in the health care system?
b. what are the characteristics of victims who come in contact with public health social workers
c. how effective are current clinic/hospital policies and procedures for identifying, coding, treating and referring victims of assault.

In the area of services:

*NASW should review procedures pertaining to emergency care for victims of violence and pay special attention to the processes of victim identification, assessment, treatment and referral.
*critical attention should be given to the adequancy and sensitivity to the health care given to young minority men in low socio-economic status who at greatest risks for repeated assaults and homicides.

*psychosocial histories should include, whenever possible, as history of past victimization and/or perpetuation of violence, the victim's risk profile and an assessment of his or her total health needs.
*training for public health social work in effective identification, treatment and referral services for the victims of violence.

In the area of practice needs:

*reduce drug/alcohol abuse among children, young males and pregnant women
*reduce behaviorally related morbidity and mortality
*include violence risk assessments in practice
*develop more health education programs directed at:

a. self-identity and self-control
b. appropriate parenting skills
c. values clarification (hard work, respect for family, and denial of personal opportunity)

In the area of program development needs:

*re-examination of other non-medical psychosocial issues that impact on violence:

a. impact of ethnicity/race
b. impact of racism
c. impact of separation of certain classes of people from the mainstream - economically, socially and culturally
d. family instabilty
e. expressive functions of the family in terms of guilt, self-hatred, class differences and the division of labor
f. instrumental functions of food, clothing and shelter
g. unemployment/underemployment of males (particularly blacks and other minorities)
h.permanent generational joblessness
i. decline of reinforcing institutions (school, church and home)
j. lack of opportunities for males (particularly blacks and other minorities)
k. the association of manhood with money
l. impact of the underground economy - the drug culture

Public health social work must move into the 1990's - prepared for the major technological, economic, social, political, specific socio-demographic and health manpower and training

trends that will impact on violence. Therefore, our specific priorities should address behavioral-related morbidity and mortality, strategies for prevention of youth suicide; homicide and minorities; the relationship of drugs/alcohol to violence and violence prevention in general. Additionally, we must also look at the indirect impact of ethnicity and politics, economics, technology and social trends on the violence issues if we are to achieve a better quality of life for all members of our society. We must save the children for it is crucial to our future survival.

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DOMESTIC VIOLENCE DURING PREGNANCY

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Wife battering, spousal abuse, wife beating--by whatever name it is known--occurs among all socioeconomic classes, races, religions, and educational levels(1). Inadequate reporting by medical, legal, and police sources, as well as under-reporting by the victims themselves, makes it difficult to determine the magnitude of the problem. Lenore Walker, a psychologist prominent in the wife abuse field, estimates that as many as 50 percent of all women at some time will be battered (1). A startling one-third of all women homicide victims in California in 1986 were murdered by their husbands(2).

When the battered woman is pregnant, she can be considered a high-risk maternity patient, the latter conceptualized by Ramona Mercer as having one or more medical, social or physical characteristics needing special attention or care(3). The battered pregnant woman meets these criteria by virtue of physical or inadequate economic, supportive, and emotional resources. This holds true whether she stays within the battering relationship or chooses emancipation.

But the problem and the risk do not end there. Both during and after her pregnancy, the battered woman must also be considered a parent at risk. Mercer considers that any factor which interferes with a parent's emotional, social, or cognitive life may deplete the energy that otherwise would be available for attaching to and cuing in to the infant and its needs(3).

If the woman remains with the battering mate, then the child is also at risk, since one out of every three or four of these men has been reported beating his children as well as his wife(4,5). Another frightening aspect of family violence is that one out of three battered women is likely to abuse her children(1). Apparently the mother turns on her children in rage and despair or vents her resentment toward them, since they make escape more difficult(5). In a recent news broadcast on Channel 5 Women in Prison, 80 percent of all women in prisons are murderers, of that 80 percent, 60 percent were victims of Domestic Violence. (1986)

What are the dynamics in such relations? As one answer, Walker has postulated a cycle theory of violence from her field study of 120 women. She identified three phases through which the couple passes time and again: the tension-building stage, the acute battering incident, and then a period of kindness and contrite, loving behavior(1). Obviously, the woman's symptoms, behavior, and attitudes toward her spouse and the relationship will vary according to where the couple is in the cycle. (This is illustrated in the appendix).

Battered women offer a host of reasons for not leaving their husbands: feelings of love or sorrow for the partner; a hope he will reform; fear of reprisals for him; unwillingness to deprive children of their father; nowhere to go; inability to support self and family emotionally and financially; societal or family pressure against divorce; low self-esteem; and a paralyzing sense of lack of control over one's own life(1,6). These reasons also explain why many women do not readily disclose the battering situation to health care personnel.

Another conceptual approach to battered women describes their experience as a grieving process(7,8). Whether she remains in the situation or gets out, the woman experiences loss of health, self-respect, security, trust in her partner, and her idealized role of wife. In the grief response that follows, the woman may displace her anger with her husband and self on those attempting to help. She usually demonstrates this in a passive-aggressive manner, such as missing appointments, disregarding advice, and the like(8).

Why During Pregnany?

Pregnancy is frequently linked with an increase in battering behavior. Walker identifes pregancy as one of three distinct periods during which there is an increase in the number of acute battering incidents(1). Another survey of 150 cases verifies that pregnancy was one of nine factors that led to violent confrontation(9).

Several reasons why pregnancy provokes greater violence have been postulated. Pregnancy generally creates a greater strain on the relationship, which may lead to frustration and, in turn, to violence. The husband may appear jealous of the unborn baby and resent the intrusion on his relationshp with his wife. At times during pregnancy, the wife may be less inclined to care for the husband's daily, emotional, or sexual needs. One observer has noted that, consciously or subconsciously, the husband's violence may represent an attempt to end the pregnancy and relieve himself of the burden of another individual(0). Some women who were interviewed even felt their men were attempting to prevent another human being with their same "bad genes" from being born(1).

Eva Rubin's developmental aspects of pregnancy are as follows:

Phase 1: Initial reaction may be ambivalence: most women, even if they want a child have doubts, misgivings about being pregnant now. She is confused.

Phase 2: Orienting selves to bodily changes, questioning own ability to have and care for baby. Thoughts on delivery date - ?-all future plans now revolve around EDC. If she is working, will take a leave of absence, vacation plans.

Makes space in her life for arrival of this child.
Object of concern and attention from family and friends...she is special, vulnerable and special.
Her concern is for self at first.
Searches environment for models (never noticed so many babies and mothers-to-be).
Fantasy - images of what baby will look like.

As she feels fetal movement, the "fantasy" child is transformed into a real living child. In Phase 3 - third trimester, she is most vulnerable. Feelings of dependency and concerns for the baby become a primary concern. She will begin feeling fear regarding the labor, delivery, her own health, and strong concerns regarding the health of the child are eminent, an internal process occupies her thoughts.

During the normal course of pregnancy, men go through the same feelings at different time span, he usually lags a trimester behind. The pregnancy loosens and re-aligns affiliative bonds, and fathers-to-be often complain of "being-left out". They may feel they are "losing a wife", and gaining two dependent and vulnerable people. The fetal bonding, which the mother may feel, becomes, in the immature or emotionally handicapped man, a barrier to his loved one.

What Kind of Man Beats His Wife?

Research shows a common profile for battering husbands. He believes in male supremacy. He blames others for his actions. He has low self-esteem. He fears intimacy and may use sex as a act of aggression. More than half of the time, he was a battered child or witnessed his mother's abuse. He has difficulty expressing his feelings verbally. He may have had an unusual "love/hate" relationship with his mother. He may have driving violations. He is unable to deal with frustration. He feels inferior to his peers. He is pathologically jealous and possessive, a trait which usually shows up in the courtship period but is frequently mistaken for devotion and love by the female.

These tendencies, fears, and inferiorities may be intensified and triggered in the mother during the pregnancy. The "love/hate" relationship in the mother may become transferred to the wife at the point she begins her motherhood role--during pregnancy.

Identifying the Battred Woman

Nurses and physicians in maternity settings are in an excellent position to be case-finders for battered women. Indeed, as pointed out, it is during pregnancy that many battered women come to the attention of health care personnel(1). Symptomatology or presenting problem may differ depending on the part of the battering cycle the woman is experiencing.

During the phase of rising tension, for instance, the woman may complain of symptoms that usually have an emotional component, such as chest pain, choking sensations, hyperventilation, gastrointestinal symptoms, pelvic pain, conversion reactions, allergies, backache, heartache, or hypertension. After the acute battering, women may seek the anonymity of a hospital emergency room rather than their regular care-givers. Therefore, the presence or history of the following types of injuries should raise the practitioner's index of suspicion: serious bleeding injuries, broken bones of the vertebrae, skull, pelvis, jaw, arms, or legs; or burns from cigarettes, appliances, stoves, irons, or scalding liquids. If the injury is not consistent with the woman's account, the care-giver may want to probe a little, but always with sensitivity to the woman's hesitancy, embarrassment, or evasiveness.

Special attention should be given to bruises of the abdominal wall. Abdominal trauma, a pediatrician has suggested, may be an etiologic factor in antepartum hemorrhage and premature labor. He reports having identified three cases of congenital deformities (two tibial deformities and one genu recurvatum hip dislocation with same-sided scleral and inter chamber opacity) that appeared to be caused by midpregnancy violence from the mother's mate(1).

How to Help

Health care professionals, nurses and social workers may need to examine their own attitudes in these situations, especially in reconsidering some of the common misconceptions of spousa abuse. There is no evidence, for instance, to support the belief that the woman enjoys being beaten or else she would depart; or that family violence is a lower-class phenomenon.

If the battered women is to be identified and helped, then the health care professional must create situations where this woman will feel comfortable and supported; where she can talk freely and confidentially. If the husband is present throughout the entire prenatal visit, the woman is considerably less likely to disclose the true cause of injuries or to discuss her concerns.

Once the woman has disclosed her battering situation, the social worker or nurse will want to make appropriate referrals as well as alter her own plan of care. She needs to be knowledgeable about local resouces so that she can make referrals promptly at times of crisis. Once informed about the resources and alternatives available to her, however, the woman herself must decide how best to maintain her physical safety and psychological integrity.

For the woman who chooses to leave her mate during her pregnancy, prenatal management becomes more complex. Not only is the woman now faced with single parenthood, but also with the problems of shelter and financial support. The woman will discontinue prenatal

care often due to shame at not being able to apply for services. If a relatively permanent shelter is not available, the battered woman may assume a transient lifestyle. She also will need nutritional counseling that emphasizes foods that are convenient and economical while meeting basic protein, caloric, and food-group distribution requirements.

For all battered women, close prenatal supervision is advisable to monitor progress of fetus and mother; at the same time, support must be provided for these women whose energies may be depleted by the demands of daily living under their unfortunate circumstances. Continuity of care is paramount, since the establishment of trust relationships with a nurse is critical for both mother and fetus. Borrowing from the principles of health management used in special folow-up of high-risk babies, telephoning the victim between visits, scheduled visits more frequently, and hold visits without appointments throughout pregnancy during particularly disorganized periods of her life.

A Support Network

Not only the present but the future situation must be considered. As pointed out earlier, this may be a case of parents, child, and entire family at risk, so anticipatory counseling and preventive measures are very important.

Since there is a high incidence of child abuse from both parents in violent families, the practical therapeutics described by Barton Schmitt and C. Henry Kempe are appropriate(12). The care-givers in the intrapartum setting should be made aware of the battering situation, so that they will tailor their care to the woman's needs, try to raise her self-esteem, and give her a feeling of understanding and support.

Those who will be providing pediatric care also need to be informed about the situation, to enable them to offer additional support and interpret the situtaion on the basis of the background data. Because of the interrelatedness of child and spousal abuse, a network that includes those giving prenatal, intrapartal, postpartal, and child care is vital to facilitate exchange of information. One out of three victims of domestic violence becomes a child abuser.

In fact, the period of the baby's homecoming is one of the first problem situations for violence-prone families(5). The father cannot tolerate the baby's crying; the mother's tension rises as her fear of the baby's crying increases; and the infant is, therefore, in danger of abuse from both parents. The woman is also especially vulnerable at this time, since the period when infants and small children are first home has been identified as one of the three times when the greatest number of acute wife beatings occurs(1). Special support is needed at this time, and health care professionals should coordinate their efforts to keep in touch with the family and evaluate the mother's conditions, father's responses, and the infant's behavior.

If other children in the family have witnessed and perhaps experienced parental violence themselves, then their needs, too, must be considered. Frequently, these children need psychological counseling and remedial educational assistance.

Since unplanned or unwanted pregnancy has been identified as a precipitating factor, counseling is very important. By exploring previous contraceptive practices, current attitudes, and the realities of actual contraceptive use, the nurse can help the woman to select an appropriate method for child spacing.

There are two recommendations for social work departments:

1) Conduct inservice training for nurses and physicians on Assessment of Domestic Violence, the cycle of abuse and resources available. In this way the nurse on the OB unit or in the prenatal setting can identify women at risk or currently battered. From the March of Dimes manual, I have included in your handouts an assessment form which can be presented at the inservice (page four). There are the assessment forms, as well as actions which may be suggestive. Be aware of uncomfortableness with the topic.

2) Empower your staff in the recognition of battering and self-care behavior. Resources, such as business cards can be made available to staff that they can give any woman they may suspect is subject to Domestic Violence.

   Teach them to observe signs suggestive of battering such as:

- injuries inconsistent with explanation,
- vague physical complaints,
- complaints of "problems with husband" or "problems at home",
- crying, sighing, laughing at abuse assessment questions,
- no eye contact or searching, engaging eye contact when assessing for the battering,
- fear when discussing battering, or
- ambivalent statements about battering.

Conclusion

The pregnant woman who is beaten by her mate is in a high-risk situation in which not only her own health but that of her fetus are threatened. The abuse, psychological or physical, she receives comes at a time when her own feelings of vulnerability are heightened. Ironically, in light of the potentially devastating effects of wife-battering during pregnancy, pregnancy itself my precipitate family violence.

Health Professionals who are sensitive to the problem of wife battering during pregnancy and familiar with its clinical manifestations can do a great deal to minimize its possibly deleterious effects on both maternal/fetal outcomes and maladaptation to parental roles. Through appropriate intervention and referral, they can help the woman to improve her decision-making skills. By making the best use of available resources, these efforts will not only help promote health and safety for the mother and baby, but may foster more adaptive affectionate patterns within these families in the future.

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APPENDIX

Helton, Anne, Rn, MS, Acce, Protocol of Care for the Battered Woman March of Dimes Foundation, 1987.

EFFECTS OF BATTERING OVER TIME ON:

Women Isolation from others • Low self-esteem, depression • Increased alcohol or drug abuse • Emotional problems, illness • Apparent denial of terror, anger • Pain and injuries • Permanent physical damage • Death

Children Emotional problems, illness • Increased fears, anger • Increased risk of abuse, injuries, and death • Repetition of abuse behavior.

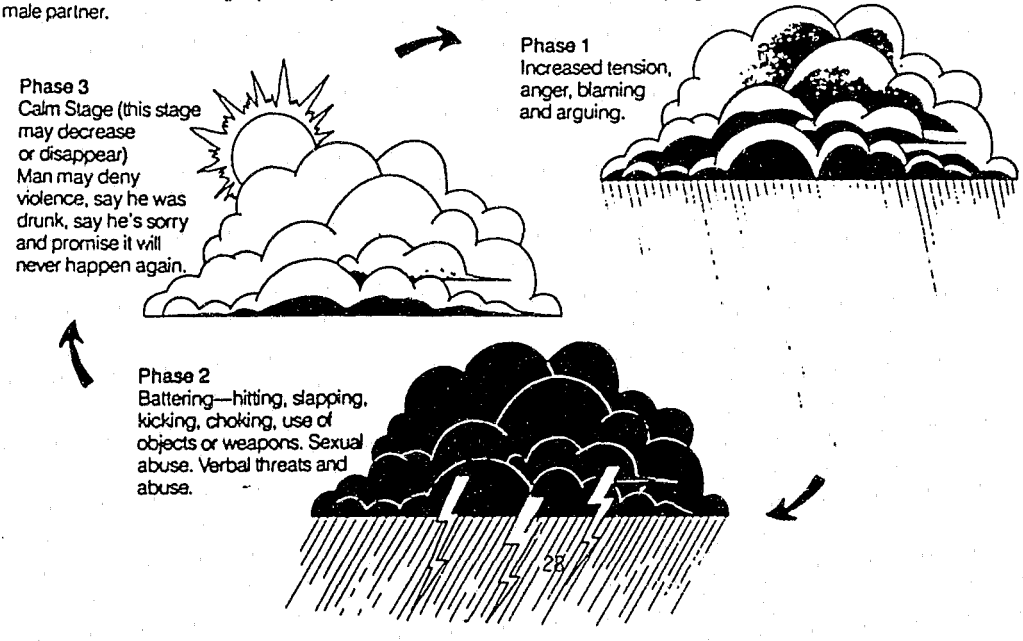
Men Increased belief that power and control are achieved by violence • Increase in violent behavior • Increased contact with law enforcement • Increased emotional problems • Decreased self-esteem.

Society Increase in crime • Increase in legal, police, medical and counseling costs. Cost of prison • Lost work time, increased insurance costs • Perpetuation of myths of inequality of women and men • Perpetuation of Cycle of Violence • Decrease in quality of life

CYCLE OF VIOLENCE

Most batterers exhibit a behavioral pattern that has been described as a cycle of violence. The cycle of violence has three phases. PHASE ONE: The need for power and control, a history of family violence, and learned behavior are some factors underlying battering behavior. For some men, phase one begins with anger, blaming, and increased tension. It is followed by phase two, the battering incident. PHASE TWO: This may be a one time slap, push or punch, or it may be hours of repeated beatings, and ritualistic terror, with objects or weapons used to further injure or threaten the woman's health. Sometimes sexual abuse also is present. In some situations, phase three follows. PHASE THREE: The man may deny or minimize the battering, promise to never hit again or blame the woman for 'causing' him to 'lose his temper'.

Most battered women (and their children) recognize the behavioral pattern of the male partner and attempt various coping mechanisms to prevent or decrease the severity of impending battering. Usually no matter what the woman attempts to do to prevent the battering, she is still battered. Many battered women fear retaliation, feel guilty or worry about economic pressures when attempting to leave a violent male partner.



ABUSE ASSESSMENT

These questions may help you when assessing female patients for abuse. For some women, answering "sometimes" to abuse questions is easier than *yes* or *no*.

1. Do you know where you could go or who could help you if you were abused or worried about abuse?
   Yes _____ No _____
   If yes, where _____.
2. Are you in a relationship with a man who physically hurts you?
   Yes _____ No _____ Sometimes _____
3. Does he threaten you with abuse?
   Yes _____ No _____ Sometimes _____
4. Has the man you are with hit, slapped, kicked or otherwise physically hurt you?
   Yes _____ No _____ Sometimes _____

For Pregnant Patients

5. If yes, has he hit you since you've been pregnant?
   Yes _____ No _____ Not Applicable _____
6. If yes, did the abuse increase since you've been pregnant?
   Yes _____ No _____ Not Applicable _____
7. Have you ever received medical treatment for any abuse injuries?
   Yes _____ No _____ Not Applicable _____
8. If you've been abused, remembering the last time he hurt you, mark the places on the body map where he hit you.
9. Were you pregnant at the time?
   Yes _____ No _____ Not Applicable _____.

When assessing for abuse, some women may be uncomfortable with the topic and may exhibit some of the behaviors below. For some women these behaviors may be suggestive of abuse and disclosure of battering may follow at a later date.

Actions Suggestive of Abuse

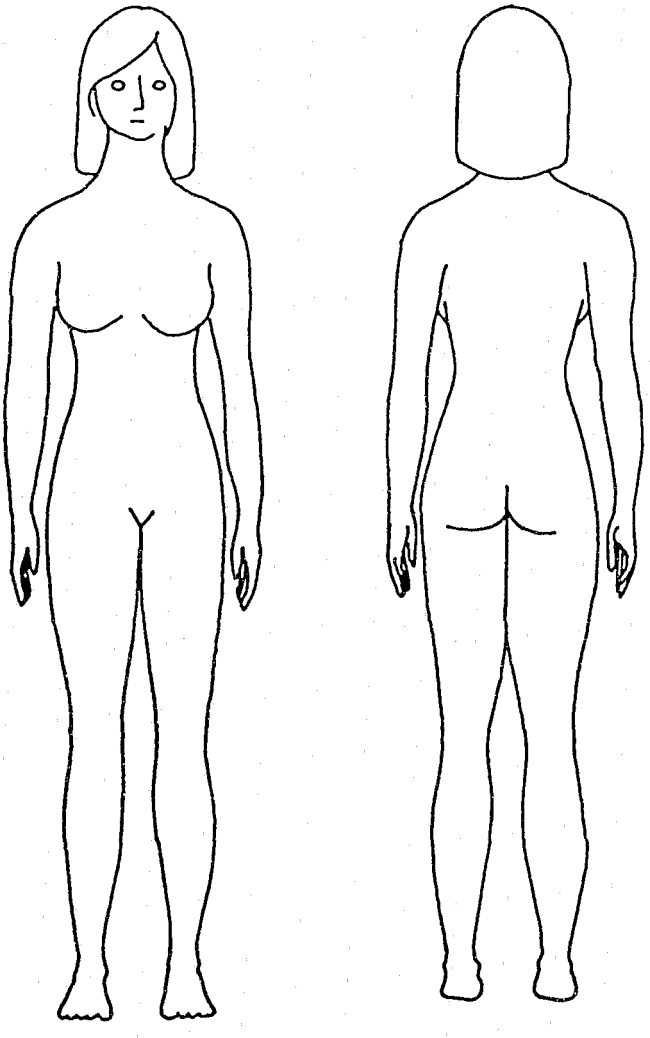
1. Laughing/"tittering"	yes	no
2. No eye contact (not applicable in some cultures)	yes	no
3. Crying	yes	no
4. Sighing	yes	no
5. Minimizing statements	yes	no
6. Searching/engaging eye contact (fear)	yes	no
7. Anxious body language (standing to leave, dropped shoulders, depressed)	yes	no
8. Anger, defensiveness	yes	no
9. Comments about emotional abuse	yes	no
10. Comments about a "friend" who is abused	yes	no

EVALUACION DE ABUSO

1. ¿Conoce Ud. adonde y con quién una mujer maltratada o preocupada con la posibilidad de ser maltratada podría recurrir?
   si _____ no _____
   Si sí dónde y con quién? _____.
2. ¿Tiene Ud. una relación con un compañero o esposo que la maltrata fisicamente?
   si _____ no _____ a veces _____
3. ¿Su esposo o compañero la ha amenazado? (Ha dicho que le va a pegar o maltratar?)
   si _____ no _____ a veces _____
4. ¿Ud. ha sido golpeada, boleteada o le ha dado palmazos en la cara su esposo o compañero?
   si _____ no _____ a veces _____

Para Pacientes Embarazadas

5. ¿Él la ha golpeado o maltratado desde su embarazo?
   si _____ no _____ no aplica _____
6. ¿Se ha incrementado el maltrato desde que se embarazó?
   si _____ no _____ no aplica _____
7. Alguna vez, ¿Ud. ha recibido tratamiento médico (cuarto de emergencia, hospital o doctor) por injurias causados por el maltrato?
   si _____ no _____ no aplica _____
8. Si la ha maltratado, por favor, marque en esta hoja los lugares donde fue golpeada la última vez.
9. Durante esa última vez, ¿estaba Ud. embarazada?
   si _____ no _____ no aplica _____



INDICATORS OF POSSIBLE BATTERING

(Not necessarily in order of prevalence)

IN FEMALE:

- Change in appointment pattern: either increased appointments with somatic, vague complaints or frequently missed appointments
- Self directed abuse, depression, attempted suicide
- Severe anxiety, insomnia, violent nightmares
- Alcohol or drug abuse
- Complaints of jealous, possessive male partner
- Frightened of partner's temper
- Defends partner's behavior ("rescues")
- Hit, slapped, kicked, shoved or had objects thrown at her by partner
- (For some women) Abused as a child or seen mother abused

IN MALE:

- Explosive temper
- Criticizing and denigrating female partner, frequent "put downs"
- Controlling of female, attempts to control health care setting environment (may arrive unexpectedly)
- Breaks, throws objects when angry
- Makes all decisions on money and family
- Overprotective
- Jealous, suspicious
- Has hit, slapped, pushed partner
- Alcohol or drug abuse
- Witnessed abuse as a child or was abused as child
- Defensive, particularly about inquiries regarding relationship with partner

IN CHILDREN:

- Child Abuse, unexplained injuries, scars
- Somatic, emotional and behavioral problems
- Violent behavior (particularly in boys)
- Sleep disturbances
- Difficulty in School, poor attention span
- Complaints of headache, stomachaches
- Increased fears

APPROACHES FOR ASSESSING THE BATTERED WOMAN

PREPARATION:

1. Always assess women for battering in a private place, away from the male partner.
   Questioning in front of the male partner may place a battered woman in danger. Batterers frequently threaten the woman to maintain the secret of violence.
2. If children are present with the woman, utilize staff to watch the children in order to allow privacy when assessing the woman for battering.

PROCESS:

1. Maintain eye contact when assessing women for battering. (For some cultures this may be inappropriate.) Battering is a health problem. Approach the topic as you would when assessing for other health risks. If a woman does deny battering, or becomes upset at being questioned about it, explain that all your patients are screened for battering. Explain the concern health care providers have about the problem of violence against women.
2. Encourage but do not badger the woman to respond to the abuse assessment questions. A woman will choose when to share any history of violence with a health care provider. More time may be necessary for some battered women. Once the topic of battering has been opened, trust in the health care provider is necessary in order to encourage disclosure.
3. If you suspect or have evidence of battering, describe the cycle of violence, review the process of repetitive and escalating violence. Permit the patient to describe her situation, she may identify it as containing some or all of the elements of the cycle. Provide an environment which allows her to speak freely. *You may be the first person, particularly the first professional,* to acknowledge the problems she has experienced.
4. Provide all female patients (battered and non-battered) with written referral information for community resources for battered women (police emergency, shelter, counseling, legal, etc.).

HELPING COMMUNITIES BUILD EFFECTIVE CHILD ABUSE PREVENTION PROGRAMS: THE ARKANSAS MODEL

Becky Williams

In March of 1983 children in Arkansas were having a rough time. A number of interested citizens representing child welfare agencies set up a meeting with Governor Bill Clinton to discuss the growingly visible problems of physical, emotional and sexual abuse. At the meeting the Governor's administrator said that child abuse was second only to drunk driving in the number of letters received at the Capitol from the public. The Governor, concerned about social issues, appointed a one year Task Force on Child Abuse with the primary focus to be on sexual abuse. The purpose of the Task Force was to develop legislation for the coming legislative session. A comprehensive package of legislation passed the legislature. In addition the Arkansas Child Sexual Abuse Education Commission was formed.

A new focus for the Task Force was added in 1984 when the Prevention Subcommittee originated. Title XX agreed to pay the salary for a staff person for fourteen months to assist the Task Force. This funding indeed proved to be critical in allowing the manpower to lobby for legislation and do the leg work for development of a prevention plan.

I was asked to chair the Prevention Committee in the Spring of 1984. Child abuse prevention to me at that time was a vague ideal which sounded wonderful but unattainable. What could really be done to prevent abuse other than foster care?

The Prevention Committee worked for 1 1/2 years researching, brainstorming, writing and even visiting other states, to formulate a comprehensive plan for developing a Child Abuse Prevention Plan for Arkansas. The small committee included a representative from school, health, cooperative extension, mental health, church, law enforcement, social services, media, industry, and a parent center.

An interim report in 1985 listed the following objectives for the final eight months of work:

1. To identify high risk groups in Arkansas.
2. To identify and study effective prevention programs already existing in Arkansas and in other states.
3. To target specific prevention programs that would reach those groups identified as high risk.
4. To prepare a plan which could be implemented through agencies and community based prevention task forces.

The committee discovered a wonderful breakdown of levels of prevention and intervention - The Maine Triangle (Attachment 1). This triangle clearly defines the difference between prevention and treatment, a distinction which is difficult for many people to understand. The difference however is critical for funding of prevention programs.

A public health epidemiologist participated in the planning and contributed a valuable, unique perspective. She calculated abuse rates for each county and the state, not previously compiled by any other agency. She also developed a plan by which child abuse reporting information and vital records information (birth weight, age of parent, number of prenatal care visits) could be correlated by sharing data between two state agencies. This would pinpoint specifically who in Arkansas is at high risk.

The Task Force staff person visited two states, Kansas and Iowa, with statewide prevention programs. Through these visits he learned about Children's Trust Fund legislation and the National Committee for Prevention of Child Abuse, two prevention strategies which would develop into key components of the Arkansas Plan.

Iowa was funding a number of model programs in the state (Attachment 2). These programs represent prevention services which reach families at critical stages of their development. Some of the services target specific types of families more at risk for potential abuse.

The Committee recommended four courses of action:

1. Public and private agencies need to emphasize preventive services.
2. The three state agencies that work with families, Department of Health, Department of Human Services and Department of Education would (a) develop training for staff in prevention services, (b) develop primary and secondary prevention programs, and (c) develop a coordinated relationship leading to model projects at the state and local levels.
3. Public, private sector, foundation and advocacy groups should work cooperatively to promote a comprehensive system of prevention.
4. A Children's Trust Fund to support prevention programs should be established.

The report went to the Governor, the Task Force disbanded and the responsibility was left in the hands of the community to take some action on these recommendations. This was a critical time as it is in the development of any new initiative. Committees make recommendations but often reports are filed, staff move to new projects and no institutional change occurs.

However in Arkansas a core group of people decided to incorporate an Arkansas Chapter of the National Committee for Prevention of Child Abuse to implement the recommendations.

The NCPCA board set two goals: supporting legislation for the formation of the Children's Trust Fund and providing support, direction, and consultation to county child abuse task forces. Board members represented all regions of the state and included legislators, the business community, advocacy groups, social service and health agencies, and private citizens (Attachment 3).

The board set membership fees ($5), nominated officers and develop committees. They selected three primary activities for 1986-87.

1. Passage of Children's Trust Fund Legislation
2. Child abuse Prevention Month
3. Child Abuse Prevention Conference

Children's Trust Fund Legislation

The Board knew that 1987 would be a tough time for passage of any new revenue raising legislation. Arkansas suffered a severe recession the previous few years resulting in many layoffs, elimination of programs, and a very conservative fiscal perspective on the part of legislators. The Governor decided to include the Trust Fund legislation in his legislative package, a tremendous boost.

The key components of the legislation included:

a) Administration: The Trust Fund Board would be an autonomous agency receiving administrative assistance the first two years from the Governor's Office. Members on the Board would represent each Congressional District. The Board could use a portion of the funds for administrative staff and maintenance and operation of the Trust Fund.
b) Funding: A $5.00 surcharge on marriage license fees would raise approximately $160,000 the first year.
c) Local Councils: Each county interested in competing for funds would have to form a local to review all grant proposals and select one to represent that county. Representation on the council must include the Health Department, Law Enforcement, Children and Family Services, local school district, and a private citizen. The local council concept would assure community support and agreement on the priorities established within that county.

A Board member on staff with Arkansas Advocates for Children and Families led the lobbying effort. She laid a firm foundation for passage before the legislation was even presented.Legislative lobbying concentrated on key legislators supportive of chldren's issues. The national Junior League included Children's Trust Fund legislation as a priority so the Little Rock Chapter was recruited for assistance through individual lobbying and hosting a legislative lunch.

To our joy the legislation passed unanimously to become effective July 1987. The first grants were submitted two weeks ago to be funded the Summer of 1988. Councils developed in over half the counties in the state and over 25 proposals were submitted to the Trust Fund Board. In 1989 Arkansas will become eligible for federal challenge grant funds administered through The Department of Health and Human Services.

Child Abuse Prevention Month

Until 1987 Arkansas focused almost entirely on identification, reporting and treatment of child abuse. The Board felt a strong need to conduct an extensive public awareness campaign showing that child abuse is a problem and has to stop; it can be prevented; and, here is how you can help.

This was a fun committee for me to chair. With donated time and money from a wonderful ad agency, two banks, an insurance company and a hospital, we produced a beautiful brochure with no cost for the Chapter. Public awareness activities occurred all during the year with the concentration of the campaign happening in April to coincide with National Child Abuse Prevention Month. We co-hosted a reception at the Governor's Mansion and presented the Governor and the two legislators who sponsored the Trust Fund legislation baseball caps with our emblem, ACAP (Arkansas Child Abuse Prevention). With the enthusiastic cooperation of a school, children released 1,000 balloons with little tags which were returned to the children through the mail from as far away as southern Arkansas. The media loved the color of this event. We all became instant celebrities on television public affairs shows, radio talk shows and newspaper blitzes. I knew we were getting the word through when a friend told me they heard me at a Wal-Mart Store over the radio being interviewed about child abuse prevention.

Child Abuse Prevention Conference

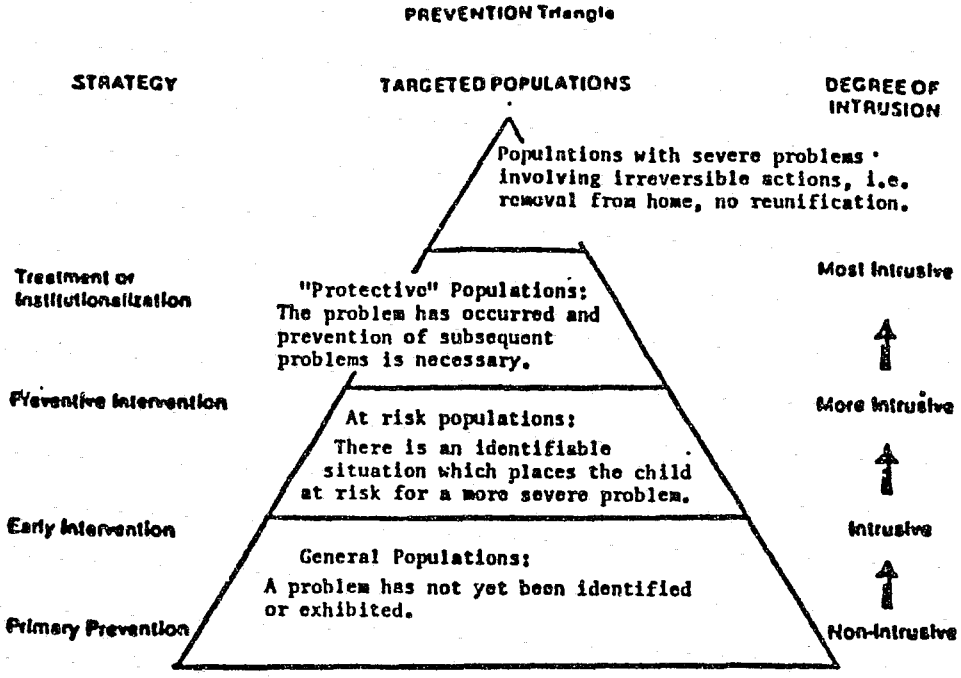
Three months later in July the NCPCA accomplished its final goal for the first year. The Chapter co-sponsored with 16 other community agencies the state's first conference devoted solely to child abuse prevention. The program committee designed the

conference with three purposes in mind: to help groups identify prevention programs, to devise strategies for achieving community based prevention programs and to build coalitions to facilitate local programs.

Conference stipends were supplied for representatives from all parts of the state. The Conference proved to be a foundation for local councils and community prevention strategies.

Where do we go from here? Two agencies in Arkansas received grants from the National Center of Child Abuse and Neglect to work with pregnant and parenting teens to decrease their potential for child abuse. The projects funded from 1986-1990 match teen parents with either college student "Special Friends" or community "Grandmothers." The Arkansas Department of Health incorporated one model into its ongoing services at the end of the grant period.

The Arkansas Model presents one state's development of an exciting, integrated prevention system. Hope is present in the state as well as a feeling of competency. This spirit will save children's lives and will allow families to be healthy homes for our state's most precious resource.


PREVENTION Triangle
STRATEGY
TARGETED POPULATIONS
DEGREE OF INTRUSION
Populations with severe problems involving irreversible actions, i.e. removal from home, no reunification.
Treatment or Institutionalization
"Protective" Populations: The problem has occurred and prevention of subsequent problems is necessary.
Most Intrusive
Preventive Intervention
At risk populations: There is an identifiable situation which places the child at risk for a more severe problem.
More Intrusive
Early Intervention
Intrusive
General Populations: A problem has not yet been identified or exhibited.
Primary Prevention
Non-Intrusive

IOWA PREVENTION PROGRAMS

Attachment 2

1. Home Health Visitor
2. Respite/Crisis Child Care
3. Parent Aide
4. Parenting Education
5. Young Mom's Project
6. Sexual Abuse Prevention
7. Services to High Risk Youth

ARKANSAS CHAPTER
NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE

Attachment 3

BOARD MAKE-UP

Regional representation
Private citizen
Business community
Legislators
Media
Ad agency
Judge
School of social work
Social agencies

COMMITTEES

Public Awareness ---------- Media Campaign
Legislation (Advocacy) -- Children's Trust Fund
Membership ---------- Recruitment
Nominating ----------Broaden Board Representation
Local Coalitions ---------- Local Development
Programs ---------- Prevention Programs
Finance ---------- Funding

PUBLIC HEALTH SOCIAL WORK AND CHILD WELFARE SOCIAL WORK: A TEAM APPROACH TO CHILD ABUSE INTERVENTION

Rhonda R. Brode, M.S.W., L.I.S.W.
Pamela Stokes, M.S.S.W.

Introduction

Child abuse or maltreatment more than likely has been with us as long as there have been parents and children. The dramatic rise during the last 25 years suggests that it has only recently been discovered. Yet the well publicized case of a child named Mary Ellen brought about the founding of the Society for Prevention of Cruelty to Children in 1874. Since then, the legal responsibility to protect children has been moved from the private sector to the public sector with the passage of the Social Security Act of 1935.

The present surge of attention to child maltreatment stems from the rediscovery of child abuse by the medical profession with the development of radiology. This invaluable diagnostic tool allows for discovery of seemingly unexplained injuries to children such as subdural hematomas, skull fractures and radial fractures of limbs that have occurred as a result of inflicted trauma. In 1962, Kempe and several colleagues coined the term "battered child syndrome" to describe the phenomenon which could now be medically documented. Their trend-setting report sparked the interest of a variety of professional disciplines and led to increased allocation of resources to deal with the problem. In the late 1960's legislation mandating the reporting of child maltreatment had been enacted in every state. In 1974, PL93-274 was signed establishing the National Center on Child Abuse and Neglect (NCCAN) to coordinate the federal response to the child maltreatment problem. Although the reporting laws have extended legal responsibility to a wide range of professional disciplines, child maltreatment has always been the domain of social work in terms of program development and service delivery.

Definitions

Like other social phenomena, child maltreatment is plagued with vague and imprecise definitions. Part of this is the result of a lack of uniformity in state laws. Most statutes do differentiate between abuse and neglect, and some make a distinction between physical and emotional maltreatment (up until March 1988, Ohio did not).

Some definitions focus on outcomes in terms of injury; others are concerned with the intentions of the perpetrator. Often the distinction between abuse and neglect in the law is the difference between acts of omission and acts of commission. Physical maltreatment is typically the easiest to identify because it is overt in outward appearance. Yet the water gets murky as neglect and emotional maltreatment enter the picture. Sexual abuse has further clouded the issues in definition. "...Given the ambiguity surrounding statutory definitions of abuse and neglect, the application of these definition necessarily involves interpretations and judgments based on the values and attitudes of the decision maker. Thus, definitions used by professionals designated as mandated reporters often vary according to the discipline of the reporter, whether social work, medicine, psychiatry, psychology, sociology, law, or education. These professional groups recognize the lack of clarity in criteria for judging maltreatment. Moreover, confusion about definitions is not limited to professionals, but extends to the general public..." [Encyclopedia of Social Work, 1987, p.223.]

Reports of abuse and neglect are typically directed to public child welfare agencies for investigation. Once reports have been substantiated, plans for intervention can be developed and implemented. Again, the determination of whether abuse or neglect has actually occurred reflects the judgment and values of the protective service worker who conducts the investigation. Thus, social work plays a primary role in the official labeling of a case as abuse or neglect, thereby determining whether the case gains entry into the protective service system. [Encyclopedia of Social Work, 1987, p. 223-224.]

The potential for bias in labeling cases is enormous as it often involves judgment calls based on the values and personal experiences of the reporter and the worker receiving the report. This problem stands in the way of much of the quantitative research on child maltreatment. Researchers base their studies on what is reported and recognized. The difficulty in definitions affects what we have to work with in determining incidence of child maltreatment. Available incidence statistics represent at best an underestimate of the true incidence of maltreatment.

Incidence

In 1970, David Gil attempted to document the scope and magnitude of physical abuse. Focusing on cases that met the study definition of physical abuse as intentional acts of commission or omission, Gil's data yielded an incidence of 5.883 cases for 1967 (8.4 per 100,000 children under 18 years of age in the total population) and 6,617 cases for 1968 (9.3 per 100,000 children under 18).

The fact that reported cases underestimate the true incidence of abuse is illustrated by projected estimates reported by Gil (1970). Based on an earlier survey of public opinion and knowledge about physical abuse using a nationally representative sample, estimates indicated that from 2.5 million to 4 million adults knew families who physically abused their children, for a rate of 13.3 to 21.4 incidents per 1,000 persons. Gil pointed out that these figures were likely to overestimate the incidence of abuse because of overlap in families known to more than one respondent. Based on revised calculations from Gil's survey dates, Light (1973) estimated the annual incidence of physical abuse to be between 200,000 and 500,000 cases.

Under the auspices of the National Center on Child Abuse and Neglect (NCCAN), a study was carried out to determine the national incidence and severity of child abuse and neglect for a one-year period from May 1979 through April 1980 [National Center on Child Abuse and Neglect, 1981]. Based on data from a sample of child protective service agencies and other community agencies, such as schools, hospitals, courts and police, the projected estimate for the annual number of abused and neglected children nationwide was 652,000 (10.5 per 1,000 children under 18). Given the study findings that a substantial proportion (79 percent) of maltreated children known to non-protective service agencies were not officially reported to protective service agencies, the investigators viewed their incidence estimate as conservative and the actual incidence more likely to be at least one million. The incidence rates for abuse and neglect were similar: 5.7 per 1,000 children for abuse (including physical assault, sexual abuse, and emotional abuse) and 5.3 per 1,000 children for neglect (including physical, educational and emotional neglect). Restricting the type of maltreatment to physical assault and physical neglect showed that the rate for abuse (3.4) was twice that for neglect (1.7). [Encyclopedia of Social Work, 1987, p. 224-225.]

The most elaborate data base of the incidence of reported cases of maltreatment has come from American Humane. In an analysis of trends for a seven year period from 1976-1982, Russell and Trainor found the following: although there was a dramatic increase (123 percent) in the number of reports of all forms of maltreatment from 416,000 in 1976 (10.1 per 1,000 children) to 929,000 in 1982 (20.1 per 1,000 children), the rate of increase declined each year [American Humane, 1984.]

This increase in cases did not necessarily signify an actual increase in incidence, but did show increased attention to reporting. The study showed that the proportion of reported cases has remained somewhat constant over time. Composite figures for the seven year period showed 25 percent of reported cases involved physical abuse (ranging from 19.4 percent to 27.6

percent) and 64 percent involved neglect (ranging from 59.4 percent to 70.6 percent.) Categories of sexual, emotional, and other maltreatment were excluded from these figures.

These figures stand in contrast to those from the National Incidence Study (National center on Child Abuse and Neglect, 1981), which showed that the rates of incidence for abuse and neglect were approximately equal when each was broadly defined and that abuse cases outnumbered neglect cases when only physical abuse or physical neglect was considered. These differences in findings are likely to result in part from the inclusion of unreported cases in the data of the National Incidence Study.

Again, the definitions of emotional and sexual abuse have been so clouded that no good data is available on the incidence of either one on a national basis.

To bring this information to a level where it is related to micro issues, the incidence of cases for Dayton (Montgomery County), Ohio will follow. Montgomery County is characterized by the following features: Dayton is the central city of a four county metropolitan area in southwestern Ohio, approximately 50 miles north of Cincinnati. In the 1960's, Dayton's population peaked at nearly 300,000. Currently, the population is 181,159 which is 1/5 of the region's population and 1/3 of Montgomery County's. Thirty percent of the city's population is Black and approximately 30 percent are first and second generation Appalachian migrants. A large percentage of the area's poor, unemployed and "at Risk: populations are located in the Dayton city area, although there are intermittent pockets of at-risk populations throughout Montgomery County.

For 1987, Montgomery County Children Services, the local public agency, showed the following intake statistics:

Families Served:

Family cases carried over fro 1986	350	
Family cases referred during 1987	4,093	
Total families served 1987		4,443

Intake Case Dispositions:

Families closed at intake	2,930
Families transferred for ongoing service	1,075
Families continuing in intake	438

Referral by Type Complaint

1987 "New" Referrals Total			4,093
Neglect referrals	2,018	(49.3%)	
Physical abuse referrals	1,130	(27.6%)	
Sexual abuse referrals	508	(12.4%)	
Dependency referrals	245	(6.0%)	
Other referrals	192	(4.7%)	

36.4 percent of referral complaints were substantiated or indicated. This represented a 10.8 percent increase over 1986 figures.

In addition, the following statistics apply for protective, in home services:

Families Served:

Family cases carried over from 1986	1,284	
Family cases added from intake 1987	1,075	
Total families served 1987		2,359

Family cases closed 1987	1,067
Family continuing to receive protective in home services (12/31/87)	1,292

This represents a 25.9 percent increase over 1986.

This nagging issue continues to be why abuse occur, when do we intervene in families where maltreatment occurs, and how do we prevent maltreatment before it occurs? As the primary gatekeepers, social workers are in a unique position to answer these questions.

The multi-dimensional nature of child maltreatment calls for a multidimentsional approach to problem solving. The key lies in coordination of services within and among service delivery systems. A logical point to begin coordination is with the health and child welfare systems.

Differing Roles of Public Health and Child Welfare Social Workers

A. Child Welfare

One of the most frustrating aspects of discussing child welfare social work is the lack of uniformity of models or interventions used. No one particular model is used across the board nor do state laws even closely resemble each other. Model statutes and protection acts have been proposed, but none widely implemented. We do know that ..."Currently, most states have a hotline to receive abuse and neglect reports (34 states), a state central registry (45 states, 32 computerized), specific guidelines for conducting investigations (48 states, 12 with specialized handbooks), and the capacity to respond to reports 24 hours a day (47 states, 32 through on-call systems). Only nine states separate the task for investigation from the provision of social services statewide; some do so in individual counties. Thirteen states respond to all calls within 24 hours; three states complete investigations within ten days." [Child Welfare, Nov./Dec. 1987, p. 531.]

The role of the protective service worker is complex and demanding and becoming more so every day. The legal issues, liability suits and severity of cases further compound the problem. If you were to ask a child protective service(CPS) worker, what they perceived their role to be, they would probably answer "to be all things to all people"--and some of that perception is accurate.

American Humane, is an excellent volume entitled Helping in Child Protective Services, relay the following about being a protective service worker:

1. As a CPS worker, you are the individual most directly involved with safeguarding the rights and welfare of children.

2. Your overall responsibility comes from the many different roles which you must play.

    a. You are first a treater. You work directly with families in helping them to stop maltreatment and to learn new ways of relating to and being responsible for the involved children.
    b. You are also an assessor. You study and analyze information about the client, the client's problems, available services, treatment strategies, etc.

c. You are a professional. You embody the principles, standards, theories and techniques of social work as a method of working with people and a personal life philosophy.
d. You are an administrator. You maintain accurate records on your work.
e. You are a supervisee. You maintain close contact with your supervisor for assistance in decision making and in dealing with the many personal problems and conflicts that protective services work can cause.
f. You are a case manager. You orchestrate all planning, referral and follow-up activities related to your cases.
g. You are an advocate for both the child and the parents. In other words, you represent them in all agency matters.

3. You, as a CPS worker, perform all of these roles at different times and are the sum of these roles all the time. [American Humane, p. 16.]

Child welfare work is very difficult work for the reasons explained previously,but also for some very individual reasons. Child welfare is an intrusive field of practice. The responsibilities of the PS worker are legally mandated, with the mandates becoming more complex as time goes on.

The intrusive nature of the work almost automatically creates hostility and resistance on the part of the client. The questions a PS worker must ask during an investigation may appear to question a client's worth and capability to parent. Often they are explosive or personal issues.

Child welfare workers experience a tremendous burden of responsibility which makes their job more difficult. American Humane explains it as follow:

"1. The community gives you an incredible task in terms of identifying and rehabilitating abusing/neglecting families.
2. You must respond immediately to referrals. You may have more referrals than you are able to manage.
3. Nevertheless, immediate response is important because a child's safety may be at stake. The decisions you make about a child's safety may be life or death decisions.
4. At the same time, you must make these decisions on the basis of a relatively brief encounter, and you must decide whether to recommend that a family be separated or that a child be removed from his or her home..." [American Humane, 1980, p. 17.]

This is compounded by the effect of trying to balance the authority and treatment roles.

"1. In your humanistic, helpful role you perceive the parent as a victim along with the child.
2. However, if you are inclined toward the authoritarian role, you may see the parent as a perpetrator who must answer for his or her actions.
3. These two roles appear to be in direct conflict and may result in frustration. However, both roles are important, and they are compatible.
   a) While law and policy define your responsibility in terms of the expression of authority, authority can be invoked humanistically (see the chapter on The Use of Authority).
   b) Consulting with supervisors and others can help you to be more objective so that your compassion does not blind you but at the same time you do not become punitive in your approach..." [American Human, 1980, p. 17-18.]

There are some additional broad issues that affect the overall scheme of child welfare practice which bear mention here. As previously alluded to in the introduction section, child abuse and neglect reports are on the increase. Between 1976 and 1983 the increase in reports was 142 percent for the United States (American Association for Protecting Children). A caseload for an average worker in our county was 40 families in 1987. Child Welfare League of America maintains a standard of 21 cases. Montgomery County is not unique.

Workers continue to struggle with how to respond in a timely manner to referrals and to serve the best interests of the child.

*B. The Role of the Medical Social Worker

The practice of social work in the health arena provides social workers with a unique opportunity to impact on the incidence of illness and disease. Psychosocial factors, such as low self-esteem, can potentially aggravate a medical condition and determine its length and severity. Medical social workers are involved with "patients" and their families during all stages of the life cycle and can assist with illness prevention and improvement of social functioning.

One of the elements of medical or public health social work that makes a distinction between other areas of social work is practice in the multidisciplinary setting. Social workers are members of a multidisciplinary team which consists of a physician, nurse, occupational therapist, chaplain and

dietitian. Each team member is responsible for contributing their particular skills and knowledge toward the team goals of providing quality health care and maximizing health and/or social functioning. This team work insures that "patients" and families receive comprehensive care. Another distinction is that "...the social worker, in order to function effectively as a member of the professional team in the health field, must master a considerable body of technical medical and related knowledge; the basic concepts and principles relating to health, disease, and medical care must be thoroughly grasped; selected knowledge regarding the major conditions and diseases is necessary; and the needs, attitudes, and behavior of the sick person must be understood." [Harriett Bartlett, 1961.]

Another element that differentiates public health social work from other social work settings is the emphasis on prevention, especially with respect to large population groups. In 1981, the National Association of Social Workers developed standards for public health that included an emphasis on health promotion and illness prevention:

> "Social workers in public health settings focus on the promotion of positive health behaviors in the development of lifestyles by individuals, families and groups; enhancement of the environment; and avoidance of risks.
> "They use the epidemiologic approach in solving community health problems. They assess the health needs of the target population and determine the association between social factors and the incidence of health problems. They plan interventive strategies on the five levels of prevention: (1) promotion of health, (2) specific protection, (3) diagnosis and prompt treatment, (4) limitation of disability, and (5) rehabilitation.
> "Their emphasis is on reducing the social stress associated with the health problems and determining the social supports that will promote well-being and provide protection against ill health. Even though the social worker's point of entry into a health problem may be in the pathogenic phase, he or she has responsibility to study the extent and distribution of the health problem in the community and to participate with members of the public health team from other disciplines in reducing the incidence of the health problems and the severity of its impact."

C. Jean Morton, in the publication "Public Health Social Work in Maternal and Child Health, A Forward Plan," listed the following objectives of public health social work:

1. To assure provision of psychosocial services for individuals and families, directly or through referral;
2. To provide knowledge about community service networks to consumers and other health care providers;

3. To work with other disciplines to ensure delivery or comprehensive care;
4. To promote social work values within the health care system (e.g. self-determination);
5. To encourage consumer participation in the planning and evaluation of services;
6. To acknowledge characteristics of the system that prevent access or decrease the utilization of services;
7. To document for program policy changes the social conditions that interface with attainment of health.

The medical social worker's role is also "complex and demanding." The medical social worker operates in a setting that primarily functions within the medical model and it is sometimes difficult for medical personnel to understand the correlation between psychosocial problems and illness. A health setting may not offer the degree support that a social services agency would offer a social worker. Medical social workers on a day-to-day basis are resolving conflicts concerning what "the patients want," what "the family wants," and what "the Physician wants." We, too, feel as if we have "to be all things to all people.

"Characteristics of Referrals to Child Protective Service

The health setting is an entry point for many cases of suspected child neglect and dependency situations. Some of the typical referrals are:

A. Child Abuse

1. Injuries that conflict with the parents' explanation (i.e. a spinal fracture is caused by a twisting motion and is a very suspicious injury, particularly if the parents' explanation is that the child fell).
2 Drug use during pregnancy and subsequent "drug withdrawal" of infants are major concerns in Montgomery County. With the rise in the incidence of crack use, we are seeing an increase in the numbers of women who use drugs during their pregnancy. In Ohio, maternal drug abuse is not recognized as child abuse under the state statues and it is difficult for the child protective agency to intervene unless the infant experiences a drug withdrawal. Unfortunately, cocaine is a drug that inhibits the respiratory system and can cause Sudden Infant Death Syndrome (SIDS) or respiratory distress syndrome--a disease associated with prematurity--but does not necessarily result in the tremors that we usually associate with "drug withdrawal." Also, some drugs will not cause a

withdrawal effect until two weeks of life, which presents a serious health threat to a drug dependent newborn. Drug addicted mothers [have also been known to] administer drugs to their infants in an attempt to perhaps quiet a colicky and teething infant.

3. Sexual Abuse. As mentioned previously, reporting of sexual abuse cases is on the rise. Suspicious infections of the vagina, anus or throat of young children are reported to the child protective agency as possible sexual abuse cases. We very seldom can observe signs or symptoms of physical indicators of sexual abuse. Sometimes sexual abuse is discovered when preteens become pregnant. We have a sexual abuse team in Montgomery County that consists of a hospital social worker, Children Services Board caseworker, police detective and victim witness worker. The sexual abuse team responds as a collaborative effort to insure that children are treated with dignity and not forced to repeat their stories over and over.

B. Child Neglect

1. The homeless situation is a crisis in our country and across the nation. We do not permit newborns to stay in emergency shelters with their parents; but there is generally only a very small percentage of parents who do not have some type of housing for their children.
2. Poor nutrition/failure to thrive and noncompliance of medical follow-up are concerns that can usually be well documented by medical personnel. It is important for social workers to recognize that there are two types of failure to thrive: a. Organic. Usually associated with a medical abnormality. b. Non organic. Usually associated with lack of adequate nutrition and/or bonding.
3. Poor judgment usually occurs as a result of inadequate parenting skills. There was a case at Miami Valley Hospital where a 17-year old young woman jumped out of her second story window with her 2-year old daughter because she did not want her parents to know that she was leaving the house. As a result, the young woman was injured and taken to the emergency room of the hospital. The toddler, who was not injured, was placed in the custody of the young woman's parents.

C. Child Dependency

Women who have severe mental health and/or mental retardation concerns are referred to CSB, particularly if they do not have a strong family support system. Infants and children who require a lot of high tech home care (i.e. oxygen

equipment, apnea monitors, 24-hour close supervision) are a source of referrals to CSB, particularly if the parents possess inadequate parenting skills or need additional support. Children whose caretaker is hospitalized and have no other relatives to care for them are dependent and referred to CSB.

Barriers

In health settings, problems are usually quickly identified, assessed and treated. Medical staff are trained to follow a specific treatment plan that produces specific results. Child protective service cases can create conflictual working relationships between the medical social worker and the child protective service caseworker. There is seldom any one cause for abuse, neglect or dependency, nor any one treatment plan that results in immediate desired results. It is difficult for medical personnel to understand why, for instance, a child with a spinal fracture is returned to the home. In an effort to make a concerted attempt to prevent child abuse, the Miami Valley Hospital Medical Social Services and Discharge Planning Department developed the "First Time Around" project.

Joint Project: First Time Around

Miami Valley Hospital's Medical Social Service and Discharge Planning Department, Montgomery County Children Services Board, Montgomery County Combined Health District and Womanline developed a consortium that will provide parenting education, home visits and an emphasis on first time parents. Studies have shown that children from birth to five years of age represent the highest percentage of abused children. [Child Abuse and Neglect: An Informed Approach to a Shared Concern. U.S. Department of Health and Human Services. March 1986.] Physical and emotional indicators of child abuse and neglect may be more difficult to determine with the very small child because of their potential isolation and lack of advanced communication skills. The consortium is interested in targeting parents of infants and toddlers by requesting referrals from local health care providers, child care providing agencies and community services agencies such as the Montgomery County Parent Aide Program.

Montgomery County has as extremely high rate of premature births. The prematurity rate for 1980-1985 for Montgomery County is as follows: 60 per 1,000 births for white infants and 128 per 1,000 births for black infants. Infants who are premature and/or chronically ill have a higher incidence of child abuse than the rest of the population. By receiving referrals from area hospitals, the consortium can also provide parenting education, resource information and support to this particular high risk population.

There are many stresses often associated with being a first time parent. the responsibilities of caring for an infant can often impact the relationship between parents and/or siblings. First time parents are often insecure about their knowledge concerning baby care, and unsure of the best time to alert their pediatrician or health center. Child abuse and child neglect by first time parents is often the result of the following:

1. Lack of adequate support systems.
2. Lack of positive social outlets--inability to release stress and frustration.
3. Unrealistic expectations of child--directly correlated to lack of understanding of growth and development issues.
4. Postpartum depression.
5. Inadequate knowledge of appropriate discipline methods.

, This project is proposing to provide the first time parent with needed parenting information and assistance in developing a peer support system to prevent child abuse and neglect. This project will be community based and offered at three different sites (Miami Valley Hospital, East Dayton Health Center, Montgomery County Children Services Board's Westown Office) to insure that the program is accessible to the community at large. The sessions will be offered as an eight week series and followed by a joint home visit by the Montgomery County Children Services Board Caseworker III, or the Miami Valley Hospital Medical Social Service and Discharge Planning Department Medical Social Worker II and the Montgomery County Combined Health District Public Health Nurse to those participants that attend at least five sessions. During the home visit, the members of the consortium will complete an assessment tool to determine if the information and experiential activities provided in the eight week sessions were assimilated by the participants. Child care, transportation, refreshments and gift items will be offered as incentives to encourage participation in the proposed project.

Quality medical care, health education, parenting education, emotional support and resource are crucial services in view of the risks involved with this population. Early intervention by the consortium will provide a comprehensive, collaborative approach to this problem and potentially affect the incidence of child abuse and neglect by first-time parents.

Objectives

A. Goal

To provide a program that will decrease the incidence of child abuse and neglect by focusing on the development of

first-time parents' parenting skills and enhancement of their coping abilities.

B. Objectives

1. To engage ten participants per session.
2. To assess each participant's parenting abilities and knowledge during the follow-up home visit, after completion of the class series.
3. To provide information on infant safety, childhood, growth and development, bonding and sexuality, substance abuse and alternative discipline methods.
4. To increase awareness of community resources.
5. To improve understanding of emotional aspects of parenting.
6. To assist the first time parent in developing more effective life management skills.
7. To provide an opportunity for discussion and support regarding the first time parents shared concern.
8. To provide skilled nursing assessments for participants with health care issues identified during the home visits.

AIDS IN WOMEN AND CHILDREN: PRACTICE AND POLICY ISSUES

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SCOPE OF THE PROBLEM

As social workers, we have an exciting and challenging role to play in fighting acquired immunodeficiency syndrome (AIDS). Since the first cases of AIDS were reported in 1981, a global pandemic has evolved, creating unprecedented demands on health care and social services. Despite impressive medical research efforts to combat the virus, prevention remains the only effective means of control. The medical crisis of AIDS has been exacerbated by the fearful responses to the illness by health care providers and lay community alike. This case typifies the confusion about the illness which has immobilized and/or decreased the effectiveness of society to respond to this challenge.

This paper represents a summary of the AIDS' workshops presented at the Pittsburgh Conference, April 26, 1988. We are grateful to the participants who enriched the workshops by sharing their experiences of working with women and children who have AIDS. The focus of this paper is the role of social workers in meeting the unique needs of women and children who have AIDS. Women and children are always discussed together because the mother is the primary mode of Human Immunodeficiency Virus (HIV) infection to children. Often, the mother finds out that she has AIDS when her infant is diagnosed. She must deal not only with two life-threatening illnesses but also her feelings about transmitting the illness to her child. This paper will: 1. examine the medical and psychosocial features of this subset of AIDS patients, 2. highlight key issues which are adversely impacting the care of women and children and, 3. suggest essential contributions that social workers can make in the intervention and research arenas. The majority of women and children with AIDS are Black or Hispanic. As social workers, we have the expertise to provide ethnically sensitive and culturally relevant services to these women and their families. The following description of one of the author's experiences highlights the complexities of working with women and children who have AIDS.

CASE ILLUSTRATION

As the Chief Pediatric Social Worker in a teaching hospital in Central New York state, I supervise a staff of 16 social workers who see most of the high risk pediatric cases at the Medical Center. To date, we have seen approximately 15 HIV+ screens and 5 children with AIDS. Like the rest of the country, we anticipate a sharp increase in the incidence of pediatric cases and are beginning to plan for the upcoming demand. A recent personal experience with an oral surgeon heightened my awareness of some of the critical issues we are facing. I had to see an oral surgeon to have an impacted wisdom tooth extracted. While waiting for the novocaine to take effect, we chatted briefly about AIDS. After donning his gloves and goggles, the surgeon stated that he would really rather not treat AIDS patients. He was concerned about infecting himself and his family. Indeed, according to a recent poll conducted by the American Dental Association(Social issues, 1988) only 21% of over 2,000 dentists polled were willing to treat people with AIDS.

My dentist was critical of the huge amounts of money going into AIDS research and services when other diseases were needing similar attention and not receiving it. He felt that the government appropriated so much money because gays with influence and power had pressured legislators. He wondered and worried about whether there might be more gay politicians than most of us were aware of. These opinions were of interest because the women and children affected by AIDS that I have worked with were not influential, powerful or wealthy. Let me use Mrs. S. as an example.

Mrs. S. is a Black woman in her thirties. She has four children and a grandchild. Her eldest child is 18 and lives with her baby and boyfriend. Her 16 year old son lives on the street. He was expelled from high school because of chronic truancy. She worries about him a lot because he is doing drugs. He comes home sporadically to shower, get clothes and eat an occasional meal.

Her eight year old daughter and ten year old son live with Mrs. S. Both children are in special education classes at different schools. Mrs. S was told that they were slow learners but she doesn't think they are. Her daughter has buck teeth and cavities which make her mouth smell. Other children tease her about her appearance and frequently she comes home crying because of this. Her son has been repeatedly suspended from the bus for fighting. If he has one more incident, he will be kicked off the bus

permanently. Both children need regular medical check-ups, glasses and dental care.

Mrs. S. was a high school dropout who became an intravenous drug-abusing prostitute. She spent time in jail and the state prison. Four years ago she found religion and a new way of life. Last summer she was hospitalized with pneumonia and diagnosed with AIDS. Currently she comes to the hospital weekly for treatment and a public health nurse visits two days a week to provide medical care. Her minister is the only community member aware of her diagnosis.

Mrs. S. requested social work assistance in providing for her children. As the case progressed, I became the case manager to coordinate needed resources ranging from assistance with daily living activities, applying for SSI, housing assistance, legal assistance to plan guardianship for her children and medical care for all family members. To date, she has not been able to tell her children that she has AIDS or that she is dying. Her biggest fear is that they will be ostracized should her diagnosis be known.

I think about Mrs. S. a lot. She has pride and faith despite being robbed of energy and ravaged by this illness. We commiserate with each other about the high cost of sneakers for kids and the lousy hospital food. We are united in our common bonds of being women, mothers and by now friends. She is certainly a far cry from the fantasy of the wealthy, influential gay person described by my oral surgeon. Mrs. S's needs are similar to many other women and children who are HIV positive or have AIDS.

WOMEN AND CHILDREN: EPIDEMIOLOGY

WOMEN WITH AIDS (WWA)

By the end of 1987, approximately 50,000 were diagnosed with AIDS, and about 28,00 had died from the disease (CDC, December 28, 1987). Five to ten million people are already HIV positive (HIV+). In the next five years this will increase ten to thirty times. Patterns of where AIDS cases are being identified are shifting. In 1985, fewer than 60% of AIDS cases in the United States were reported among persons residing outside New York City and San Francisco but by 1991 more than 80% of the cases will be reported from other localities (US Public Health Service, 1986).

As of October 31, 1987 three thousand on hundred twenty six (3,126) women were reported to have AIDS (Allen &

Curran, 1988). In New York City, AIDS is the leading cause of death for women 25-34 years old (Joseph, 1988).

Blacks and Hispanics represent 12% and 6% of the U.S. population respectively and have disproportionately contracted AIDS at rates of 25% and 14% of all reported AIDS cases (CDC, 1986). The statistics for women affected are even more disproportionate. The Children's Defense Fund (1988) reports that when adjusted for population size, the rates of AIDS cases are 11 to 13 times higher among Black and Hispanic women than among white women. Minority women's lack of access to health care increases their own and their babies health risks
(Children's Defense Fund, 1988). The implications of these demographic trends need to be addressed by every treatment program and prevention program targeted to women.

A woman is at high-risk for contracting AIDS if she is an IV drug user, had blood transfusions between 1979-85, has unprotected sex with a partner who is an IV drug user, gay, bisexual or a hemophiliac (since 1977). The risk increases as the number of sexual partners increase. Rosenberg and Winer (1988) reported that the prevalence of HIV antibodies among prostitutes ranged from 0-65%. In non-drug using prostitutes, the risk is almost nonexistent. Prostitutes who are IV drug users or who have unprotected sex with IV drug users are at the greatest risk.

IV drug use or being a partner of an IV drug user is the most important risk factor for all women in our country. Galea et al. (1988) studied voluntary HIV screening among long-term substance abusers. Ninety-eight percent undergoing treatment voluntarily requested HIV screening and eighteen percent were HIV+. Client discussion groups revealed clients were more willing to change their IV at-risk behavior than implement safer sex practices.

Frequently, the mother is asymptomatic during pregnancy and becomes aware of her infection with HIV when her child is diagnosed. In some cases, the other spouse and/or other children may also test HIV+. Also, the infant's diagnosis may lead to the discovery of previously unknown high-risk behaviors (for example, a bisexual husband) which can severely stress the family unit (Lewert, 1988).

Mothers experience their suffering in a context of public condemnation... "How could you do this to your baby?" WWA's face unique psychosocial problems as a result of being diagnosed with a disease that is primarily identified as a gay male disease (Macks, 1988). They report feelings of isolation, secrecy, and rejection (Poquette, 1988). Many

mothers avoid services because they are afraid their children will be removed (Woodruff and Sterzin, 1988). These women and children represent the ejected and rejected of society (Fox, 1988).

For mothers who have the disease, the problem is compounded since they must be prepared to face their own death as well as that of their offspring (Morin, 1984). Infected mothers and children are typically minority group members, poor, drug-abusing, and from fragmented families. Their stressful lifestyles tend to hinder medical compliance. They rely heavily on public insurance like Medicaid and on care and services provided by public hospitals and community agencies (Presidential Commission, 1988). Their needs are multiple: improved housing, income maintenance, long term and hospice care, home care, child care assistance, counseling, legal services, health education, and medical care.

CHILDREN WITH AIDS (CWA)

As of January 1988, there were over 851 pediatric AIDS cases (CDC, Feb 1988). The number of AIDS cases among infants and children is rapidly increasing and expected to total between 10,000 and 20,000 by 1991 (Presidential commission, 1988). This represents a tenfold increase (Leukefeld & Fimbres, 1987). The cost of caring for these children will be between two hundred and three hundred million dollars ($200,000,000 and $300,000,000). While Black children are fifteen percent of the total U.S. child population, fifty four percent of all pediatric AIDS cases are Black. Similarly, Hispanic children represent ten percent of the child population but twenty three percent of the childhood AIDS population (Select Committee on Children, Youth and Families, 1987). In New York City, approximately ninety percent of all infected infants are Black or Hispanic (Weinberg and Murray, 1987).

Currently, 70% of the pediatric cases are reported from New York, parts of New Jersey or Miami. This distribution will shift as cases increase in other areas of the country. New York State is interesting to examine because it has both the area of highest incidence and many areas of very low incidence. In the Bronx, one newborn out of every 43 carries the HIV antibody as compared to one in every 749 born in several upstate counties (New York City Department of Health, 1988). New York City has over 83% of the statewide total AIDS cases and one out of every 61 babies born in New York City tests positive for the HIV antibody.

The majority of cases of AIDS in children are a result of in utero or perinatal transmission from infected mothers. Current estimates are that about half of the babies born to infected mothers will develop AIDS. School age children become infected from transfusions of blood and blood products.

The CDC definition of pediatric AIDS does not include children over 13. Pediatric social workers must prepare to address the needs of adolescents with AIDS. Adolescents are particularly vulnerable because of high-risk behaviors (Hutchings, 1988). Homeless and runaway youth are especially vulnerable to exposure (Hanson, 1986). Adolescents, like adults, contract the infection as the result of transfusions, IV drug use, or sexual activities.

Longitudinal studies of households where there is an AIDS patient support the notion that AIDS is not transmitted by casual contact. To date, none of the children in these households has converted from sero negative to sero positive (Fischal, 1987; Friedland, et al., 1987 & 1986).

The illness expresses itself differently in children than adults. Whereas HIV+ adults may develop ARC or AIDS after months or years of good health, infants are diagnosed at nine months on average and death is usually about nine months after the diagnosis (Leukefeld & Fimbres, 1987). AIDS is frequently misdiagnosed in children who contract it from mothers who may not have any symptoms during the pregnancy (Lewert, 1988). The children experience failure to thrive, recurrent bacterial infections resulting in multiple hospitalizations, respirators, separation from family (which is more devastating than the child's impending death because young children do not really understand death) and painful discomfort (Leukefeld & Fimbres, 1987). Lewert (1988) notes that the current systems of entitlement and social support are inadequate, fragmented, and too rigid to meet the current and projected needs of this population.

Diamond and Cohen (1988) report increases numbers of children being born HIV+ and surviving for longer periods of time. Close to 80% of the CWA have some sort of central nervous system involvement. HIV+ infants who present with dysmorphic features at birth experience earlier onset of AIDS. Even mildly impaired HIV+ children in the 3 to 8 1/2 year old group demonstrated visual, spatial and perceptual dysfunction associated with positive neurologic findings. Diamond and Cohen predict that AIDS may become the largest infectious cause of mental retardation and brain damage in children.

Despite their illness, central nervous system involvement and developmental delay, minority over-representation and the fact that 79% of all pediatric AIDS cases have at least one parent who has the disease and is an IV drug abuser, Purcell (1987) concluded, "that children who are HIV positive, including those diagnosed with AIDS, are not basically different from other children. Sicker, yes. Poorer, perhaps. And dying younger, probably. But they are born with the same rights and needs as all other children" (p.20). Their future depends on others.

Before examining the implications of HIV infection in women and children for social work practice, five key issues affecting the development of and delivery of services will be reviewed.

CRITICAL ISSUES AND FUTURE TRENDS

FUNDING

In 1984, 61 million dollars were appropriated for AIDS. In 1988, four years later, the amount rose to 906 million dollars, an increase of 89% over the 1987 budgeted amount. Children have received limited funding. In 1988 $16 million of NIH's $422 million budget was designated for CWA. (Nation's Health, Feb. 1988) President Reagan's budget proposal for 1989 calls for 860 million dollars for research, 440 million for prevention and 700 million for SSI and Medicaid benefits for AIDS patients. Two hundred to three hundred million dollars will be for the care of infants (Perinatal AIDS, 1987).

Witnesses before the Presidential Commission and other experts expressed concern that our health care delivery system currently is structurally and financially unprepared to deal with the diverse needs of people with HIV infection, as well as those with other chronic illnesses (Presidential Commission, 1988). McTigue (1988) predicts that the AIDS crisis will force the United States to create a new health care system. The multidisciplinary team has been reintroduced as the treatment model of choice.

The Harlem Hospital study (1981-87) analyzed the costs for caring for 37 infants and children with AIDS, ARC or HIV positive status. Total expenditures were 3.4 million dollars for in-hospital care. The authors estimate that 30% of all hospital days and 20% of all costs could have been avoided if suitable arrangements and payment for out-of-hospital care had been possible (Perinatal, AIDS, 1987).

New funding strategies need to be explored. What the appropriate balance is between payment by insurance companies versus government versus private patient payment for medical care must be examined. Further funding dilemmas involve questions about who should fund research and services, and in what combination. We simply do not have the physical and fiscal resources needed to respond to the upcoming crisis.

The obstacles to establishing effective and humane public health policy are political, social, cultural, scientific, and medical. Since no single intervention will adequately address the complexities of this disease, any successful approach to dealing with AIDS requires careful thought. Shulman (1987) notes that "progressive policy has been impeded by indifference, fear, or prejudice". He comments that a major missing link has been the development of a continuum of services and increased availability of long term, non-hospital, care options. The Harlem Hospital (Invisible Emergency, 1987) report clearly states when a community does not respond appropriately, the acute care hospital becomes the major provider of medical and psychosocial care. Tertiary care centers are experiencing resource reduction and rationing of health services under the DRG driven payment system. Cimino (1987) compared the average length of stay (ALOS) in New York City and San Francisco. In 1985 the ALOS in New York was 21 days while the San Francisco ALOS was 12 days. The difference is largely attributable to the increased availability of home health care in San Francisco. It behooves us to develop and support less costly, community based care. In treating one of the most significant public health problems to confront society thus far, we have a tremendous opportunity to develop a unified approach to treatment.

As predicted, maintaining patient confidentiality has been difficult to ensure. There have been at least 75 cases of AIDS-related breaches of confidentiality and 233 acts of AIDS-related discrimination reported to the states (States report AIDS-related discrimination and breaches of confidentiality, 1988). Who should know about the diagnosis and what should the punishment be for breaches of confidentiality?

Recently the Presidential Commission on HIV (1988) issued a strong call for a unified AIDS policy:

> The Commission believes that curbing drug abuse, especially IV drug abuse, through treatment is imperative to deter the progression of the HIV epidemic. What is needed is a clear Federal,

state, and local government policy, in other words a national comprehensive policy, unequivocally committed to providing "treatment on demand" for intravenous drug abusers, with a coherent funding structure that provides for an ongoing, stable ten year commitment to providing drug treatment services and treatment research.

The interim report cites an ambitious agenda for improving the treatment and research regarding AIDS consisting of 212.8 million in federal and 52.2 million in state funding for improving care. Included is the recommendation that Regional AIDS Comprehensive Family Care Centers to provide comprehensive services be established.

Additionally, the Commission (1988) calls for the NHSC to establish scholarships, loans, and workstudy opportunities to recruit, train, place and retain 100 Masters degree-level social workers per year to staff facilities in underserved, AIDS-endemic areas.

While these recommendations appear well thought-out, it remains to be seen whether the current administration elects to take a leadership role in implementing them.

ATTITUDES OF THE PUBLIC AND HEALTH CARE PROVIDERS

The impact of AIDS, has been exacerbated by the response of the lay and professional communities. The public response has ranged from the ostracism of the Ray family, to calls for tattooing AIDS patients, to quarantine of those affected, to carrying ID cards. In May 1988, the Surgeon General sent an unprecedented AIDS mailing to every household in the United States as part of an attempt to provide more accurate information.

Health care providers have refused to treat people with AIDs. There is clearly a need for more knowledge about HIV infection among health care providers (Link et al., 1988; Presidential Commission, 1988; Wertz et al., 1987). A survey of 263 medicine and pediatric residents training in New York City hospitals reported that eighty two percent of the participants felt hospital administrators were not concerned about the risk of exposure to the house officers (Link et al., 1988). Further, twenty percent of the pediatric and over thirty three percent of the medical interns and residents planned to make career choices that would lessen the likelihood that they would care for AIDS patients.

Educational sessions with health care professionals are revealing some promising trends. Wertz, Sorenson, Lebling, Kessler, & Heeren (1987) administered questionnaires before and after AIDS educational programs and reported significant improvement in accuracy of knowledge about modes of transmission and means of infection control. Results suggest a need for education at all levels of the health care system. Education should be offered on an ongoing basis to keep providers current with new research developments. Additionally, further attention needs to be paid not only to the accuracy of providers knowledge but their attitudes toward caring for these patients.

Caring for people with AIDS is difficult. The attitudes of caretakers reveal their frustration about the lack of a cure for AIDS, the lack of adequate resources, and discomfort regarding the patients' lifestyle. It also reveals their anger and often depression in view of the relentless progression of the disease which usually leads to an ugly, wasting death of young people.

CONTINUUM OF CARE

The epidemic has differentially impacted the nation. Most of the country has not experienced the tremendous demands on health care delivery services being reported in New York and San Francisco. As the rest of the country prepares to address AIDS locally, we can learn from the experiences of New York and San Francisco. Non-hospital care is less costly than inpatient care (Cimino, 1987). As the spread of AIDS continues, community based care will become an increasingly important aspect of care.

The ideal medical patient care management system of the future would place preventive education, testing, and care of the HIV+ person in the primary care medical setting. Tertiary care settings would handle only the sickest of patient and provide consultation to primary caregivers. Lastly, community based organizations would provide general education, counseling and case management services.

The report, The Invisible Emergency (1987), analyzed the problems experienced by hospitals in providing services to HIV+ children. They noted that "convoluted administrative procedures of bureaucratic sluggishness often prevent timely access by these children and families to assistance" and "there is a grievous lack of synchronization among administrative agencies, inter-related roles in the problem-ridden lives of these children and families". The Commissioner of Westchester County Medical Center noted that by the end of 1987, the 21,600 inpatient days required to

care for pediatric patients with AIDS in New York state will have cost about 12 million dollars (Weinstein, 1987). He urged planners to consider financing for and creation of innovative non-hospital placements for the core of the hard to place children with AIDS.

The diagnosis of AIDS has a lifelong impact on all aspects of the person's existence. Services need to be designed so that the patient has access to a continuum of care. Shulman (1987) and others have identified several essential ingredients of the care continuum:

1. Hospital inpatient and outpatient services
2. Home health care and skilled community nursing
3. Hospice
4. Long term care
5. Foster and day care services for children
6. Multidisciplinary medical and psychological care team
7. Dental care
8. Care management and advocacy
9. Health education
10. Transportation
11. Volunteers to provide concrete services and support
12. Housing enrichment
13. Individualized care plan respectful of cultural and ethnic differences

For women and children this continuum must view the biologic family as the preferred caregiver with other relatives involved as needed. Most families do not abandon their children but for those who do or cannot care for them foster care is essential.

PREVENTION

Until we have a cure, education is the only weapon we have to prevent the spread of this lifestyle-driven disease. The principal purpose of preventive efforts is to thwart the

spread of infection. To date, most efforts have been directed toward male homosexuals. Allen and Curran (1988) call for a better understanding of precise populations at risk of prevalent and incident HIV infection, and to use this information to direct and monitor specific prevention programs that are likely to be effective for the populations at risk. Becker and Joseph's review (1988) of behavioral change literature discussed only one study of exclusively women who were at-risk. It is not possible to extrapolate findings from one at-risk group to another because the at-risk groups for AIDS are behaviorally distinct. Programs designed to reach women of color who are IV drug abusers or their children must be implemented and evaluated and results must be disseminated in a timely fashion.

Women who are IV drug abusers or the sexual partners of IV drug abusers or bisexual men have needs for specific information if they are of child bearing age. They need information about the transmission of the disease to family members and to children before birth and during breast feeding. Women need to know that the medical community is uncertain about the effect of pregnancy on HIV infection in the mother. Two studies suggest that there is an increased frequency of AIDS following birth (Allen & Curran, 1988). Further research into this relationship is needed. Also, they need to know that they may have a thirty to sixty percent chance of passing the illness to their children (Hutching, 1988; Perinatal AIDS, 1987). For most part, the popular press has down-played the threat to heterosexual women, frequently reassuring them that they are not at all at-risk (Gould, 1988). The President's Commission (1988) refutes this and calls for intensive education of women. Therefore we must be prepared for skepticism on the part of women who have read the popular literature and attend workshops or read literature that states they are at-risk.

An important but largely ignored aspect of AIDS prevention is relapse prevention which refers to helping individuals reinstitute preventive behaviors when they have returned to the at-risk behavior. Becker and Joseph (1988) note that the few existing longitudinal studies of behavioral change indicate high rates of recidivism and instability of behavior change. IV drug abuse is difficult to stop on a longterm basis. Further information is needed about effective methods of supporting preventive behavior.

Children also need to be educated about AIDS. In particular, adolescents engage in high-risk behaviors. Over 50 percent of adolescents have intercourse by 17 and 2.5 million teenagers get sexually transmitted diseases (Fox, 1988). Our country has the highest rate of illicit drug use

among young people of any country in the industrialized world. Of last year's high school seniors, 57% tried an illicit drug and over one third experimented with drugs other that marijuana (Presidential Commission, 1988).

DiClemente et al. (1988) surveyed adolescents in San Francisco and found that white adolescents were more knowledgeable than Black adolescents about the cause, transmission and prevention of AIDS while Black adolescents were more knowledgeable than their Latino peers. Becker and Joseph (1988) summarize the adolescent and young adult behavior change literature as providing little documentation that this group is altering its at-risk behaviors.

Schools must develop relevant programs that address the needs and developmental levels of students. Programs should address specific informational needs of minorities and people with handicapping conditions (CDC, 1988). Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health program that establishes a foundation for understanding the relationships between personal behavior and health (Allensworth, D. & Kolbe, 1987; L. Noak, 1982).

ROLES FOR SOCIAL WORKERS WORKING WITH WOMEN AND CHILDREN

Clearly, the social work presence in the care of people with AIDS and their families is a central one because social workers interact with numerous systems including:

1. persons with AIDS, their families, friends and lovers

2. the "worried well", that is persons without AIDS but who have engaged in risk-taking behavior

3. health care provider teams who may or may not have homophobic members, who may or may not be overwhelmed and at-risk of burnout

4. legislative and political systems that have direct impact on the health systems.

Social work interventions for persons with AIDS will require strong generalists skills, ranging from the micro level to the macro level of practice. Social work interventions for persons with AIDS include the following categories: psychosocial assessment, counseling and education for patients, partners and family members, ongoing evaluation of resources and accessing necessary services, advocacy,

management of hospital systems and interdisciplinary collaboration.

PSYCHOSOCIAL ASSESSMENT

The AIDS epidemic is making unparalleled demands on the service system. It will not be possible to provide all of the needed services. A family-centered systems approach will allow the social worker to evaluate comprehensively the needs of each woman and/or child. From the evaluation, a coordinated treatment plan can be developed. The plan should be based on the continuum of care needs previously discussed. As we learn more about the progression of AIDS in women and children, it will become possible to identify service needs associated with specific stages of the illness. For example, a mother must decide legal guardianship of her children while she is still able. To complete this task, she may need emotional assistance in dealing with her (and frequently her child's) impending death and legal assistance. Moynihan et al. (1988) cite the importance of planning for survivors. Parents with AIDS worry about the emotional and financial future of their children, who will take care of them and how their death from AIDS will scar them.

The cornerstone of the psychosocial assessment will be the patient's understanding of the illness. (Moynihan et al., (1988) state that at least three factors affect how a person with AIDS confronts death: (1) the disease process, (2) the developmental stage of the person affected by the disease, and (3) the social context of the disease. An important component of this assessment will be understanding the role of the patient's ethnic and cultural background on the patient's understanding of the illness. AIDS is being treated differently in different cultures. Within particular cultures, there is considerable heterogeneity; for example, in the Hispanic culture which includes individuals of Puerto Rican, Latin American and Cuban origins, these subgroups have differences in language as well as in religious and cultural values (Honey, 1988). AIDS and the behaviors associated with its transmission have varying degrees of acceptability within these groups. As Honey (1988) notes while homosexual behavior is viewed as an aberration by much of the general population, it is especially taboo in many ethnic-minority cultures. Different levels of acceptance may also be found between generations within the same cultural group. The worker must be sensitive to the needs of each generation to have matters discussed in ways that are acceptable to them. Care must be taken to respect each individual's background and the worker

should avoid making unsubstantiated cultural generalizations.

A family-centered assessment will allow the team to know what strength the family and community bring to the case. Efforts should be made to involve the significant men and other sources of support. As Stulberg and Buckingham (1988) point out families and friends lives are shattered when their loved one is diagnosed with AIDS. They face parallel issues to the patient's. The worker may need to provide services to them also and support friends and family in caring for the patient.

A person's support network may be able to buffer some of the emotional and physical burdens. Also, the support network can help implement the necessary treatment by assisting the patient in making appointments, caring for children, or assistance with activities of daily living. If a patient is involved in religion, this can also be a source of support. In caring for women and children, links between medical and social care must be forged.

For the HIV + neonate, caretakers must consider the meaning of that diagnosis for the mother, where the baby will live, whether and how maternal-infant bonding can be supported, arranging for infant stimulation, and resolving difficult treatment issues such as how aggressive treatment will be for dysmorphic HIV + child who is born to a mother who is dying.

For children who have AIDS, the psychosocial assessment must address the child's developmental needs. Each developmental stage presents specific challenges.

The preschool stage raises questions about appropriate child care options. What does the assessment of parenting skills reveal? Has the parent's own illness affected the quality of family life? Are extended family members involved in care? What is the child's self-image? What are the best ways to teach the child age-appropriate health habits to minimize exposure to other infection? What setting will best foster the child's growth?

The school aged child faces issues relating to maintaining their activities as much as allowed by the illness. Self-image needs to be examined along with social, intellectual, and physical dimensions. The mounting evidence regarding CNS involvement suggests the need for ongoing monitoring of the school situation and modification as warranted.

Preservation of the family should always by pursued. In instances where the family is unable to care for the child, every effort would be made to retain the child in his/her extended family, if at all possible. Foster care would by sought as a last resort. Specialized foster care programs are being implemented around the country. Gurdin and Anderson report that the decision to accept a child with AIDS was significantly influenced by the special payment rate. In their study, families received about $850.00 per month in addition to added support services for a total of $10,164.00 yearly. Gurdin and Anderson note that the exceptional payment rate and cost of enriched support services are comparable to two days of hospital care for a CWA. Clearly, community based care is less costly.

It is important to note that in a study at Children's Hospital of New Jersey, Newark, twenty five percent of children diagnosed were already in foster care (Boland et al., 1987). These foster care families have needs for education and support regardless of whether or not they decide to have the child return. If Boland et al.'s study is at all representative of foster care families generally, serious consideration must be given to whether current foster care families need universal AIDS education since a high percentage may have unidentified HIV pos children.

A striking and costly problem associated with HIV-infected infants is that of babies abandoned to the hospital's care, the "boarder baby problem". Health officials report that twenty five of thirty three percent of children with AIDS will not be able to remain with their biologic families (Tourse, 1988). Community-based services designed to support the natural family as well as coordinated programs for foster placement and the availability of transitional placements would substantially reduce the need for boarding babies in hospitals. The American Academy of Pediatrics (1988) reports that keeping children in hospitals beyond the time medically indicated is costly, cruel and may place these children at additional medical and developmental risk.

New York State is adding financial, social services and counseling incentives to attract foster caretakers for these children. New York State as a matter of policy is reducing the financial support of bench research for AIDS and is redirecting state monies to direct services,program evaluation, epidemiological and health services studies. New York Governor Cuomo directed the Social Services Department to implement regulations to make all children who test positive for the virus and their families eligible for mandated preventive and treatment services designed to

preclude placement outside the home (Aids and Children are among top priorities for governors, 1988). In Detroit, community based organization, Children's Immune Disorder (CID) is dedicated to preventing the boarder baby situation by providing support services to the babies' families and foster care families. Currently, there are no boarder babies in Detroit and 90% of the children are still living with their biological families (Poquette, 1988).

All of these families need extensive emotional support in coping with upcoming losses. A terminal illness is always difficult and AIDS poses unique challenges. Each member of the family needs an opportunity to understand the illness and to prepare for others' reactions to it.

Clinicians report that families are hiding the diagnosis from others for fear of discrimination and stigmatization (Lewert, 1988; Poquette, 1988; Stulberg & Buckingham, 1988; Woodruff & Sterzin, 1988). This response is, and of itself, problematic. At a time when the family needs support the most, it is unavailable. This secrecy also negatively affects the grieving process. Some professionals are advocating not telling pediatric patients. Lewert (1988) recommends against using the term AIDS with affected children because of its stigmatizing impact. It has been our experience in working with pediatric cancer patients that the children either figure it out themselves or find out their diagnosis from a staff member. It is next to impossible to keep the diagnosis from a child who wants to know.
By avoiding use of the term, AIDS, the social worker is contributing to the stigma of the illness because the avoidance implies that it is taboo to discuss the illness. The authors suggest that the child needs to know the accurate terminology in order to deal with the responses of others. Again, this illustrates the need for community-based educational interventions.

The woman may be faced with dealing with her partner's double life. This discovery can be even more devastating when a child is infected as a result of this (Buckingham and Rehm, 1987).

ADVOCACY

The advocacy opportunities to help create a more humane environment for women and children who have AIDS are limitless. Social workers must assume more visible roles in protecting the rights of AIDS patients (Ryan & Rowe, 1988) and in developing a continuum of care that is accessible to all AIDS patients. The needs of women and children are

particularly evident. The Presidential Commission (1988) made detailed reference to this largely ignored patient group. On the local level, the Commission's Report can guide service development and social workers can advocate for the implementation of the Commission's recommendations nationally.

Homelessness is a significant problem for the AIDS patient (Honey, 1988). It is not uncommon for AIDS patients to have extended hospital admissions because housing is unavailable. Locally, efforts need to be made to find affordable housing and to encourage nursing homes and hospices to provide care. In Detroit, efforts are underway to develop a shelter for woman and their children who are homeless because they have AIDS or ARC (Poquette, 1988).

Foundations and funding sources must be encouraged to fund services which provide for a coordinated continuum of care for health and other services including home care and transportation. Philanthropic organizations have been slow to respond to the AIDS crisis. Recently, the National-Community AIDS Partnership was established by a coalition of foundations to finance care for people with the disease and to assist their families (Teltch, 1988).

INTERDISCIPLINARY ACTIVITIES

AIDS has given new life to the interdisciplinary model of service delivery in health care (Cote & Drusin, 1984). The literature repeatedly affirms that AIDS is as much a social as a medical condition. The patient will benefit from the coordinated efforts of the team.

EDUCATION OF HEALTH CARE PROFESSIONALS AND COMMUNITY SERVICE PROVIDERS

As Macks (1988) observes, the AIDS epidemic requires health care professionals to discuss uncomfortable and disquieting issues. Sex, death, prejudice, and drugs, four societal taboos, are issues closely tied to AIDS. The majority of people who contract AIDS are involved in behaviors that most people find distastful.

Fear of contagion influences the way health care providers treat their patients. Frequently, the personal reactions of health care providers, policy makers and community members influence the provision of services and the development of policies (Macks, 1988). Careful prospective studies show that there is an extremely low risk of infection for health care workers (Allen & Curran, 1988).

Despite this knowledge, fear persists and must be addressed in order to improve the provision of patient care.

Health care providers have strong negative feelings about diseases perceived to be self-inflicted (Cook, 1987; Jenna, 1987). In pediatric cases, staff may become angry at the parents for infecting the child (Jenna, 1987). It is not surprising that the professional and lay communities are having a difficult time understanding AIDS and responding compassionately to it. Frequently there may be a conflict in the provider and patient's values. Macks (1988) notes that health care providers are apt to advise a pregnant woman who is HIV positive to terminate the pregnancy. If she elects not to, their values are conflicting.

Educational efforts of professionals must address not only the knowledge base but facilitate the health care providers examination of his/her attitudes. Service providers must possess a high level of self-awareness. Efforts must be made to examine homophobia and other forms of prejudice (Walker, 1988). There is a tendency to assign blame in these cases. Lopez & Getzel (1988) comment that each AIDS patient is an innocent victim and efforts should be made to avoid scapegoating people who are members of high-risk groups.

Support and education addressing the differential risk levels of the members must be provided to the health care team. For example, a labor and delivery nurse is at greater risk than a food server. Since AIDS is not spread by casual contact and social workers do not provide direct medical care, social workers are not at risk for HIV infection when working with clients who have AIDS (Ryan & Rowe, 1988). Service providers need support and reassurance as they work with this patient group. Terminal illness is stressful and the stigma of AIDS creates unique stresses on the team members. Administrative and direct-care staff alike have realized the need for mutual support groups. Kaiser-Permanente Medical Center and others have developed support groups which combine education and support on an ongoing basis. Health care providers need information about AIDS and its psychosocial issues, including the family's coping styles and the meaning of AIDS to their culture.

An important educational aspect is the involvement of students from the health care and social service professions in pre-service training. One of the authors has developed a course for undergraduate social work students. The intent of the course is to prepare future social workers to provide service to this needy population. Professionals currently providing care to AIDS patients need accurate information

and self awareness regarding their reactions to the illness and its associated conditions. A social worker needs to understand his/her level of comfort in working in this area. Other health care professionals have similar educational needs. Prince et. al. (in press) report that perinatal nurses can benefit from ongoing inservices.

Finally, community professionals need AIDS education and can benefit from ongoing consultation from the health care community. Boland et al.'s (1987) research suggests that child welfare agencies and foster families are particularly in need of education.

Ideally, most case management in the future will be coordinated by community based organizations. Case management is increasingly being cited as a central need of AIDS parents (Presidential Commission, 1988; Sonsel, et al., 1988; Woodruff & Sterzin, 1988). The importance of case management evolved from patient's difficulty in gaining access to public and private services for which they were eligible. Social workers in health care need to assist the community in preparing for this task. It may be necessary to coordinate care from the medical center until the community agencies are appropriately prepared. Efforts must be made to identify educational needs and to find appropriate leaders to assure cultural and minority representation in mounting the community effort. Additionally, health care social workers can provide support to the staff in the community agencies. In particular, the social worker in a health care setting can help community workers gain access to needed medical information.

As discussed earlier, there is a well documented need to provide ongoing education and training to the community. Currently employed service providers and pre-service providers are important target groups. Efforts to educate community groups, religious congregations and support groups about ways that they can help in the AIDS crisis are important.

RESEARCH

There is a tremendous need for research on women and children with AIDS. In reviewing the social work literature, limited research was reported. The majority of the social work literature contains descriptions of the author's practice experiences which is an important body of information for the initial phases of knowledge development. Additionally, review of the public health literature revealed limited findings relevant to women and children. Becker and Joseph (1988) call for interdisciplinary research

designed to increase the understanding of AIDS-relevant behavioral change. We are now at an important juncture where research must be initiated so that findings can be used to guide practice and policy development.

Social workers are in a unique position to document the strengths and needs of women, their children and families. The ecological "person-in-environment" perspective guides the generalist to assess the role of the environment in the process. It is impossible to consider the impact of AIDS on women and children without assessing the environmental strengths and weaknesses. For example, a woman who is an intravenous drug user and desires treatment, may be unable to get treatment for an extended period of time. As the Presidential Commission (1988) reported, drug treatment programs must be made available on a widespread basis. As programs are developed to respond to these needs, their effectiveness must be documented. All of this information will assist future development of strategies to enhance the community's ability to provide an environment supporting humane treatment of women and children with AIDS. Based upon the literature reviewed, there appear to be a number of appropriate research directions which are highlighted briefly below.

First, information is needed about the differing responses of cultural groups in our country. A more systematic understanding of their responses will guide efforts to enlist their support or to develop alternative supports when the primary group is unable to help. This information should be provided to health care professionals to assist service delivery efforts. It may be fruitful for researchers to examine training programs developed to educate social workers and other health care professionals about providing culturally sensitive services (for example, Krajewski, in press). All training efforts will be enhanced by evaluation efforts.

Gender differences in response to the illness is another area of research interest. To date, the literature reflects primarily the experiences of caucasian, homosexual or bisexual males. Evidence is mounting that male and female intravenous drug users have differing service needs. Exploration of the impact of gender on the use of services and differing treatment needs will be of interest.

As noted earlier, adolescents with AIDS are a group needing particular attention. We must address the needs of adolescents by researching their experience with this illness. They will be treated by pediatric services and will need appropriate services. Developmentally, their

needs will be different from the adult patients's and further understanding of these differences is warranted.

The projected demand for services will exceed the available services. It will be invaluable to document the need for services and to identify high-need agencies. For pediatric cases, innovative approaches to family preservation coupled with the use of support networks may help provide the services. Research will help guide policy development.

The literature identifies the stressful nature of working with AIDS. As Helquist (1986) notes, the health practitioner has never been immune from the emotional impact of AIDS. Few studies, however, have attempted to determine how physicians and other care providers cope with the stress that comes with their work. Additional research is needed to facilitate the planning and support of intervention to amelioraiate this stress.

Since the numbers of maternal and pediatric cases seen around the country is comparatively small, multi-site collaborative efforts will be the most informative. Finally, social workers must network with other social workers to disseminate information.

CONCLUSION

Women and children are increasingly being infected by HIV. In New York City, AIDS is the leading cause of death in women aged 25-34. Minority women and children are disproportionately being affected. The grim realities of the epidemic compel us to provide leadership in caring for this largely neglected patient group. As social workers, we can work toward making the lives of infected women and children as full and as close to normal as possible. We can advocate for care and treatment to be open to advances in technology and responsive to the changing family needs.

We can also strive to improve the workplace for healthcare and social service workers in terms of training, caseload size, salary and support so that we can attract and retain motivated and skilled teams.

The current social work role parallels the role of social work in combating tuberculosis. Similar to AIDS, tuberculosis was controlled as much socially as medically. The Committee on the Prevention of Tuberculosis was the first attempt to coordinate medical science as social work to combat illness. The Committee assumed the tasks of increasing public understanding of illness coupled with

advancing patient treatment (Heinel, 1988). We face a similar challenge today.

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++For course information, contact Susan Taylor-Brown, Social Work Department, Eastern Michigan University, Ypsilanti, Michigan 48197, (313) 487-0393.

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AN HISTORICAL OVERVIEW OF CHILD PROTECTIVE SERVICES: MSPCC'S FOUR GENERATIONS OF SERVICES

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Background

The emergence and evolution of child protective services and the Massachusetts Society for the Prevention of Cruelty to Children reflect the ongoing struggle of our society with opposing legal principles: inherent rights of parents to rear their children; the rights of the child to have higher basic needs met; and the rights of the state under the common law doctrine of parens patrie, which declares the state to be the ultimate guardian of every child and to have a vested interest in the well being of all children.(1)

Inherent in the laws governing child abuse and neglect are the assumptions that in certain aspects of child care: 1) there are norms of parental behavior; and 2) there is an identifiable level of care below which there shall be societal intervention.(2) However, as we know, the norms of child care emerge from community standards and vary from place to place and change with time. Therefore, the criteria for societal intervention is more subjective than objective.

Historically, there have always been situations in which some children could not be cared for by their own parents because of illness, death or special circumstances. One example of such a special circumstance, which may be the first documented example of foster care, is the writings about Moses in the Old Testament. Here was a situation where a child was hidden in foster care to prevent injury. England, through the Elizabethan Poor Laws of 1601, gave local officials the responsibility for caring for children whose parents were unable to do so. The American system of placing children in almshouses or institutions was derived from the English Poor Laws. However, social activists were divided in their views as to the best way to care for children whose parents were unable to do so.

The group presented evidence that children placed with families were indentured servants, expected to pay for their meals and board through labor and, in fact, received poor treatment and were exposed to immoral influences in their placements. This group advocated almshouse and institutional care as the most responsible way to care for children. The second group argued that children placed in almshouse were mixed with delinquents and adults who could not care for themselves for reasons of insanity, retardation, blindness, etc.

Therefore, these children could not receive the proper education and moral guidance from their available adult role models to become responsible adults. Hence this group advocated for raising children in a Christian home where they could receive good moral training and learn good work habits which was the best way to save them from the evils of urban life.(3) However, either option was available only to children whose parents could not care for them.

The Beginning - Law Enforcement

Prior to 1874, children came under the auspice of the state only when they became a problem to society by virtue of their status of being homeless, abandoned, etc., or from the resulting delinquent behavior. There was no protection available for children from cruelty experienced in their own home as children were viewed as chattel or property of the parents to do with as their parents deemed appropriate. Furthermore, the parents' rights to use corporal punishment as a means of discipline was accepted as a principle of common law.

In New York, however, a Society for the Protection of Cruelty to Animals was establish in 1866 which granted its members the authority to investigate complaints of abuse and maltreatment of animals and to take custody of such animals when necessary and to place them with a caring owner.

In 1873, a friendly visitor to an elderly woman was advised by the elderly woman of the plight of Mary Ellen. Mary Ellen, an eight year old child, was frequently beaten by her caretaker. The elderly woman requested that something be done on Mary Ellen's behalf. Reportedly the friendly visitor shared the story of Mary Ellen with a minister, who attempted unsuccessfully to involve local officials and child welfare agencies. However, the minister did not give up and expressed his concern to a friend who was the founder of the American Society for the Prevention of Cruelty to Animals. The NYSPCA took the issue to court and, argued that Mary Ellen was a mammal, "a little animal that happened to have a soul", and since she was a helpless animal, she fell under the SPCA's jurisdiction. The court conceded and granted the custody of Mary Ellen to the SPCA. Thus the precedent was established authorizing society to intervene in family situations to protect children from harmful acts caused by their parents or guardians.(4) As a result of this action the Societies for the Prevention of Cruelty to Children were established in New York in 1874 and in Boston in 1876.

In the early history of the MSPCC, the mission focused on enforcing minimal standards of child rearing. The function of the MSPCC was to enforce existing laws through the prosecution of parents, not to provide direct services to parents or children.(5) -

The method of intervention adopted by the MSPCC, however, differed from the pure legalistic position taken by the NYSPCC in three ways:

1) it sought to reunify families and stressed education and reformation of offenders to accomplish this;
2) it believed it was more favorable to keep family together than to place children in institutions; and,
3) it identified the advantage of developing close working relationships with other child welfare agencies, local authorities, schools, and the police.(6)

The emphasis on prosecuting offenders and on securing and enforcing child protection laws can also be viewed as a tertiary prevention program. It attempted to rescue children who were being harmed and to prevent further harm to children through the prosecution of offending adults thereby instilling a fear in them of further intervention and punishment by society.

Second Generation - Social Services

The second generation of intervention by the MSPCC began in 1903. The President of the Board, Grafton Cushing, was uncomfortable with the law enforcement approach. He felt the legal approach was inadequate in that it did not seek to find the underlying causes of the problem and, therefore, could prevent its recurrence. Cushing advocated that the preventive efforts which were previously secondary to the tasks of prosecution, should become primary so that the conditions that brought about the agency's intervention would be improved.(7) In taking this position, the MSPCC changed from a law enforcement agency to a social and charitable agency. The basis for this change was the reconceptualization of the problem of cruelty to children, from a conscious willful act of the parents to a respondent behavior caused in part by social conditions. Consequently, the previous rational interventions of punishing inappropriate behavior and providing education and moral guidance as the means to rehabilitate offending parents were determined to be insufficient.

During this period, the treatment of child abuse focused not only on improving the personal attributes of parents but also on changing the social conditions(8) affecting the welfare of children by developing legislation and participating in community action.(9) MSPCC's social action efforts included work on behalf of child labor laws, development of mother's pension legislation, pressing for proper care for the so-called feeble minded and mentally defective, and identification of the need for services for the problems of alcoholism, nutrition and children born out of wedlock.(10) These new interventions did

not replace but were added to the historical method of providing protective services through the sanction of the court and with the use of police and other public and private agencies.(11)

While some of the energies of the MSPCC and other social agencies were directed at the social causes of cruelty to children, there was equal emphasis on the personal causes of cruelty to children. The negative personality characteristics of surliness, laziness and shiftlessness, were characteristics assumed to be under one's control. Possession of these traits led to an attribution of personal rather than social cause for family's problems. Therefore, regardless of the social conditions involved, person's possessing these traits who could not provide for their children's need were determined to be unfit for parenting. However, both these negative personality traits and the social conditions which induced them were viewed as a threat to normal family life,(12) the essential ingredient for preventing cruelty to children. accordingly, the focus of intervention changed from rescuing the children to strengthening the family unit. Efforts to strengthen the family unit included recommendations that formal training courses in parenthood be offered on the high school and college level as a remedy for family discord and divorce. As a result of these changes, the MSPCC's identity as social service agency became clearer.

Third Generation - Public Responsibility

The Third Era in child protective service began in the 1930's. MSPCC and other social agencies reported a significant decrease in physical cruelty to children. This was attributed to three factors: 1) a decrease in actual incidence because of a fear of punishment; 2) an increase in family living standards; and 3) the results of the prevention work of child protective service agencies and other groups. With the passage of the Social Security Amendment in 1935, financing and standard setting for Child Protective Services moved from the local public and private agencies to the state and federal agencies. Also during this period, a new method of intervention in protective services, family casework, was introduced. It was derived from the social casework method developed in the social work profession and psychoanalytic theory.(13) It should be noted that although the acceptance of psycholoanalytic theory by the social work profession had significant impact on the identification of the emotional needs of children at risk of child abuse and neglect and the methods of treatment, it also brought about a division within the field of social work which still exists. Many family agency social workers who embraced psychoanalytic theory focused on the emotional needs of individuals and emphasized need for individual treatment, but they also considered the social component of the problem and the service aimed at environmental change to be separate from pure casework. Hence, there was a disproportional expansion of

psychological versus environmental services by the private agencies and a separation of private family services and public child welfare agencies and a separation of private family services and public child welfare agencies. Private agencies were staffed by professional social workers interested in pure clinical casework while the public agencies were seeking staff to provide both environmental and casework services.(14) The MSPCC, however, attempted to integrate both approaches. Having already embraced social work as its host discipline, it sought to hire professional social workers who could apply a family-centered approach along with environmental change techniques.

Further developments in this generation of services included the addition of foster care and adoption programs through which MSPCC became a multi-service child welfare agency unique in its adherence to a protective mission. Having established offices throughout the state, it was also the only private agency providing protective services on a state wide basis.

With the introduction of the diagnosis of "The Battered Child Syndrome"(15), the problem of child abuse reappeared as a major social problem in the 1960s. A problem perceived as having been brought under control, now reemerged as a priority issue in our country. As a result of the national attention the medical profession was able to bring to the problem, multilevel responses were developed. Funding for staffing child protective service programs was increased. Research on both the causes of the problem and methods of intervention was encouraged.

The resources available through Title IVA and XX of the Social Security Amendments not only supported the public agencies' protective service efforts but permitted them to purchase services from the private sector. MSPCC, for example, through the purchase of service program, was able to significantly increase its protective service efforts. Along with the shift in funding, the responsibility for defining the problem and determining the nature of the services to be provided was placed with the public agencies. Unfortunately, the split between the protective intervention and the family treatment component gained more support in spite of the increased documentation in the practice literature of the need to integrate the approaches. In part, this may be attributed to the heated debates in the academic literature about the definition of the problem, its underlying causes, and optimal solutions.(16) However, by the end of the 1960's there was concensus on four observations that supported the efforts to provide treatment to victims of child abuse in their own homes:

1) Punishment of the parents was not an effective way to modify their abusive behavior.

2) A child's bonding to his/her parent is of critical importance in shaping the child's personality development.

3) Removing a child from his/her parent(s), does not terminate the bonding. Therefore, based on the depth of the child's bonding with his/her own parents, placement in foster care causes a child to experience separation anxiety which often prevents the child from forming an attachment with substitute caretakers and results in further psychological damage to the child.

4) The cost of protective service to a child in his/her own home is far less than the cost of foster care.(17)

Modern Era - Prevention

The Fourth Era of child protective services in MSPCC began in, 1981 with the introduction of preventive services as a program along with the historical program goals of protective services and advocacy for children and families. In the process of reaffirming these goals through long term planning activities in 1986, MSPCC concepturalized the problems of child abuse/neglect as multidimensional. Elements of causation were identified in the social, family and individual systems as well as in the child welfare systems.

Societal causation was identified in stress generated 1) by the widening gap growing between families from middle and upper socioeconomic backgrounds and the poor in their average income levels, 2) by unemployment, 3) by the unavailability of housing, and 4) by the lack of resources to deal with the problem.

Variables resulting in child abuse/neglect in the family system were primarily attributed to the increased and unplanned demands placed on the family units which varied in composition from the traditional family unit of legally married, biological parents and children. Single parents, low income families, remarriages resulting in reconstituted families, families caring for both young children and elderly parents, and teenage parent were identified as non-traditional families at risk of child abuse/neglect. Stress induced by the structural and functional changes occurring in these families was believed to come from the increased complexity in family members' efforts to balance work, child care, interpersonal and social demands.

At the individual level, increased incidence and the seriousness of mental health, health, and social problems such as teenage suicide, substance and alcohol abuse, AIDS and the lack of universal health care coverage were variables associated the risk of child abuse/neglect.

In relation to the child welfare system, several trends were identified that have potential to negatively impact services and resources available to communities, families and individuals to assist them in their efforts to deal with previously described problems and thereby become risk variables themselves. These child welfare delivery systems risk variables included:

* governmental cost saving and cost containment efforts which may make unproved short term quick fix, low cost projects more attractive than longer term, more expensive but effective interventions;
* competition of other special need groups such as, elderly, minorities, disabled, with children for resources;
* increased criminal prosecution of child abuse/neglect as an alternative to social services;
* decrease in support for private and corporate giving to private agencies;
* increased competition among disciplines each claiming primary responsible to define the problem causation, and proper intervention in order to assure access to the available funding.

Presently, to accomplish its goals of protection, prevention, advocacy, MSPCC has initiated primary, secondary and tertiary prevention services. Primary prevention services consist of Community Education programs to acquaint the public with causes of child abuse and neglect, and with available resources to deal with the causative factors before they occur; and Parent Education programs for individuals, having no identified rsk potential, seeking information on child development and parenting techniques. Secondary prevention services include use of outreach volunteers to support and link families of newborns identified at risk of child abuse/neglect with community resources; parent education and courseling services for teenparents, and outreach counseling services to risk families. Tertiary prevention efforts involve a cluster of services available to families where an incident of child abuse or neglect has occurred. They included protective, counseling, parent aide and parent education services(19) and self-help groups. In addition, the agency is in the process of developing mental health clinics in each of its offices. Based on MSPCC's historical experience, the majority of its families with a documented problem of child abuse/neglect and require mental health services.(20) These families were referred to but did not link with mental health agencies. However, they continued to request services from MSPCC. To better meet the clients needs, the MSPCC decided to develop mental health services within the Agency which is in keeping with its modern goal of developing a comprehensive program to prevent child abuse and neglect. Also, MSPCC recognizes that harm and pain is incurred by victims and family members from the multiple, often

contradictory, interventions imposed by competing agencies operating in isolation of each other.(21) Learning from other agencies' experiences(22) MSPCC has developed several programs, especially in the area of child sexual abuse, which attempt to integrate and coordinate the services of the various agencies involved in families receiving services from the Agency.

Finally, to strengthen its advocacy efforts, MSPCC has employed a half-time advocate to monitor child welfare legislation and has established a Research Department to study both the causes of the problem and the impact of alternative interventions.

Conclusion

The history of MSPCC's efforts to deal with the harm and hurt children receive from family members highlights the status of children in our society. Through the intervention of the NYSPCA, children were moved from a status of things, unprotected property of their parents, to the status of beings, animals with a souls, deserving of the protection of society since they could not protect themselves. However, during the slow transition of responsibility for the care of children from the private to the public sector, the struggle between parents' rights and responsibilities, child's rights, and state's rights to intervene suggests that the absolute right of a child to have his/her basic needs met has not been secured.(23) Furthermore, the challenges to remove child pornography laws and the extent and seriousness of the present problem of child abuse and neglect dampen the claims of progress in preventing the problem. Likewise, although prevention strategies were identified from practice experience and research(24), arguments about the cost effectiveness of the efforts and demands for guaranteed results are thwarting the expenditure of resources in preventive services.

Perhaps the concern is a more basic fear and knowledge that the successful solution to the problem will result in major changes in the values and social structure of our culture. Children will emerge with equal value to adults. Women will have equal value to men. Racial and other forms of prejudice used to justify the uneven distribution of resources will be abandoned in favor of a higher guaranteed minimum standard of living for everyone. All people will receive equal representation in the decision making process. Violence against other people will be totally unacceptable and sexual expression will be limited to specific circumstances. Children will never be permitted to be the object of implicit or explicit sexual expression. The expression of such a thought would be repugnant and would require counseling and/or value clarification. Knowledge of child development and family living skills will be

integrated into the formal educational experiences beginning in preschool. Finally, the resources required to meet basic human needs of all people will receive first priority in the budgeting process.

When this occurs, professions and disciplines will adopt standards of behavior requiring interdisciplinary approach to all problem solving efforts and will equip their members with the skills necessary to perform these tasks. Could this be the focus of the Fifth Generation of Services? The first steps toward the realization of these could be 1) concensus among the disciplines that such an effort is necessary and 2) an unconditional commitment to propose, advocate for and help implement the necessary changes. What prevents us from taking these steps?

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CHILD MALTREATMENT: A JOINT PREVENTION PROJECT BETWEEN PUBLIC HEALTH AND CHILD WELFARE

Deborah J. Stokes, M.S.S.A.

INTRODUCTION:

Two decades of involvement by researchers and practitioners with the problem of child abuse and neglect have provided a foundation on which we continue to expand our knowledge about this complex phenomena and our ability to translate this knowledge into help for troubled families. We have learned that children of both sexes and all races, and from every income level and geographic area are harmed by child abuse and neglect. However, in 1987 we are still puzzled and horrified by the startling evidence that the number of children dying of abuse is skyrocketing. Consequently, public health officials are continuously looking for avenues/methods/ mechanisms for prevention of child abuse and neglect.

Ohio, one of the ten largest states in the nation with 10.8 million residents, had 3.5 million children under the age of 20 representing 32 percent of the population. There are 88 counties covering a land area of 41,222 square miles. Fifty-three counties are designated as rural with 35 urban counties having 50 percent of their population living in metropolitan areas. Twenty-eight of the rural counties are designated as Appalachian (see Appendix 1).

In 1985, the incidence of child abuse and neglect nationally was 652,000, this meant that 10.5 children were abused and/or neglected for every 1,000 U.S. children under age ten. Approximately 63.5 percent of the reported number (329,000) are incidents of neglect. In Ohio, 65,000 reports of abuse and neglect were received in 1984. Over half of these reports received were reports of neglect. This trend seems to be consistent with the national incidence.

With the risk of child abuse and neglect cases, both nationally and in Ohio the following issues became apparent.

1) THE RESPONSIBILITY FOR THE HEALTH AND WELFARE OF CHILDREN EXISTS IN MULTIPLE HEALTH AND HUMAN SERVICES AGENCIES.

It is the current policy in Ohio that investigations of abuse and neglect are carried out by child welfare agencies.

It is during intake that reports of alleged child abuse and neglect are evaluated. Effective services to children depend greatly on the ability of staff to correctly analyze service needs of children and their families and to determine the appropriate intervention at the point of intake and during the ensuing twenty-four hours, when the allegations of child welfare workers at intake, and during the course of an investigation, are subject to at least two types of potential errors: rejecting appropriate referrals; and accepting clients appropriately, but using a process that lacks clearly defined criteria.

When child abuse allegation reports are accepted at intake, workers have little difficulty in determining their appropriate course of action to take during their investigation. However, workers have more difficulty in assessing allegations of medical neglect, especially organic and "failure to thrive." Additionally, difficulties arise in child welfare workers making their final case determination and providing appropriate referral/follow-up services to meet their needs. This problem is further documented in national statistics which indicate that 63.5 percent of families reported have stress factors primarily related to health. Jenkins, Schroeder and Burgdorf's (1981) reports also revealed that after 90 days, 27 percent of neglect cases were still open compared to 12 percent of the abuse cases. This trend seems to be consistent with Ohio in the significant number of neglect cases reported and the high number of cases still open. It is important therefore, that child welfare workers not versed in the knowledge of medicine utilize health professionals appropriately in order to provide necessary services to the families in need.

2 HEALTH PROFESSIONALS HAVE THE LOWEST PERCENTAGE IN REPORTING ALLEGED CASES.

Health professionals who were in a position to identify children at risk of neglect or who were presently being neglected only comprise eleven (11) percent of the reported population nationally for both abuse and neglect reports. In Ohio, the Department of Human Services cited that only two percent of abuse and neglect reports were made by physicians and thirty (30) percent were made by hospitals.

White, Cornely and Gately (1978) point out that prevention of the social, emotional and physical conditions that might impair individuals and families from achieving their full potentials is a primary objective of both health and child welfare programs. Each field possesses the knowledge and skills that could supplement the knowledge and skills of the other in the area of child neglect. Child

welfare agencies could increase their levels of expertise by acquiring health knowledge in the areas of targetting of high-risk groups and assessing the possibilities for preventive measures at both the primary and secondary levels. Similarly, the child welfare agencies possess knowledge about psychosocial factors within the family that are related to child neglect.

3) CHILD NEGLECT CASES WERE THE HIGHEST PERCENTAGE REPORTED AND OPENED FOR AN EXTENDED PERIOD OF TIME.

The high percentage of stress factors, health (44.7%), economic (948.2%), family interaction (76%), alcohol/drug dependency (18.8%), and spouse abuse, led us to believe that early identification was still not being addressed adequately by health professionals (Russell and Trainer, 1984). Furthermore, the present maternal and child health service delivery system (as documented in Ohio) which is the most appropriate source for early identification has some constraints in that:

a. the low income population is for the most part, the only population receiving the services; and

b. reduced staff and high caseload resulted in follow-up of only those families identified as high risk.

Consequently, families who may not fall into the above two categories and who may have been at-risk for child abuse and neglect were lost to the system.

As a response, the Ohio Department of Health and the Ohio Department of Human Services submitted to the Bureau of Maternal and Child Health, U.S. Public Health services a coordinated application for a Special Project of Regional and National Significance (SPRANS) to address the above issues. The project is designed to demonstrate the benefits of coordination between county protective children's services agencies and health departments in the early identification and prevention of child neglect. The specific components of the project are:

1. Early screening of home conditions of newborns (1-4 months) to identify vulnerability for neglect and offer supportive services;

2. Cooperation on investigations of reports of suspected medical abuse/neglect;

3. Cooperation in preparation of intervention plans for families assessed vulnerable or those where medical abuse/neglect has been substantiated;

4. Provide continuing education to health and child welfare professionals on interdisciplinary cooperation in prevention and treatment of child neglect;

5. Provide consultation to schools of nursing, medicine, and social work to increase content on child abuse/neglect, particularly the element of interdisciplinary cooperation in this work.

This proposal was not designed to glorify any one discipline or agency, but rather to maximize the sharing of program foci, problem identification, treatment methods, and program assessment among agencies to enhance early problem identification, intervention strategies, needs assessment and program effectiveness (White, 1978, p. 553-554). Although governed by separate legislative mandate, both the fields of public health and child welfare have reciprocal concerns and common interests that necessitate collaboration among professional agencies responsible for planning and delivering services to meet the needs of children. Finally, and most importantly, each field embodies knowledge and skills that supplement the knowledge and skills of the other. Child welfare personnel can increase their expertise by acquiring public health knowledge in the areas of:

1) Collection, quantification, and classification of data;

2) handling of mulitiple factors in epidemiological studies;

3) methods for studying the natural history of a condition;

4) determination of high-risk groups; and

5) assessing the possibilities for preventive measures at both the primary and secondary levels. Similarly, the field of child welfare has extensive experience inagency operations, service delivery, intervention strategies, community responsiveness, and the development and utilization of community resources that should be shared with the field of public health (White, 1978, pp. 554).

In summary then, the proposed project would describe the collaboration of the public health and child welfare agencies in early identification, investigation, intervention, and follow-up of suspected cases of neglect; and to propose a model curriculum for professional schools of social work, nursing, and medicine as well as an in-service training curriculum for health professionals already working in the field.

METHODOLOGY

The implementation of the project is divided into two parts. Part one is the demonstration project. Part two addresses the educational needs of students within the professional schools of medicine, nursing, and social work, and the health professionals currently working field.

Part One There are two alternative systems of service delivery being field tested in four counties (two urban, two rural). Three (3) sites two urban, one rural) have one public health nurse located within the health department. One (1) site (rural) has two public health nurses, one nurse located at the health department and the other located at the children's protective service agency. The responsibilities in all of the sites are as follows:

1. Conduct newborn assessment on the target population, using an adaptation of the Family Stress Checklist developed by Schmidt and Carroll (See Appendix 2) and the Nursing Child Assessment Tool (NCAST) developed by Barnard (See Appendix 4).

2. Develop a coordinated care plan with children's protective service agency on those families identified as vulnerable. (See Appendix 4).

3. Assist the caseworkers in conducting investigations of alleged medical neglect;

4. Make case referrals to the health department for follow-up when appropriate.

The criteria for selecting the four sites involved were:

1. geographic location:

2. percentage of reported abuse/neglect cases in relation to the population of that county,

3. success rate of the county's maternal and child health clinics and children's protective service agency,

4. what was politically acceptable to both department directors and the legislative oversite committee.

Greene, Richard (rural) and Summit, Hamilton (urban) were the four counties selected for the project meeting all of the criteria cited above. Given that it would be impossible for one nurse to make home visits to every newborn in the county, a target population representative of the county as a whole, was established. The demographics included:

1. urban and rural
2. socioeconomic ratio, and
3. culture/ethnicity (Appendix 5)

Through the use of the birth certificates, the public health nurse makes a home visit to assess all families of newborns in the target population, and to identify those homes with stressors that make them vulnerable for neglect: develops a collaborative plan with the children's protective service agency on those families identified as vulnerable for direct intervention: and provides a follow-up visit at six (6) months to reassess the stress level that had previously indicated vulnerability. Additionally, names of all families (vulnerable and non-vulnerable) are followed for two years to see if they are reported to the protective children's service agency. This serves as a form of predictive validity for the assessment process. The nature of this project allows us to share information on the families within the target population. This would normally violate confidentiality laws governing both agencies, however, those families identified as vulnerable do sign informed consent forms before services are delivered.

The development of the instrument used in the assessment was done by the project co-directors. The literature review did not identify an instrument which was directly useful. The situation demanded that the instrument be able to be completed by a nurse in a non-intrusive interview and observation with a parent (probably mother) in the home setting.

The Nursing Child Assessment Tool (NCAST) developed by Katherine Barnard was designed to assess mother-infant interaction in four areas - feeding, sleeping, teaching, and home. Although it is a popular tool used by nurses throughout the country, it was felt by the co-directors to be deficient in two areas for the purposes of this project -

1) It was found difficult by some nurses to do assessment on newborns and,

2) It was not able to identify the stressors existent in a family.

Consequently, only the "Home" portion of the NCAST is being used as a supplement to the primary tool. The primary tool used for this project is the Family Stress Checklist developed by Schmidt and Carroll. Ten items are rated as zero if the negative elements are absent; five if mildly negative and ten if seriously negative. A total score of 25 qualified the family as vulnerable. The Family Stress Checklist was later adapted to include knowledge and willingness to parent. It was felt that the tool was identifying those in need of support except for those not having parenting skills. Therefore, another indicator for parenting skills was added.

The second component of the demonstration project involves the use of the public health nurses either located in the protective children's service agency or on consultation from the health department to assist in investigation of medical/neglect reports. This part of the project is progressing slowly. It became evident that some counties were more clear on the procedures and goals of the assessment portion than on joint investigation. Consequently, counties were resisting the implementation of this portion. Following discussions with each individual county, misunderstandings were clarified and collaboration undertaken. Efforts to assess the impact of the program on investigative and interventive activities would be conducted through interviews and case reviews.

Part Two An interdisciplinary committee, comprised of representatives from health, child welfare and professional schools of nursing, social work, and medicine will assist the project co-directors in revising the "WE CAN HELP" curricula for utilization within the professional schools around the state. Also, seminars will be developed and conducted on early identification, referral, follow-up , and prevention of child abuse and neglect. Surveys have been sent to the professional schools requesting information on their present curriculum and continuing education programs in the area of child abuse and neglect. Following an analysis of the surveys, a committee meeting will be held to begin to draft a model curriculum.

Most important to any project of this nature is an Advisory Committee. To meet the requirements of SPRANS,(i.e., be of regional and national significance,) the project

established an Advisory Committee representing three major disciplines, (social work, nursing and medicine), and including experts in public health and child welfare. The Advisory Committee meets once every year and provides advice to the project with reference to implementation and to assess the potential for utilization of this project in other states, and at the national level.

EXPERIENCE TO DATE

The project is into the second year of implementation. During the first year, training was given to all four sites over a two month period on the NCAST and Family Stress Checklist instruments.

The four sites selected are quite heterogeneous and could be somewhat representative of the state as a whole. Each has its own unique way of addressing the problem of child abuse and neglect. Interpretation and implementation of statewide policies and procedures vary based on the philosophy of local administrators and resources. It has been re-discovered by State Administrators that for every policy, there are two or three ways of doing it. But, as yet, these administrators have not learned how to allow this phenomenon to occur.

The four sites have assessed over 900 newborns and their families. Of those assessed, only 74 were identified as vulnerable. Below is a profile of the target and vulnerable population.

POPULATION

TARGET POPULATION

Married
Mother's age between 21-36
Father's age between 21-37+
Mother's education - high school or college graduate
Father's education - high school or college graduate
Mother is not employed
Father is employed
Source of income - employment and public benefits
Level of income - lower that $9,999 or $20,000 and up

VULNERABLE POPULATION

Not married
Mother's age between 17-24
Father's age betrween 17-36
Mother's education - 9th through 12th grade

Father's education 9th through 12th grade
Mother is not employed
Father is not employed
Source of income - public benefits
Level of income - lower than $9,999

A comprehensive plan was developed by both agencies on the vulnerable families. If the family was currently an open case with Children's Services, they maintain direct case management. If the family was not an open case with Children's Services, then the public health nurse assumed case management responsibilities. An additional visit was made to the family to offer support services. The family did not have to participate and could refuse service. The public health nurse then makes a six month follow-up visit and re-assesses the family using the same assessment tools.

Follow-up has been a difficult process. The majority of the families are highly mobile and may have moved when the public health nurse returns. On those families seen at the six month follow-up, approximately 50 percent have followed through with no significant change.

All families in the target population are given a client satisfaction form with a stamped-return envelope to mail directly to the evaluation consultant. At present, the response is minimal with less than 25 percent returned.

EVALUATION

An evaluation consultant has been contracted to evaluate the effectiveness of the project. The consultant has skills in the area of evaluation research, but also with a knowledge base of both agencies.

The evaluation consultant evaluates the project according to the following expected outcomes:

1. Coordination of the two state and local agencies (Health and Human Service; knowledge and skill of both agencies, and to utilize scarce resources)

2. Increase the knowledge base of health care professionals and students thereby creating an environment for increased reporting

3. Early identification of medical neglect cases and appropriate intervention and follow-up resulting in reduction of cases reported and time case is open

FINDINGS

There are numerous clinical, administrative, program, and research issues identified in this project that should be addressed and have implications for public health social work.

1. Birth certificates in some counties were not received until the fourth month after delivery. This is totally unacceptable for early intervention programs. If there had been a crisis it would have been resolved; and those mothers who work often had returned to their jobs. The public health department must provide incentives for receiving the birth certificates in a timely manner.

2. Birth certificates with misinformation. Often times the public health nurse made a home visit with incorrect information. The public health department must provide training that will yield more consistent and accurate information.

3. Families want and are anxious for a public health visit. They need reassurance on their parenting skills in their own environment. Although this may be considered a costly endeavor, however, it is utilizing the case management model in empowering families toward good health behavior.

4. Follow-up on vulnerable families has been difficult due to their mobility. Highly mobile populations pose unique problems around accessibility and availability of services. Studies need to be conducted around programming for this special population.

5. What is "Early Intervention," i.e., does it mean intervention at newborn, toddler, preschool, school age, adolescence or all of the above. Should we be looking at early intervention in each stage of the child's development?

6. Confidentiality. What can be shared or not shared? To what extent does it become detrimental to what we are trying to achieve? It is important that agencies begin discussion around this issue to determine the needs of the population we serve.

7. Consistent/uniform interpretation of state policy.

8. Compromising. The willingness to give for the overall goal. For example, the definition which uses ... the term "vulnerable" rather than "at-risk" which is a term

readily used in public health as the latter is beginning to be used in child abuse and neglect rules.

9. How much do our attitudes, biases, perceptions influence the outcome of vulnerable versus non-vulnerable. Studies need to be done to examine these phenomena further.

10. Many articles have been written about multidisciplinary teams. Howver, continued studies in this area would help address the relationships of different cultures/ethnicities to decision making withing the team approach.

11. Are support services such as mental health, parenting classes, food stamps, effective in reducing child abuse and neglect? Studies should be done to examine this issue.

12. Service delivery systems which do not always allow for services to be accessible and available. Public health programs should begin developing models to effectively address this issue.

13. Duplication of services in the hospital making direct referrals on vulnerable families to the child welfare agency.

14. There is currently no valid or reliable assessment form for identifying stressors in the family that can be used in a public health visit. Studies need to be conducted to develop this form.

SUMMARY

The success of this project is a direct result of a commitment that has given two agencies an opportunity to work together as a community toward a common goal. Consequently, "I" became "We", both agencies moved in concert with one another, decided on one course of action, and forged ahead; both agencies have derived mutual benefits from this association as have also the communities that we serve.

It is important for us to recognize that we collectively are the community - that we are the family - that what happens to thee also happens to me - and that all children are our children. This thinking should direct us toward collective policy development, program planning, and implementation of prevention and intervention in child abuse

and neglect. If successful then, the familiar children's prayer,

> Father, we thank thee for the
> night
> And for the pleasant morning light
> For rest, and food and loving care
> And, all the makes the world so fair,

will be a reality.

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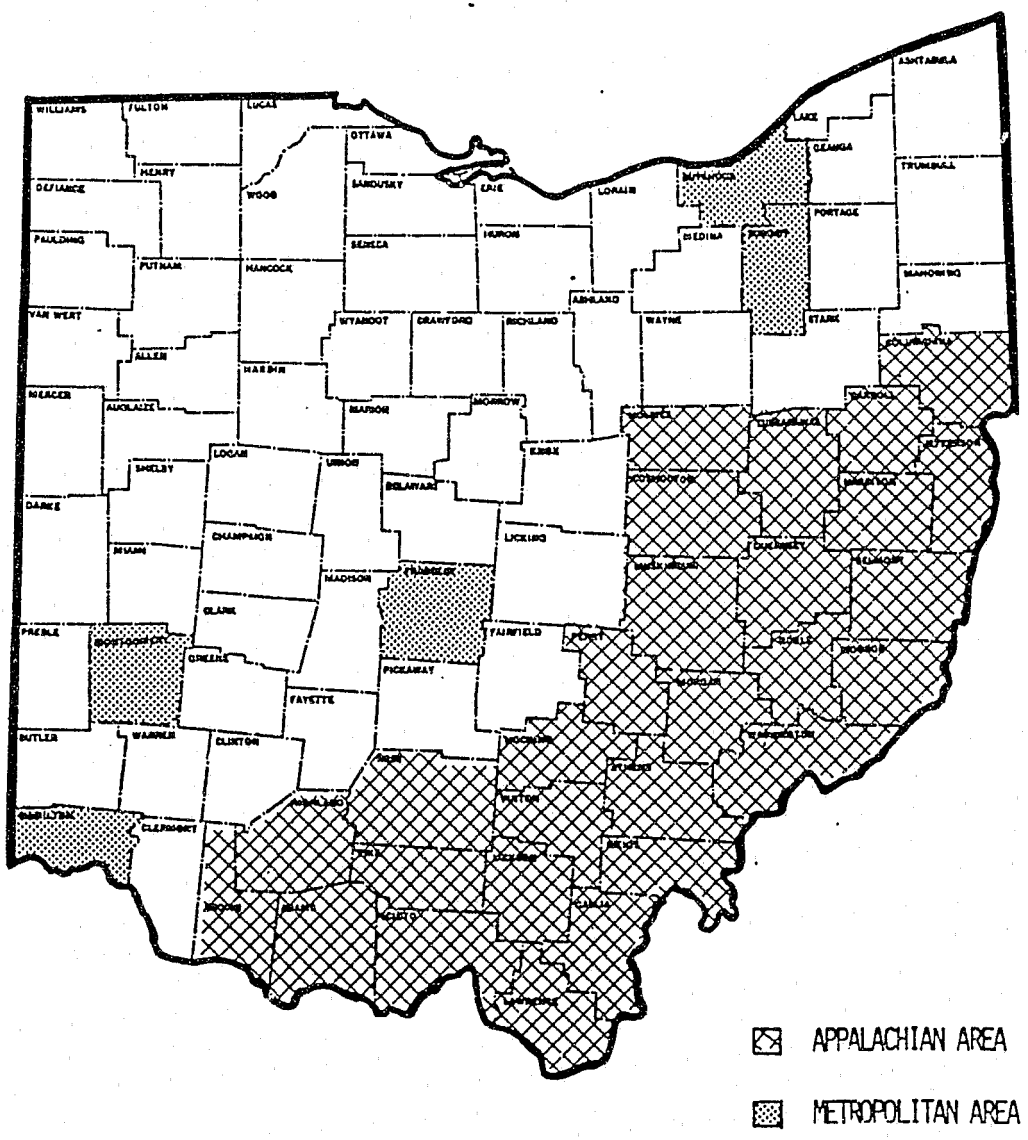
APPALACHIAN AND METROPOLITAN AREAS OF OHIO



CHILD MALTREATMENT PREVENTION PROGRAM

FAMILY STRESS CHECKLIST REVISED*

Factors		No Risk, Score 0		Risk Score 5		High Risk, Score 10	
J	1. Parent beaten or deprived as child	Infrequent spankings, Consistent "parenting" Unknown	___	Frequent spankings, some bruises; received intermittent "parenting"	___	Severe beatings; repeated foster homes. No helpful parent model in childhood	___
D,E,F,N	2. Parent has criminal or mental illness record	Not present Unknown	___	Present, but demonstrates rehabilitation	___	Current psychosis; chronic pattern of psychiatric problems	___
J	3. Parent suspected of abuse in the past	Not present Unknown	___	Official report of mild abuse; child not placed in foster care	___	Official report of serious abuse children placed in foster care or died	___
D,E,F,M	4. Parent with low self-esteem, social isolation, or depression	Not present Unknown	___	Intermittent coping skills; no current lifelines or unreliable ones	___	Severely depressed. No lifelines in past or present	___
D,K,N	5. Multiple crises, or stresses	Not present Unknown	___	Moderate environmental and/or marital problems	___	Chaotic life style, severe environmental and/or marital problems	___
D,F	6. Violent temper outbursts	Not present Unknown	___	Damages property	___	Attacks people	___
D,F,H	7. Rigid, unrealistic expectation child's behavior	Not present Unknown	___	Afraid of spoiling child, unrealistic expectations	___	Intolerance of normal behavior very strict parent	___
D,F,H	8. Harsh punishment of child	Not present Unknown	___	Current frequent spankings or use of belt, not in head area	___	Physical punishment of baby prior to crawling; sadistic and/or dangerous punishment	___
B,C,D,I	9. Child difficult and/ or provocative or perceived to be by parents	Not present Unknown	___	Child triggers abuse intermittent provocative behavior	___	Child triggers abuse by constant provocative behavior (i.e., seen as having no good points)	___

Factors		No Risk, Score 0	Risk Score 5	High Risk, Score 10
A,C,D,F,H,I	10. Child unwanted, or at risk of poor interaction attachment	Not present ___ Unknown	Child unwanted but parent-child interaction/attachment adequate ___	Child unwanted and parent-child interaction/attachment poor ___
	11. Parenting skills reasonable and appears willing and able to apply them.	Present Unknown ___	Parent does not have reasonable parenting skills or is not willing ___ to apply them.	Parent does not have reasonable parenting skills and appears unwilling and unable ___ to apply them is learned.

History of Prior Maltreatment: ____No ____Yes ____Suspected ____Case Reported (Suspected)

Vulnerability Assessment: __No __Yes __ Service Accepted __Refused

* Developed by Schmidt and Carrole, Colorado

UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING
NURSING CHILD ASSESSMENT TRAINING

HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT

(BIRTH TO THREE YEARS)

PERSON OBSERVED (CIRCLE)
MOTHER FATHER OTHER

MAJOR CAREGIVER (CIRCLE)
YES NO

MOTHER'S EDUCATION (CIRCLE)
6 YRS OR LESS 7-8-9-10-11-12-13-14
15-16-17-18-19-20+

MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED

RECORDER'S NAME_____

DATE_____

CHILD'S FIRST NAME_____

CHILD'S AGE (IN MONTHS)_____

CHILD'S SEX_____

CHILD'S RACE_____

PARITY_____

MOTHER'S AGE (AT BIRTH OF CHILD)_____

	YES	NO
I. EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER		
1. MOTHER SPONTANEOUSLY VOCALIZES TO CHILD AT LEAST TWICE DURING VISIT (EXCLUDING SCOLDING)		
2. MOTHER RESPONDS TO CHILD'S VOCALIZATIONS WITH VERBAL RESPONSE		
3. MOTHER TELLS CHILD THE NAME OF SOME OBJECT DURING VISIT OR SAYS NAME OF PERSON OR OBJECT IN A "TEACHING STYLE"		
4. MOTHER'S SPEECH IS DISTINCT, CLEAR AND AUDIBLE		
5. MOTHER INITIATES VERBAL INTERCHANGES WITH OBSERVER—ASKS QUESTIONS, MAKES SPONTANEOUS COMMENTS		
6. MOTHER EXPRESSES IDEAS FREELY AND EASILY AND USES STATEMENTS OF APPROPRIATE LENGTH FOR CONVERSATIONS (E.G. GIVES MORE THAN BRIEF ANSWERS)		
*7. MOTHER PERMITS CHILD OCCASIONALLY TO ENGAGE IN "MESSY" TYPES OF PLAY		
8. MOTHER SPONTANEOUSLY PRAISES THE CHILD'S QUALITIES OR BEHAVIOR TWICE DURING VISIT		
9. WHEN SPEAKING OF OR TO CHILD, MOTHER'S VOICE CONVEYS POSITIVE FEELING		
10. MOTHER CARESSES OR KISSES CHILD AT LEAST ONCE DURING VISIT		
11. MOTHER SHOWS SOME POSITIVE EMOTIONAL RESPONSES TO PRAISE OF CHILD OFFERED BY VISITOR		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		
II. AVOIDANCE OF RESTRICTION AND PUNISHMENT		
12. MOTHER DOES NOT SHOUT AT CHILD DURING VISIT		
13. MOTHER DOES NOT EXPRESS OVERT ANNOYANCE WITH OR HOSTILITY TOWARD CHILD		
14. MOTHER NEITHER SLAPS NOR SPANKS CHILD DURING VISIT		
*15. MOTHER REPORTS THAT NO MORE THAN ONE INSTANCE OF PHYSICAL PUNISHMENT OCCURRED DURING THE PAST WEEK		
16. MOTHER DOES NOT SCOLD OR DEROGATE CHILD DURING VISIT		
17. MOTHER DOES NOT INTERFERE WITH CHILD'S ACTIONS OR RESTRICT CHILD'S MOVEMENTS MORE THAN 3 TIMES DURING MY VISIT.		
18. AT LEAST TEN BOOKS ARE PRESENT AND VISIBLE		
*19. FAMILY HAS A PET		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		
III. ORGANIZATION OF ENVIRONMENT		
20. WHEN MOTHER IS AWAY, CARE IS PROVIDED BY ONE OF THREE REGULAR SUBSTITUTES.		
21. SOMEONE TAKES CHILD INTO GROCERY STORE AT LEAST ONCE A WEEK.		
22. CHILD GETS OUT OF HOUSE AT LEAST FOUR TIMES A WEEK		
23. CHILD IS TAKEN REGULARLY TO DOCTOR'S OFFICE OR CLINIC		
*24. CHILD HAS A SPECIAL PLACE IN WHICH TO KEEP HIS TOYS AND "TREASURES"		

	YES	NO
25. CHILD'S PLAY ENVIRONMENT APPEARS SAFE AND FREE OF HAZARDS.		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		
IV. PROVISION OF APPROPRIATE PLAY MATERIAL		
26. CHILD HAS SOME MUSCLE ACTIVITY TOYS OR EQUIPMENT		
27. CHILD HAS PUSH OR PULL TOY		
28. CHILD HAS STROLLER OR WALKER, KIDDIE CAR, SCOOTER, OR TRICYCLE		
29. MOTHER PROVIDES TOYS OR INTERESTING ACTIVITIES FOR CHILD DURING INTERVIEW		
30. PROVIDES LEARNING EQUIPMENT APPROPRIATE TO AGE—CUDDLY TOY OR ROLE PLAYING TOYS		
31. PROVIDES LEARNING EQUIPMENT APPROPRIATE TO AGE—MOBILE, TABLE AND CHAIRS, HIGH CHAIR, PLAY PEN		
32. PROVIDES EYE-HAND COORDINATION TOYS—ITEMS TO GO IN AND OUT OF RECEPTACLE, FIT TOGETHER TOYS, BEADS		
33. PROVIDES EYE-HAND COORDINATION TOYS THAT PERMIT COMBINATIONS—STACKING OR NESTING TOYS, BLOCKS OR BUILDING TOYS		
34. PROVIDES TOYS FOR LITERATURE AND MUSIC.		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		
V. MATERNAL INVOLVEMENT WITH CHILD		
35. MOTHER TENDS TO KEEP CHILD WITHIN VISUAL RANGE AND TO LOOK AT HIM OFTEN		
36. MOTHER "TALKS" TO CHILD WHILE DOING HER WORK.		
37. MOTHER CONSCIOUSLY ENCOURAGES DEVELOPMENTAL ADVANCE.		
38. MOTHER INVESTS "MATURING TOYS" WITH VALUE VIA HER ATTENTION.		
39. MOTHER STRUCTURES CHILD'S PLAY PERIODS.		
40. MOTHER PROVIDES TOYS THAT CHALLENGE CHILD TO DEVELOP NEW SKILLS.		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		
VI. OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION		
41. FATHER PROVIDES SOME CARETAKING EVERY DAY		
42. MOTHER READS STORIES AT LEAST THREE TIMES WEEKLY.		
43. CHILD EATS AT LEAST ONE MEAL PER DAY WITH MOTHER AND FATHER.		
44. FAMILY VISITS OR RECEIVES VISITS FROM RELATIVES (APPROX. ONCE A MONTH)		
45. CHILD HAS THREE OR MORE BOOKS OF HIS OWN.		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		

*ITEMS WHICH MAY REQUIRE DIRECT QUESTIONS.

ENTER TOTALS FOR EACH CATEGORY	
EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER	
AVOIDANCE OF RESTRICTION AND PUNISHMENT	
ORGANIZATION OF ENVIRONMENT	
PROVISION OF APPROPRIATE PLAY MATERIAL	
MATERNAL INVOLVEMENT WITH CHILD	
OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION	
TOTAL SCORE (NO. OF YES ANSWERS)	

EXAMPLES OF SELECTED QUESTIONS FOR THE HOME (BIRTH-3 YEARS)

SECTION I. EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER

ITEM 7, MESSINESS: "DOES HE SOMETIMES WANT TO PLAY IN HIS FOOD OR IN HIS BATH? OR, "DO YOU SOMETIMES LET HIM PLAY AND BE MESSY?

SECTION II: AVOIDANCE OF RESTRICTION AND PUNISHMENT

ITEM 15. DISCIPLINE: HOW DO YOU MANAGE HIS DISCIPLINE AT THIS AGE—WHAT WORKS THE BEST? IN GENERAL, DOES HE MIND PRETTY WELL, OR DO YOU HAVE TO OCCASIONALLY SLAP HIS HANDS OR PHYSICALLY PUNISH HIM IN SOME WAY?"
IF YES: PROBE FOR NUMBER OF TIMES IN THE PAST WEEK.

SECTION III: ORGANIZATION OF ENVIRONMENT

ITEM 20. "HOW ABOUT YOUR TIME OUTSIDE THE HOME AND AWAY FROM YOUR CHILD; DO YOU HAVE A REGULAR SITTER THAT YOU CAN COUNT ON OR DO YOU HAVE TO GET SOMEONE DIFFERENT EACH TIME?"
PROBE FOR: GROCERY STORE (ONCE A WEEK)
RELATIVES (MONTHLY)

ITEM 21 & 22. HOW ABOUT HIS TIME OUT OF THE HOME, WHERE ARE SOME OF THE PLACES YOU TAKE HIM AND ABOUT HOW OFTEN DOES HE GET OUT OF THE HOUSE EACH WEEK?"
PROBE FOR: GROCERY STORE (ONCE PER WEEK)
RELATIVES (MONTHLY)

ITEM 24. SPECIAL PLACE FOR TOYS: USUALLY ASK THIS AT THE END OF THE INTERVIEW SAYING, "I'M INTERESTED IN SEEING SOME OF YOUR CHILD'S TOYS, WHERE HE KEEPS THEM AND SOME OF HIS FAVORITE THINGS TO PLAY WITH."

SECTION V. MATERNAL INVOLVEMENT WITH CHILD (CAN ASK WHILE LOOKING AT CHILD'S TOYS)

ITEM 36. DO YOU SOMETIMES FIND YOURSELF MAKING CONVERSATION WITH HIM WHILE YOU'RE WORKING AROUND THE HOUSE OR IS HE USUALLY ASLEEP WHILE YOU'RE DOING YOUR HOUSEWORK)

ITEM 37. "WHAT ARE SOME OF THE THINGS YOU'RE HELPING YOUR CHILD TO LEARN AT THIS AGE?
PROBE FOR DEVELOPMENT AGE APPROPRIATE THINGS, I.E. SELF-FEEDING, WALKING, ETC

ITEM 38. "HOW DOES HE USUALLY GET STARTED PLAYING WITH A NEW TOY—DO YOU SHOW HIM HOW TO WORK IT AND TRY TO GET HIM INVOLVED WITH IT OR DOES HE USUALLY FIGURE IT OUT FOR HIMSELF?"

ITEM 39. "ON A DAY TO DAY BASIS, HOW DOES HE GET STARTED PLAYING WITH HIS TOYS? DO YOU SOMETIMES SIT AND PLAY WITH HIM OR DOES HE USUALLY GET STARTED BY HIMSELF AND PLAY ALONE?

ITEM 40. "HOW DO YOU USUALLY DECIDE WHAT KINDS OF TOYS TO SELECT AND OFFER YOUR CHILD TO PLAY WITH AT THIS AGE—WHAT ARE SOME OF YOUR GUIDELINES?"

LISTEN FOR TOYS THAT WILL CHALLENGE CHILD TO DEVELOP NEW SKILLS

SECTION VI. OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION

ITEM 41 & 42. HOW ABOUT BOOKS, DOES HE HAVE SOME OF HIS OWN YET?"
PROBE FOR NUMBER OF HIS OWN BOOKS

"DOES HE SOMETIMES LIKE FOR YOU TO READ TO HIM?"
IF YES "HOW MANY TIMES A WEEK DO YOU HAVE TIME TO DO THAT?"

ITEM 43. "WHAT DOES HE DO WHILE YOU AND YOUR HUSBAND EAT YOUR MEALS? DOES HE USUALLY EAT WITH YOU OR DOES HE EAT AT ANOTHER TIME?"

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DEFINITION

Definition of "Vulnerable"

Stress factors that have been identified, which if not corrected, could ultimately contribute to the occurrence of child abuse or neglect.

Stress Factors listed by Cohen which can affect the mother's perception of the child and her ability to relate to him:

1. relocation of the family;
2. marital infidelity discovered during the pregnancy or loss of support from the husband for other reasons;
3. illness in self, husband, or a relative who must be cared for during a critical period;
4. loss or death of a close friend or relative;
5. serious reverses in the mother's own career pursuits, or the current pregnancy being of a series of pregnancies occurring very close together;
6. previous abortions, sterility periods, traumatic post deliveries, or loss of previous children.

Other indicators which may alert us to parents who are having trouble relating to their newborn are:

1. have no name for their baby;
2. did not receive prenatal care and/or have a negative attitude toward the pregnancy;
3. have other small children who do not live in their home;
4. have an unstable childhood history;
5. are isolated, living alone or only with their other small children, and have no continuing relationship with the baby's father or father substitute;
6. are experiencing marital instability;
7. express no interest in visiting the newborn;
8. wanted a baby of the sex other than their own;
9. are teenagers or over 40 years of age; and
10. demonstrate affect disturbances: depression, psychosis, mental retardation

STATISTICS

Child Abuse and Neglect
1985 Reports Received

RURAL

CATEGORIZATION

County:	Total #of Reports Received	County Population <18:	Physical Abuse	Sexual Abuse	Neglects	Medical Neglects	Combined Abuse and Neglects	Data Not Available	% Substantiated Of Total Received
Greene	791	37,983	0	0	361	0	430	0	18.20%
Richland	830	38,463	210	149	471	0	0	0	50.00%

URBAN

CATEGORIZATION

County:	Total #of Reports Received	County Population <18:	Physical Abuse	Sexual Abuse	Neglects	Medical Neglects	Combined Abuse and Neglects	Data Not Available	% Substantiated Of Total Received
Hamilton	2,593	243,172	1,571	0	1,022	0	0	0	46.16%
Summit	3,218	143,719	949	524	1,343	110	216	76	37.20%

OHIO

* Counties used in the demonstration project.

PARENTING FOR PEACEFUL FAMILIES

Barbara Oehlberg

Is it true that "What happens in families behind closed doors is their business" represents the prevailing attitude in our culture? Thinking critically, should we be asking whether or not there is a correlation between this notion or disengagement from the use of power within families and the undeniable prevalence of domestic, street, and institutional violence in our society?

Does the manner in which families traditionally discipline their children and deal with domestic conflict relate to the manner by which institutions and governments conduct business?

Have we failed to recognize that the "traditional" family pedagogy and structure contains the same power relationships we find in the larger society? In families, power is held by recent phenomenon, younger adults over the elderly. The causes of abuse lie not in the "deviant" population but within what acceptance of violence as a fact of life.

Is the family the laboratory for hierarchical thinking and perceptions of controlling power? Are the roots of violence subtly established through condoned child rearing practices? Adults who claim it did them no harm, that it was even good for them, are contributing to the continuation of cruelty in the world by refusing to take seriously the destructiveness to which children are subjected.

Ashley Montagu asserts "The traditional child-rearing weaponary which parents wield against their children will long continue in our violent culture, unless we perceive that violence toward children in any shape or form breeds and perpetuates violence. The way `power and authority'is handled within the realm of childrearing will determine the manner in which children will exercise `power and authority' when adults.

But how do we achieve peaceful families? How do we nurture peacemakers?

Peacemaking is not initiated by institutions or governments. Peacemaking is activated by individuals....to individuals. Peacemaking must be learned and experienced as children within families for these skills to emerge in adults.

Family peacemaking, all peacemaking, is an active and energetic process, not an end goal. It requires renewed commitment every moment of every day. Family peacemaking is a way of life.

A peaceful family is far more than a non-violent family or one where there is an absence of excessive physical or verbal aggression. Parenting for peaceful families means each person within the family, regardless of age, is empowered to recognize their own competencies and abilities; that through cooperation in the group of intimately attached persons, they can achieve collective strength and productive solutions through positive alternatives.

The primary prevention of discord and aggression in families is COOPERATION and the development of social cooperation is a joint enterprise of adult and child. If parents and teachers project that they believe a child will eventually choose a more appropriate action, given a chance to work through the situation, they empower the child to define his work through the situation, they empower the child to define himself/herself as a problem solver: a peacemaker.

The child/adult who is capable of formulating meaningful alternatives is the child/adult who is free to choose cooperative, harmonious behavior. However, freedom and responsibility are inseparable; we cannot teach one without the other. The method by which a family exercises decision-making and negotiation will determine whether or not their children will choose democratic methods of exerting influence on others, be they family or friends.

The communication mode practiced for generations in our society is to fix blame. The sad result of fixing blame is that it inhabits opportunities to identify and "fix" the problem. Blaming also allows for the rationalization of what is said or done to the erring party and helps the powerful justify their actions of power over others....it results in a win/lose relationship.

Peacemaking relies on empowerment or the sharing of positive power resulting in win/win situations.

We need to give children, from very early childhood on, the "gift" of making appropriate productive choices. Without choices, there can be no problem-solving AND no development of self-discipline; there is only obedience.

I submit we provide integrated education towards a level of citizenship that will permit youth and adults to use freedoms, not be afraid of them.

Are we ready to examine a holistic, integrative perspective in addressing violence; violence in families, in institutions and governments, and make the commitment to envision productive changes? Are we willing to take these risks so children and adults can once again hope; hope that there will be a future and that it will be just and harmonious.

The CHOICE is ours!

TOPIC TUMBLERS:

Topic Tumblers are offered as a facilitating tool for generating group discussion as session openers.

The task of each group is to rank each item of the Topic Tumbler according to importance beginning with 3 for "Absolut Essential"; 2 for "Important"; 1 for "So-So", and Ø for "Counter Productive or False". The key to generating participation of every member is the requirement of reaching a consensus on the numerical values within each group. This can be achieved by using decimals.

This learning device allows each class member to equally share in the discussiion. Through these group-table discussions, members tend to monitor each other's responses which permeit them to deduce that no one/everyone is an expert.

We must remember that as facilitators we are not offering ourselves as experts or healers. We provide experiences and structures in which people can do their own growing (or work). We are there to facilitate their growing, not to give answrs, solve problems, or cure.

The notion that knowledge alone does not change behavior seems to be currently accented and valid. Then, the best thing we can provide for children is not knowledgeable parents, but parents who feel good abut themselves.

The answers or numbers are not the important issue. Rather, our goad is understanding and the discussions based on reflecting on the sheets will allow the facilitator to share pertinent information, as well as validate the group's insight. The

facilitator will also be able to "manage" the discussion in a way that enables class members to choose insghtful deductions as they realize the impact that one expectation or value may have on anotner from the list. In addition, these awareness exercises hopefully will permit the participants to regain a sense of control over their lives and that of their families' future. These experiences may make it possible for them to reject the role of a victim and assert their capacity to choose and to act.

Once an atmosphere of acceptance, trust, and open sharing has been establisehed the group will be ready to move forward to new understanding and growth.

Activity

Necessary Conditions For A Peaceful Family

Rank according to importance through consensus:

3 - Top Priority
2 - Important
1 - So - So
0 - Does not Apply/False

60 MINUTES

A. _____ Parents make all decisions for family.

B. _____ Children follow all directions/requests.

C. _____ Children and parents (adults) accept/respect each other's feelings and the right to have ideas that differ.

D. _____ Same family member is always the peacemaker.

E. _____ Children may disagree with parents.

F. _____ Family decisions are decided by vote.

G. _____ Children are always offered choices.

H. _____ Discipline/punishments are determined only by parents.

I. _____ Family decisions are made by consensus.

J. _____ There is never any conflict.

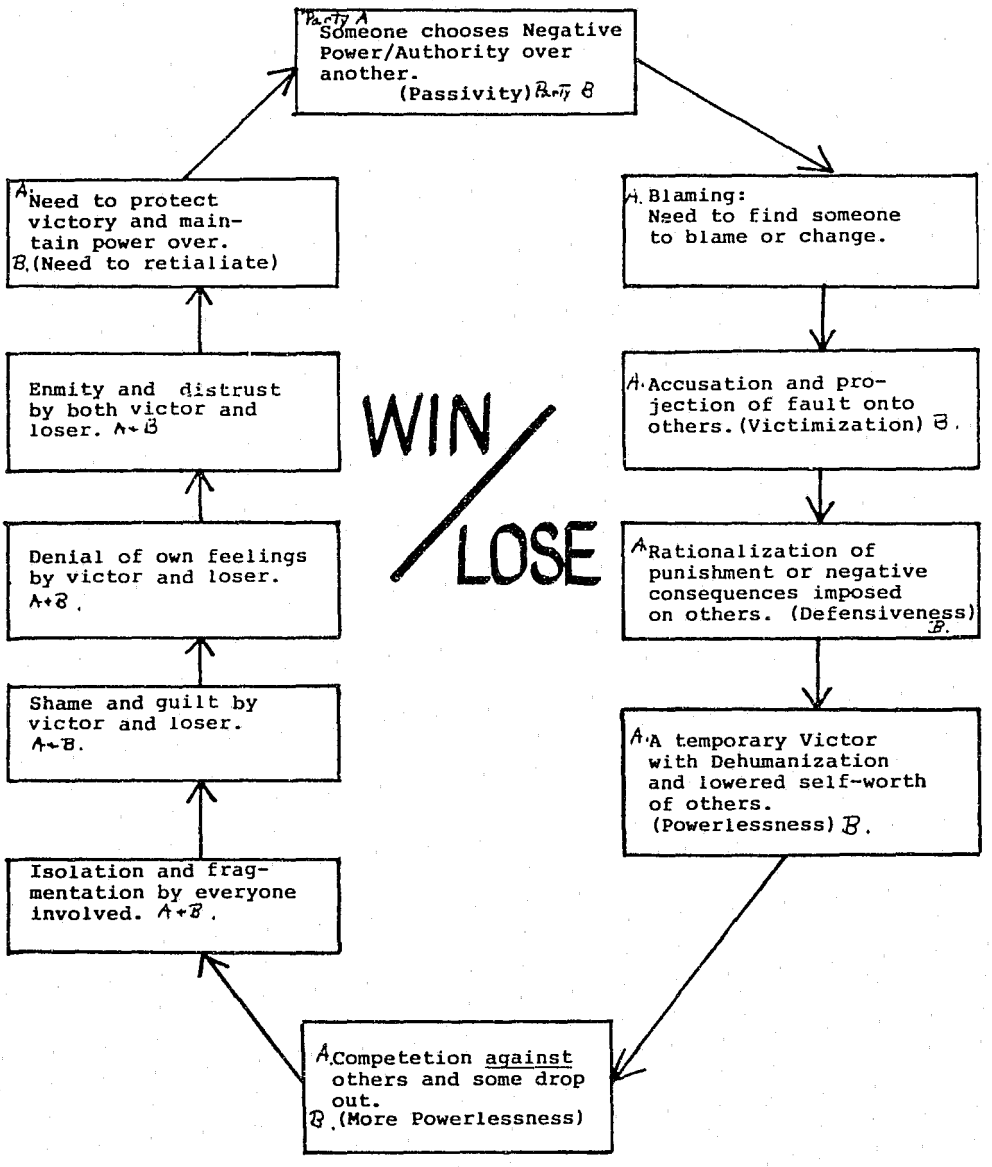
K. _____ Children's ability to problem solve is nurtured from birth on.

L. _____ Justice must be present for peace and harmony to be sustained.

Excerpts from: PFPF Resource Guide
By: Barbara Oehlberg

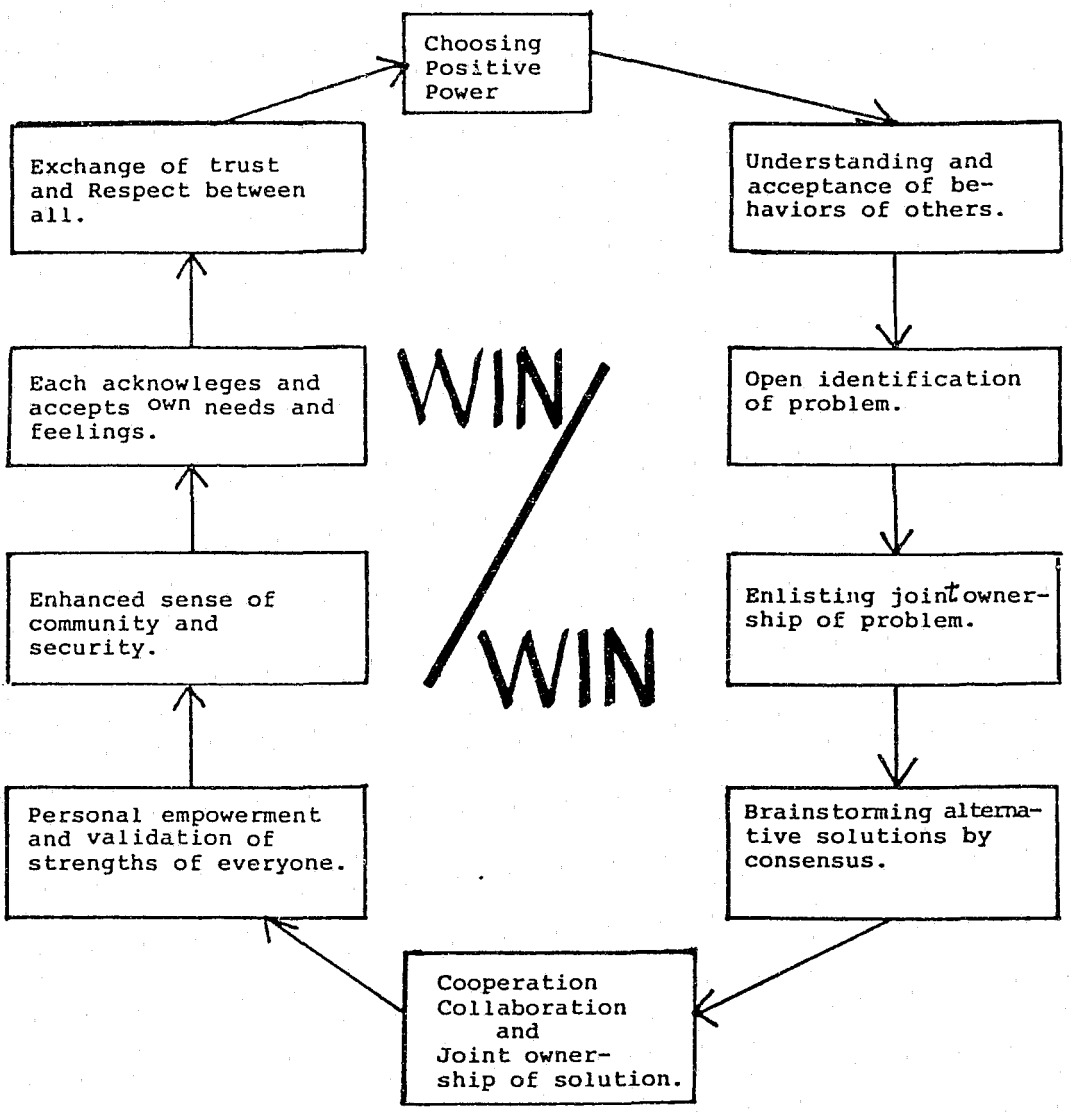
NEGATIVE POWER PROCESS

(IN RESPONSE TO A PROBLEM OR CONFLICT)



POSITIVE POWER PROCESS

(IN RESPONSE TO A PROBLEM OR CONFLICT)



THE DEVELOPMENT AND APPICATION OF A PSYCHOSOCIAL ASSESSMENT INSTRUMENT

Howard W. Kroll, Ph.D

Topics covered in the Workshop are outlined below:

I. Purpose of clinical form

1. Assess client.
2. Appropriately diagnose and intervene.
3. Provide structure/guidelines for collecting relevant data
4. Sensitize clinician to phenomena.
5. Enhance proper record keeping necessary for legal, reimbursement, and quality care reasons.

II. 1. Form used to assess adults? Children? Families in general? Families with a handicapped child?

2. Type of data and circumstances under which collected determined by target population.

III. Data

1. Type of data to be collected?
2. Amount of data to be collected?
3. Special issues in collecting mental status-type data.
4. Overlap in type of data collected irrespective of target population.

IV. Format

1. Clinical form structure/format. Checklist only? Narrative? Both
2. Advantages and disadvantages of different formats.
3. Inclusion of purpose, use, instructions, and definitions as components of form.
4. Sequential ordering of background and mental status-type items.

V. Clinician utilization

1. Form used by professionals only? Paraprofessionals? Both?

2. Discipline specific use of form? Multidisciplinary use?

VI. Training

1. Necessary before utilizing form?

2. Provided to all clinicians? Only paraprofessionals?

3. Type of training?

4. Length of training?

5. Conducted by whom?

6. Coverage issues while training occurs.

VII. Evaluation

1. Field testing.

2. Implementation agency-wide.

3. Process and outcome criteria.

VIII Legal issues/other

1. Use of copyrighted material.

2. Building upon previous work.

3. Importance of clinician input.

4. Final authority for content and structure, and possible philosophical and methodological issues arising thereof.

5. Extensive time commitment to conceptualize and develop form.

SOCIAL LEARNING, ATTRIBUTION AND INTERVENTIONS IN SPOUSE ABUSE

Oliver Williams, PhD, MPH, ACSW

Statement of the Problem

Intervention strategies in the case of spouse abuse are important in order to prevent and treat those who are at high risk of abusing as well as those who are abusing. Social learning theory and attribution theory may have value in the development of primary, secondary, and tertiary intervention strategies.

Regarding social learning and spouse abuse, first it may be useful to clarify which factors contribute to the social learning of the battering process. Second, it will be helpful to expand our traditional views and application of social learning as it relates to spouse abuse.

On the one hand, there seems to be an opinion that every man has the potential to be a batterer because "violence is a male prerogative" (Straus, 1980), "male socialization" tends to make us as a gender more accepting of violence (David and Brannon, 1976; Cicone and Ruble, 1978). Furthermore, men have historically been given implicit and explicit societal support to abuse women (McShane, 1979; Oppenlander, 1981. On this level there is an implicit acknowledgement that societal forces may influence the abusers' behavior.

On the other hand, batterers are said to be unique and distinct not only due to their behaviors but also due to their social learning experiences. These social learning experiences come, primarily, from family interactions; that is, batterers learn from their familial exposure to abuse (Straus, 1980; Star, 1980). In this scenario, society's influence is minimized.

In these two cases, which best describes the influences on the abuser: society's influence, family influence or both society and family? Although it is generally noted that these two areas influence the development of battering behavior, it is inconclusive how much one or the other contributes the most.

The social work concept of working with the "person-in-the environment" is inclusive about choosing among multiple environmental factors which may influence the acquisition of violent behavior. This may be due to the fact that, in cases of spousal battering, we tend to focus primarily on the family as the environment in which such behavior is learned. While Bandura (1962) has demonstrated that violent

behavior can be a potent learning message in non-family environments as well, the implications of this approach have not been widely recognized or discussed in the traditional social work literature on batterers and wife abuse.
Bandura (1972) has stated the following regarding social learning:

> "There is however, sufficient evidence to support the view that as a result of contiguous presentation, sensory experiences become `chained' in such a way that re-presentation of a stimulus can elicit imagined re-presentation of associated stimuli and that the perceptual-cognitive structures that are thus evoked may serve to guide behavior."

Simply stated, individuals can learn behaviors through models they have observed. Further, Bandura and others note that models stimuli not only convey information but also produce emotional and evaluative consequences that affect the acquisition of new patterns of behavior and performance of exiting behaviors. This includes models conveying attitudes, intensity of emotion, feeling states and other qualitative responses to the observer within both situational or contextual frames of reference (Bandura and Harris, 1966; Bandura and Mischel, 1965; Bandura and McDonald, 1963).

Traditional sources in the spouse abuse literature attribute the batterers' behavior to intergenerational familial learning (Straus, 1978,; Martin, 1976; Flynn, 1977; Steinmetz, 1980). In fact, researchers attribute as much as 50-80 percent of all battering behavior to intergenerational familial social learning of violence (Coleman, 1980; Star, 1980; Gondolf, 1983; Carlson, 1977; Owen and Straus, 1975; Roy, 1982; Dutton and Fehr 1983; Brisson, 1981). Regardless of the exact amount, it is entirely possible that much or all of the remaining 20-50 percent may be learned in non-familial environments.

In fact, it is entirely possible that a male who inflicts physical violence on his wife or girlfriend may never have been exposed to similar behavior by any member of his family. A child could be exposed to and learn violent behavior in a number of non-family environments, and adapt and generalize this behavior as an adult into intimate, personal relationships. Although the family may be the primary place for some children to learn violence, which will result in their violent battering behavior as an adult, perhaps in non family environments other children learn these behaviors which will result in adult battering as well.

Martin and Westra, 1980, p. 42 note that many children exposed to violence in the family learn to imitate either aggressive or violent behavior. Floyd (1985) notes that

children do learn aggressive and violent behavior in environments, such as school or in peer groups. Rosenbaum and O'leary, 1981, p. 693 suggest that the behavior learned in these environments may carry over into adult life.

The dynamics of violence learned outside the home may be essentially the same as home-based learning of violence. Floyd (1985) asserts that "children who are bullies at school tend to be abused at home and use violence as a way to identify with the aggressor (p. 11)." Conversely, children not exposed to violence in the family may learn aggressive or violent behavior from non-family environments such as school or peer environments and generalize this behavior in their adult life as well. Children who have not been exposed to violence in the home environment may learn in non-family environments that violence is a useful method of gaining dominance or control over a person or situation. Is it not possible that children who are victims of violence in non-family environments may learn, likewise, to identify with the agressor?

It is important, therefore, in social work, to develop a complete, well-rounded approach to abusive behavior; it is also important that we expand our view of the ways in which abusive behavior is learned to include the effects of violent behavior learned in non-family environments. This is particularly important if we are to develop different interventions including a range of preventive activity with high risk populations.

Effects of Violence On Children and Teens

There have been various studies and media reports which focus attention on the effects of non-family exposure to violence on childhood and teenage populations. In the study already cited, Bandura (1962) demonstrated that young children may be taught to use violent/aggressive behavior in response to frustration when this tactic was demonstrated by adult models, cartoons and violence in movies.

Kniveton (1986) demonstrated that students observing peer violence were likely to imitate, adapt, modify and include these behaviors as part of their own repertoire. In addition, children exposed to aggressive peer models would imitate these behaviors regardless of whether or not they were exposed to constructive non-violent models. He also found that the more one is exposed to violent and aggressive peer models the more likely one is to select and use violent and aggressive behaviors; and that the amount of violence one is exposed to may influence how violently that person will behave (p. 115).
Alex Kotlowitz, writer for the Wall Street Journal, in Oct. 1987 discussed the experiences of children exposed to violence in the inner-city of Chicago. In this article he noted that

these children may demonstrate a number of symptoms similar to those of Vietnam veterans. In fact, he cited a program in Los Angeles, California that treated inner-city children for post-traumatic-stress disorders as a result of that exposure. These children seemed to demonstrate characteristics similar to those of children exposed to violence between parental models or children who are physically abused by their parents. Such symptoms include aggressive behavior, passivity, developmental delays and depression. The thrust of Kotlowitz's observations and account of these childrens' experiences is that they are in an environment that promotes, demonstrates and justifies the use of violence. Moreover, many children may imitate what they have witnessed, over time, with apparent environmental support.

Bullock, Reilly, and Donahue (1983) note that investigations, such as the "Violent School--Safe School Study (1978)" reports that children are victims of violence in the school (p. 41). Nuttall and Kalesnik (1987) state that based on their "review of the literature, very few article in the last twenty years deal specifically with counseling these victims of personal violence (p. 372)." Although these studies indicate that victims are affected by the violence, they do not indicate how the victims respond to this experience. Does the violence experienced by these victims cause them to use violence, or if victims don't respond to violence from school or with peers through using violence as adolescents perhaps they may respond in this way as adults.

It would be helpful if research had compared abusers with non-abusers on this vitally important question of social learning environments. If such studies are done we may be able to clarify the question of environments. The results of such investigations may add to our usage, level, and type of interventions.

Attributions and Spouse Abuse

Another area that is worthy of clarifications between abusers and non abusers is their attributions. Attributions are the ascription made by individuals in order to assist them in both understanding and predicting their environment (Heider, 1958; Kelly, 1971).

Accordingly, one person my interpret another's behavior to mean one thing and another person may see it as something completely different. For example, one man may see an action of a person as helpful but another may interpret the same behavior as attacking.

The development of these ascriptions, which may be placed on self, others or situations, may occur due to prior environmental cues, prior experiences, prior ways the individual

has learned to view and feel about himself or others (Zillman and Jennings, 1973; Konecni, 1974; Loftis and Ross, 1973). All of these not only influence the attributions that are made but also influence how individuals behave (Younger and Doob, 1978; Snyder and Swann, 1977; Miller, Norman and Wright, 1978).

Although the concept of attributions fits very nicely with the concept of social learning (that is, life experiences influence how one interprets the world and how one behaves), in spouse abuse literature the concept of attributions is rarely discussed.

Dutton, Fehr, McEwen (1982) note that the batterer's perceived loss of control tends to trigger an arousal in him that will result in his use of violence. By using attribution theory coupled with the assertion by the researchers, batterers make attribution about their loss of control. They may attribute the cause of this loss to themselves, the situation or, most often, to their spouse. Violence, therefore, is a behavior that is a response to their ascription. It is also used to control their arousal. That is, if he can control the cause of his feelings (his wife) then his perceptions about control and arousal will change. Note, however, that the validity of the batterer's perceptions can either be real or imagined.

Attribution and Aggression

Snyder and Swann (1977) have shown that individuals who tend to view the world as competitive also tend to act on theirs as if they were opponents. These competitive types tend to view the victims as the cause of their behavior. Further, these researchers demonstrated that those people who they identified as cooperative, became competitive after being assaulted by those who they classified as a competitive. These former cooperative types made similar attributions and behave similarly as the competitive types after the assault. Thus, the researchers succeeded in socializing cooperative subjects to hostility. The competitive individuals subjective attributions served as scripts to predict and generate behavior.

In the case of spouse abuse, perhaps prior family or non family environmental experiences result in abusers interpreting certain spousal behaviors as a potential attack or threat to their control. This may be perceived as harmful; and the way that abusers have learned to respond to harmful attacks is through the use of violence. Gondolf (1985) notes that one single unifying characteristic among batterers is that of their need for control.

Roy notes that battered women remark how their husbands seem to compete with them (1982). It seems that batterers tend to feel as though they are victims rather than the perpetrators. Perhaps the competitive batterer's subjective

attributions served as scripts to predict and generate behavior. Some batterers feel justified in using violence as one of several tactics to help them control the attack from what they perceive to be the perpetrator, their wife. These Victim/Victor attributions may result in violent response in conflict situations by batterers.

A question that might be clarified is, "do batterers view or attribute the discrete conflict event, with a girlfriend or a spouse, differently than non-batterers"? or is it just that abusers respond to conflict situations differently through their violent behavior?

It is important for social workers to note the importance of these two theories with regard to the concepts of "the person in the environment." It is important because in our practice,clients demonstrate regularly that one's life experience influences not only the way one views the world but alsp how they see others. Life experiences may influence the predisposition to abuse alcohol or drugs; or to abuse children or parents; become a criminal; have emotional distress. These life experiences can occur both in family and in non family environments.

The Research Question

The study reported in this paper involves a comparison of childhood exposure to violence of a sample of male batterers and a control group of non-batterers. The study explores how groups perceived violent experience as observer, victim or participant. Roy (1982) reports that 81 percent of batterers have either witnessed or have been abused as a child. Owen and Straus (1975) found that those individuals who committed violence or were victims of violence, as children, tended to approve of the use of violence as a tactic to resolve conflict and obtain control in face-to-face situations. The three roles of participator, observer, and victim of violence were included in this study due to the fact that exposure to violent environments exist when the acts of violence occur; and the acts of violence occur in all three roles. It was expected that batterers would perceive greater involvement in all three roles than non-batterers because the literature, as reported earlier, suggest that batterers are exposed to violence due to social learning.

A violent social learning environment is an environment in which one is exposed to violent behaviors either directly or indirectly as well as to the attitudes and conditions that promote these behaviors. Potentially, one exposed to such an environment may interpret, adapt and generalize such behaviors, cues, and information in order to meet his needs. In this investigation violent social learning environment refers to environments where the acts of pushing, shoving, grabbing,

slapping, kicking, choking, scratching, jerking, twisting, biting, hitting, throwing something at someone, threatening or using a knife or gun on someone, or beating someone up occurs.

In addition, the study examined the impact upon batterers of contiguous reinforcing environments--that is, combinations of multiple non-family and family environments that may have jointly influenced the social learning of the batterer. Regarding non-family environments, school and friends, environments were first measured separately and then together in order to delineate the respondents' degree of exposure to violent acts in each of his non-family environments and in his total non-family environment. Social environments include elementary, junior high, and high school experiences. Friends environments include peers one regularly associated with, peers who were in the same clubs, or peers who lived in the same neighborhood. Regarding family environments, the respondents degree of exposure to violent acts among parents and among siblings was measured, first, separately and then together, in order to obtain a total measure of "family environments." Parents environments included parental models such as mother, father, stepmother, stepfather, mother's boyfriend, father's girlfriend, grandmother, grandfather and the like. Sibling environments included interactions with brothers, sisters, stepbrothers, stepsisters or the like.

The study also examined the influences of gender socialization on violent behavior in both family and non family. The literature generally identifies males as more violent and abusive than females (David, David and Brannon, 1976; Epstein and Taylor, 1967; Bandura, 1962; Cicone and Ruble, 1978). Spouse abuse literature likewise identifies the male parental role models as demonstrating the most violence (Martin and Westra, 1980). The present study examined the consistency of these findings between the two groups and in both environments.

With regard to attribution, the study sought to delineate how respondents perceive the causes of conflict in specific situations with a girlfriend or spouse. Respondents were ask to either accept or defer responsibility for the cause of conflict between themselves and their partner.

METHODOLOGY

The sample for this study consisted of 40 respondents: 20 batterers and 20 non-batterers. Respondents were obtained from the Second Step Program in Pittsburgh, PA; and from the Beaver County, PA branch of Catholic Charities of the diocese of Pittsburgh. Ten of the non-batterers were members of the Pittsburgh's Men's Collective, an organization dedicated to discussing self-growth and changing roles of males in our

society, and the other ten non-batters were selected by the batterers. These non-batterers were to consist of people from the batterers' neighborhood. In order to assure compliance from the respondents and separate the batterers from the non-batterers, each respondent was asked to identify on the questionnaire behaviors he had ever used with any girlfriend(s) or wives (wives). These behaviors ranged from non-violent to violent behavior. If a non-battering respondent indicated that he had used any of the violent behaviors, he was placed in the batterers group and replaced with another non-batterer.

The purpose of this method of selection was to get the best match possible for this non-probability sample. The groups were employment, sex, and age.

The Conflict Tactics Scale (CTS), developed by Murray Straus (1979), was used to measured exposure to violence in both family environments and non-family environments. Regarding expériences as victim, observer, and participant of violence a simple five point Likert scale was used. The Causal Dimension Scale (Russell 1982) was used to determine how respondents attributed the cause of conflict with a spouse or girlfriend. As stated earlier, attributions are ascriptions in order to help individuals predict their environment. Further, as stated before batterers tend to make ascriptions to the spouse as the cause of their violent behavior particularly in conflict situations. This scale will determine if batters differ from non batterers on whom they attribute the cause of their conflict. The method used to analyze the data comparing the two groups was the T-Test.

RESULTS

The results of this study demonstrate that batterers tended to be significantly more exposed to violence in non-family environments than non-batterers, particularly, in friends environment (refer to Table 1 and Table 2).

Table 1.

Subject's Combined Non-family Exposure to Violence

	Mean	SD	t	p=.027
Batterers	230.60000	58.592	2.31	
Non-batterers	192.2500	45.847		

***Significant at the .05 level

Table 2

Subject's Exposure to Violence Among Friends

	Mean	SD	t	p=.023
Batterers	111.1000	34.545	2.37	
Non-batterers	89.6000	21.281		

***Significant at the .05 level

However, the batterers in this study did not significantly differ from non-batterers with respect to exposure to violence in family environments, althought the means were in the expected direction.

Batterers also tended to participate in violence in non-family environments significantly more that did non-batterers, again this centered more in friends environment (refer to tables 3 and table 4).

Table 3

Subject's Perceptions about Participating in Violence in Combine Non-Family Environments

	Mean	SD	t	p=.031
Batterers	4.9500	2.064	2.26	
Non-batterers	3.7500	1.164		

***Significant at the .05 level

Table 4

Subject's Perceptions about Parrticipating in Violence in Friends Environment

	Mean	SD	t	p=.036
Batterers	2.4500	1.191	2.17	
Non-batterers	1.8000	0.616		

***Significant at the .05 level

Further, batterers tended to feel more like victims in both family and non-family environments particularly with parents, siblings, and school environments.

Table 5

Subject's Perceptions about being a Victim in Combine Family Environments

	Mean	SD	t	p=.010
Batterers	5.3000	1.720	2.94	
Non-batterers	3.7000	1.720		

***Significant at the .05 level

Table 6

Subject's Perceptions about being a Victim in Parent's Environments

	Mean	SD	t	p=.010
Batterers	2.7500	1.164	2.71	
Non-batterers	1.8500	.933		

***Significant at the .05 level

Table 7

Subject's Perceptions about being a Victim in Sibling's Environments

	Mean	SD	t	p=.041
Batterers	2.5500	1.099	2.12	
Non-batterers	1.8500	0.988		

***Significant at the .05 level

Table 8

Subject's Perceptions about being a Victim in Combine Non-Family Environments

	Mean	SD	t	p=.021
Batterers	5.2000	2.191	2.41	
Non-batterers	3.9000	1.021		

***Significant at the .05 level

Table 9

Subject's Perceptions about being a Victim in School Environments

	Mean	SD	t	p=.015
Batterers	2.7500	1.164	2.59	
Non-batterers	2.0000	0.562		

***Significant at the .05 level

Batterers tended not to differ from non-batterers in relationship to observing violence either in family or non-family environments. Finally, both batterers and non-batterers identified males as the gender modeling violence in all of the various environments, particiularly in non-family environments.

Regarding attributions, the analysis demonstrates that the comparison between the two groups was not significant at the .05 level (p=.379). Although the means were in the hypothesized directions, it appears that the two groups are similar regarding ascription of responsibility in conflict situations with a spouse or girlfriend.

A secondary analysis of the data, which considered the usage of various conflict tactics both violent and non violent (which was used to separate the batterers from the non batterers in this study), demonstrated that non batterers employ fewer tactics than do batterers to resolve conflict with a spouse or a girlfriend. In particular, non-batterers used fewer non-abusive responses than did batterers. In contrast batterers tended to use most of the non-battering tactics and many of the battering tactics as well.

Possibly, the batterer has a particular perception of their role as a problem solver; and this perception is different from that of non-batterers. Perhaps batterers feel that they must remedy conflict at any cost with a wide range of tactics. In contrast, either non-batterers don't perceive their role as problem solver the same ways as batterers or non-abusers feel comfortable with the few tactics that they use. Further, they may not feel as uncomfortable about the conflict issue in the same way as abusers.

IMPLICATIONS FOR SOCIAL WORK PRACTICE:

The finding of the present study point to the possibility that non-family exposure to violence, particularly in friends environment, provide batterers with the most potential to obtain social learning messages about the use of violence. As a

result, this study suggests that there is potential good in expanding the present view of social learning and spouse abuse to include non-family environments.

Further, batterers tend to feel like victims in every environment except among their friends. Maybe the lesson learned by batterers was that in order not to be victimized in one's interpersonal environment one should use violence. Such a message is then readily adapted and generalized to intimate relationships with a wife or girlfriend. Thus, the batterer behaves in what appears to him to be a powerful manner as exemplified by the male models in the various social learning environments.

The findings of this study further the notion that preventive interventions should be taken to alter social learning.

In particular, the findings regarding the critical role of friend's environment, bear close examination for their practice implications. It might be useful, for example, to consider creative interventions not only to tap into the friends network but also to tap into other environments where males are clustered; such as promoting discussion about the potential negative affects of violence in school environments; for example, health classes, or athletic programs.

Likewise, it might also be useful to discuss the negative effects of violence in neighborhood groups, parks and recreation, boys clubs and boy scouts to name a few. In addition to programs discussing the problem, perhaps it would be useful to develop programs focused on working with those individuals who participate and/or are victims of peer violence or thosewho just feel like victims, in order to help them both recover from (the primary solution) and to resolve conflict.

Regarding attributions, although the findings of this investigation demonstrate that batterers view the cause of conflict similarly to non-batterers, the secondary analysis on the issue of tactics may be interpreted to mean that batterers may see their role as conflict resolvers differently. Batterers use several tactics, both functional and dysfunctional, to respond to the conflict. In contrast, non-batterers tend not to view their role as problem solvers in the same way as batterers and thus they need not use a wide range of tactics.

Perhaps social learning to violence and feelings of victimization have conveyed to the batterer that conflict situations are intolerable; accordingly, conflict must be stopped at any cost. An implication for practice is that high risk populations to abuse may require attention in the area of conflict resolution strategies at the primary, secondary and tertiary levels of intervention.

CONCLUSION:

Violent behavior is not learned only in family environments. Peers, friends, and other non-familial environments are also of critical importance in learning violence. This study of samples of batterers and non-batterers found, that while batterers and non-batterers had been exposed to family violence in approximately equal degree, batterers were significantly more exposed to violence in non-family environments than non-batterers. This appears to suggest that batterers may, in fact, learn battering behavior outside the family. Further, batterers may also learn to feel like a victim in both family and non family environments.

Implications for practice are that, there are important possibilities for interventions with batterers in peer, friendship, neighborhood and other group settings which need to be developed.

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OUTREACH PROGRAMS FOR TEENS AT RISK

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Suicide is the second leading cause of death among young people ages 15-24. It has become a major public health problem in the United States. The teenage suicide rate has increased 226 percent since the 1960's. Over 5,000 young people killed themselves in 1983 in this country according to the most recent available statistics. Research indicates there may be 50 to 120 adolescents who attempt suicide for every adolescent who completes suicide. This research also shows that between 1.5 to 2.5 million of all adolescents in the United States may have actually made a suicide attempt. These staggering figures indicate the magnitude of the teenage suicide problem today.

STAR Center is Pennsylvania's first comprehensive program created for the early identification, referral and treatment of teens at risk. Developed through the efforts of the Pennsylvania State Legislature Sub-committee on the Tragedy of Teenage Suicide, and professionals at Western Psychiatric Institute and Clinic, STAR Center has two components: clinical treatment for adolescents identified as being suicidal, and outreach programs to individuals for the early identification and referral of adolescents at risk for suicide.

STAR Center offers the following outreach programs:

1) LEVEL TRAINING - training that alerts professionals to the behaviors, risk factors, and community resources available for suicidal teens;
2) SSOS, (Student Seminar on Stress) an educational program for adolescents that promtoes self-identification and positive coping strategies for stressful situations;
3) POSTVENTION - programs conducted to help survivors of suicide;
4) SPECIALIZED conferences and workshops - educational programs designed for a particular community or agency; and,
5) REGIONAL CONFERENCES.

Each of these programs plays an important role in the early identification and referral of adolescents at risk for suicide.

The basic component of our outreach efforts is our Level Training programs. These programs are designed for school faculty and staff, mental health therapists and other professionals who work with youths. We must identify

adolescents at risk for suicide and ensure that they receive mental health treatment. Schools play a pivotal role in early identification and referral of teens at risk. Our Level Training programs are designed to help school professionals do this. There are four levels of Training. The components are sequential and intended to increase the participants' knowledge and skill to work with suicidal adolescents.

Level I is STAR Center's basic intervention training program. This two-hour program teaches participants about the important role they play in early identification and referral of students at risk. There are several objectives to Training. Through group exercises, participants examine their level of comfort and acceptance in response to adolescents who might be suicidal.

Participants learn the risk factors associated with adolescent suicide, and intervention strategies to help suicidal adolescents. After a review of each school's suicide intervention plan, participants identify their role in the plan.

Participants gain valuable information about treatment agencies and programs that can help adolescents in crisis. STAR Center developed a "Help Card" that details these resources for professionals and students. The effectiveness of Level I Training is evaluated through a pre/post test. We use this tool to assess participants' knowledge of suicide issues before and after training. Participation in training prepares individuals for advanced Level Training programs.

Level II Training is a two-day program designed for school personnel who receive referrals of adolescents identified as being at risk. Participants learn the important role they play in referring adolescents to treatment facilities and providing follow-up information. School professionals have access to a great deal of valuable information that clinicians may use to treat suicidal adolescents. One objective of the Level II Training is for participants to also gain a more in-depth understanding of the risk factors associated with suicide and depression. Another objective in Level II Training is the development of assessment acumen. Participants are taught how to use the TIPS (Teachers Interview for Psychiatric Symptoms). This semi-structured interview is designed to effectively gather information about a student's behavior in school. This assessment instrument provides school professionals with a comprehensive psychological profile of a student. Participants also learn basic crisis intervention techniques such as overcoming resistance, developing effective listening skills, and applying problem solving techniques.

During Level II Training time is devoted to reviewing a school's suicide intervention policy. Participants discuss the programs the school will implement to help suicidal adolescents, the protocol for intervention if a student is identified as being suicidal and what action a school will take if a student does complete suicide. A pre/post text and role playing are used to evaluate the effectiveness of the Level II Training program. Participants who complete this level of training may enter Level III.

Level III Training is a one-day workshop designed to teach participants how to present Level I Training. STAR Center developed a training manual that gives participants directives and script to use in conducting Level I Training. The participants are taught the risk factors associated with adolescent suicidal behavior through a review of the literature used to prepare the Level I program. By participating in Level III Training, participants become school-based resources capable of providing educational programs on adolescents at risk to faculty, parents and students.

We evaluate the effectiveness of Level III Training in two ways. The first time Level III graduates conduct a Level I workshop, they are supervised by STAR Center staff. In addition, the pre/post test evaluation format is used to assess the effectiveness of the presentation.

STAR Center staff conducts the first three levels of training on-site, however, the fourth Level of training is conducted at Western Psychiatric Institute and Clinic. This one-day training workshop teaches participants how to conduct Level II Training. Individuals participating in Level IV Training become regional resources on early identification and treatment of teens at risk. They develop a comprehensive understanding of effective intervention techniques with adolescents who are suicidal. Participants learn how to identify and coordinate resources within their region and develop the ability to initiate other training programs. The first time individuals conduct Level II Training they are evaluated by STAR Center staff. Analysis of the pre/post test results gives the trainers information on their effectiveness. Through these Level Training Programs, STAR Center plans to create a group of highly skilled professionals who provide comprehensive training on teenage suicide intervention through Western Pennsylvania. The Level Training programs are a significant part of STAR Center's outreach efforts.

PUBLIC HEALTH AND DOMESTIC VIOLENCE: A NATIONAL PERSPECTIVE

Robert W. ten Bensel, M.D., MPH

INTRODUCTION

The child advocate's basis of practice has been that children have special needs for nurturance and protection and the family is the best place for the care of children. These assumptions come from a long history which have defined basic human needs. These common basic needs include food, clothing, and shelter, protection (safety and supervision), the need to be in a primary relationship called a "family", and the need for mental, physical, chemical, and sexual health.

Human history records two universal characteristics. These include language; the need to communicate meaningful life experiences, and the family unit to transmit culture. There also appear two sacred and inviolable taboos; incest and undeserved cruelty ("gratuitous cruelty"). Incest has been recognized to destroy the child's identity in relationships to that of the parent(s) in a family. It appears also that incest has been recognized to cause genetic harm to offspring and to have intergenerational transmission. Undeserved cruelty, also referred to as a pattern of "sadistic" or "terroristic cruelty", is severe harm without cause. Being involved in a terroristic situation leads to confusion and helplessness and is currently referred to as a "traumatic stress disorder".

HISTORICAL DEVELOPMENT

The historical development of the western value system would be summarized as "life is sacred and the prevention of harm to humans must be maximized". It has been said that "if there is such a thing as an absolute evil, it consists of treating another human being as a thing. "Children ("future life") and other humans, treated as things can no longer be tolerated in a "caring society".

Robert Bellah, et al. in Habits of the Heart: Individualism and Commitment in American Life state in the preface: "How ought we to live? How ought we to think about how to live? Who are we, as Americans? What is our character?" (1) Habits of the Heart is based on the observations of Alexis de Tocqueville on his trip to America

in the 1830s. De Tocqueville commented that the formation of the American character was based in family life, religious traditions, and participation in local politics. These created a person who could sustain a connection to a wider political community and support the maintenance of free institutions. These concepts are embedded in the American character as well as in the professional identity of Public Health and Maternal and Child Health. Maternal and Child Health deals with the concept of healthy families, healthy pregnancies, and healthy children who become competent adults. De Tocqueville also noted that the greatest threat to American character was "individualism" or personal gratification rather than the greater good of the community. This is the continuing issue of instituting effective public health issues.

THE CHANGING AMERICAN FAMILY

The status of the American family is of great concern to our society. (2) Of children born in 1987, one third will eventually be on welfare. Children living in poverty will continue to increase. Poverty in children is seven times more common than of people over the age of 65. By the year 1990, one half of children will live with a single parent. The divorce rate remains high and there is an increase of women in the workplace. It is also estimated that in 1988, 1.1 million children (under age 18) will get pregnant. This has led to the statement of the problem of adolescent pregnancy as "children having children."

These family changes are reflected in rising child neglect and abuse reports. In 1987 there were over 2.2 million reports of which over 300,000 were for sexual abuse. The most rapid increase in case reports has been in sexual abuse (up 32% from 1984 to 1986). From 1963-1987 the number of children reported rose from 150,000 to 2.2 million children (a fourteen-fold increase). More dramatically is the rise in court cases from 1975-1985, which rose from 6,000 reported cases going to court, to 113,000 (a nineteen-fold increase). The battering of women is now considered the most frequent cause of physical injury for which women seek medical care. In 1980 suicide, homicide and assault resulted in 50,000 deaths with 1.3 million years of potential life lost and costs the U.S. 1.8 million hospital days. (3)

Adolescent suicide is reported on the increase. A study done in Minnesota from data in 1980 and 1981 shows that 70% of the children who committed suicide were under treatment and that the adults "aren't listening". Nineteen percent of the events reveal "brutal" treatment by the

father in the home. Schools were also part of the problem in that 4 out of 10 events mentioned in suicide notes implied "teachers don't care". Also it was noted there was a high correlation with being bullied or being assaulted in school. A major finding in the Minnesota data regarding adolescent suicide is the increased lethality with higher death rates. The Minnesota Center for Health Statistics reports an average of six rifles per Minnesota family which would arm "25% of the entire Soviet Army". Thus, the availability of rifles appears to be a factor in the higher lethality rate. (4)

FAMILY POLICY IN AMERICA

The United States and the Union of South Africa are the only two countries in the industrialized western world with no formalized governmental "family policy". Our attitudes toward children on the one hand appear benevolent and yet on the other hand the United States is the only country in the world to certify children as adults and execute them. The United States is the only western culture which allows corporal punishments in schools (except in nine states and several cities which prohibit corporal punishment). The issue of family policy needs to establish the right of prenatal care for all women in the United States as well as a concept of once you are born, the right to be protected from the environment. Failure to be protected from one's parents is considered child neglect and abuse and being protected from one's environment is referred to as environmental safety or injury control. Why are Public Health and Maternal and Child Health involved in family violence? Family violence takes away from all of the other gains made in medicine and in public health. The data support that the time of pregnancy is a stressful time with 10% of wife abuse occurring during pregnancy. It is estimated that the prevalence of children (10-18) being physically abused in the United States is 17% and both male and female children who are sexually abused is estimated at approximately 25%.

How do we deal with the severely disturbed family which is chaotic, greatly distorted, uses denial and projection and has maladaptive coping mechanisms such as alcohol, drug misuse and acting-out behavior? How do we support the development of healthy families? Healthy families are define as being more democratic, with sharing, caring and good communication patterns. They have a strong sense of respect for others, the ability to listen, to be warm, expressive; in summary, to be compassionate. How do we build and support healthy families in America?

THE PROBLEM OF NEGLECT OF CHILDREN IN FAMILIES

In America we have "neglected neglect". We not only have neglected our children as revealed in the reports of child maltreatment, which reflect that about 60% of cases reported are for "deprivation of necessities" and another 10% for "emotional maltreatment." Neglect of children is the basic cause of most abuse and neglect. When we deal with physical abandonment of children, physical and sexual abuse, or child homicides we are dealing with the failure to protect the safety needs of the child.

Not only have we neglected our children but we have neglected our families through our lack of national family policies. This becomes even more manifest when we look at the problems of child protective services in America.

CHILD WELFARE AND CHILD PROTECTIVE SERVICES

The increase in child abuse and neglect reports also reflects an increase from the middle class, particularly in divorce and child custody situations. The rising caseloads coupled with more resources being used for the prosecution of perpetrators are straining the fiscal resource of most local communities. The nation is moving to develop risk scales of severity of abuse as well as criteria for "families in need of services" criteria. (5) The available data shows that many cases are referred to child protection services (CPS) and yet there are deaths of these children which have been reported. How does our society respond to families which are reported and how have we failed these children and families when death occurs? Some recent studies suggest that up to 60% of the deaths are not due to child physical or sexual abuse but are due to neglect with lack of supervision and appropriate care.

The American Public Welfare Association through their affiliate, the National Association of Public Child Welfare Administrators (1988), have developed model child protective services guidelines. (6) In addition, there have been consensus building workshops to develop policy guidelines for decision making in child abuse and neglect reporting and investigation. These 1988 guidelines were developed by the American Public Welfare Association, the American Bar Association, and the American Enterprise Institute (7). These published guidelines reaffirm the rights of parents to raise their children if they are willing and able to protect them, and for children to have the right to be raised by their families except in cases where there is "clear evidence" that leaving the child in the home will lead to

serious harm. It also affirms the concept of family diversity which is reflected in different values, cultures, and religions which must be respected by the child protective service agencies. (6) The entire society has the responsibility to protect the health and welfare of all children. Child protective services, on the other hand, have a very narrow responsibility to "identify, treat, and prevent child abuse and neglect; and to ensure that reasonable efforts are made to maintain children in their own home". CPS workers need to be "nonjudgemental" and offer supportive and "non-punitive" services. This objective is critical as there is false or overreporting of at least 15% in sexual abuse cases and this trend is also seen in physical abuse and neglect cases. The concept of "unsubstantiated" or "substantiated" reports is changing. The final judgments from the initial report needs to deal with the concept of a family or "child in need of further services". This is a "time for change", and "the need for change has been identified within and outside child protective service agencies." (6)

THE LEGAL SYSTEM

"American history is driven by law and a sense of justice", states columnist Anthony Lewis. (8) The child abuse and neglect reporting laws which were a response to Dr. Kempe's article in 1962 entitled, "The Battered Child Syndrome" led to the establishment of model legislation developed by the Children's Bureau. (9) From 1963-1968, all 50 states enacted reporting laws. These reporting laws, from 1968 until the present time, are the most changed legislation in the entire U.S. history. In 1974, the National Child Abuse and Neglect Treatment and Prevention Act was passed. Edward Ziegler gave the address to the First National Conference on Child Abuse in 1976. He stated that the impact of the federal legislation was "little more than putting a band aid on a cancer" and that "social change is not produced by the stroke of a pen but by intensive and persistent efforts to change the ecology within which the social target is embedded."

The current federal and state focus has taken a somewhat different approach by supporting more vigorous prosecution of child abuse perpetrators. This has been manifested in the Attorney General's 1984 Task Force on Family Violence. (10) The assumption of the report is that "a victim of family violence is no less a victim than one set upon by strangers". The first two recommendations were that "family violence needs to be responded to as criminal activity" and that "law enforcement officials, prosecutors, and judges should develop a coordinated response to family

violence". In 1985 the National Center for the Prosecution of Child Abuse was established in Arlington, Virginia. The American Bar Association has made statements that there needs to be more vigorous prosecution of professionals who fail to report and also consider "suspending professional licenses where gross disregard for the reporting laws occurs". No physician, to date, has been held criminally accountable for failing to make a report of a known case of child abuse. If criminal sanctions are introduced for failing to report, it may drive professionals away from dealing positively with the issue by discouraging teamwork and developing distrust between professionals. The unintended consequences from well-intended policies and laws may have long term negative effects for children and families.

Perhaps one of the most fruitful developments is the potential for volunteers in the court who advocate for the child. Guardian ad litems (GAL) and Court Appointed Special Advocates (CASA) represent the child's voice in the court. The CASA goal is that every child in need of one will have one by the year 2000. At the present time there are over 3,000 courts in the United States which deal with child dependency. Of these courts, 271 now have CASA/GAL programs. The goal is to include the 2,744 remaining courts reaching more than 230,000 children. This will require at least 229 new programs or 19,000 children a year. Assurances for proper training for the proper role of the child advocate in their relationship to other professionals is critical. It requires caring, nonjudgemental, and objective opinions which require great skill and supervision of volunteers.

ADVANCES IN MEDICINE AND CHILD NEGLECT

The American Academy of Pediatrics and the American Medical Association have been involved with child abuse since 1962. Dr. Kempe's article also leads to policy adoptions by the American Medical Association in 1962 on Guidelines on Prevention and Treatment of Child Abuse and Neglect. In 1984, the AMA adopted AMA Diagnostic and Treatment Guidelines which were sent to all member physicians. (11) In 1988, there is a proposed Section of Child Abuse in the American Academy of Pediatrics. Over 440 member pediatricians expressed an interest in membership. A recent survey of pediatricians published in 1988, based on a sample of 1000 random pediatricians with a 73% response rate, showed that 85% of pediatricians dealt with child abuse within the last five years. Approximately one third taught child abuse content, one fourth were medical-legal experts in court, and 17% were members of a child abuse

team. These trendlines are impressive and show the involvement of pediatricians in this area. The need to involve family physicians, who care for most of the United States children's medical and health problems needs to occur.

The Surgeon General of the United States, C. Everett Koop, has been a forceful leader in bringing public health and the issues of violence together. He initiated a Conference on Public Health and Violence at Leesburg, Virginia in October, 1985. (12) He has also worked collaboratively with the Department of Justice in a Law-Health Initiative to ensure the working together of the Department of Justice and health providers. This effort has not reached a successful conclusion and shows the opportunities and difficulties in "working together". The Centers for Disease Control, Atlanta Project, is coordinating public and private agencies that perform research and service by updating their violence data base for the United States. The U.S. Public Health Service has also instituted the Detroit Project to work on banning fire arms in public places. Other health and public health issues involve the need to improve the medical examiner/coroner systems in this country. Approximately only half of the medical examiners/coroners are mandated reporters when there is suspected child abuse and neglect deaths to report to their child protective services. Child fatality teams are being instituted in the United States working on the assumption that no child should die without a thorough review of the factors that lead to the death. This is modelled after the successful maternal death mortality review teams of the 1930s through the 1960s.

Other issues regarding health include the increased pressure for child day care facilities in the United States. Skyrocketing costs and cancellations of insurance policies have been on the increase. One of the major problems has been affordable insurance, which may range as high as $12,000-$30,000 a year. Increased reports of child sexual abuse from day care has been a major factor. DHHS is promulgating rules on Head Start to "safeguard Head Start children from child neglect and abuse". Screening of Head Start employees which will check pending and prior criminal assaults, convictions related to child neglect and abuse, and convictions for violent felonies will be completed prior to employment. These safeguards may reduce risk to children and cost to daycare in the future.

Finally, is the issue of AIDS and child sexual abuse. There have been sporadic reports regarding an association between AIDS and adult male sex offenders and sexual abuse

environment." (5) We need to use our clinical judgement as well. We need to bring together our clinical skills, available research, and management data in our decision making processes.

FUTURE DIRECTIONS

The future will require us dealing with neglect and meeting the basic needs of children and families. We must focus on primary prevention as well as therapy for the emotional stresses that children and families have suffered. We need to continue strengthening the organizations that deal with child neglect. We must realize that these issues are not confined to the low socioeconomic income or poverty. Child neglect is beyond poverty. The entire society must "own" the neglect issues and be part of the solutions. We need to realize that physical abuse of the home occurs in all socioeconomic groups. We need compassionate, moderate, and effective prevention programs as our public policy priority.

"I have met so many good people that I have almost lost my faith in the wickedness of mankind" (Will Durant, 1885-1981). It is indeed fortunate that in America, these values of altruism still exist. They work against the individualism that de Tocqueville felt would destroy America. We have the vision of Erik Erikson, who wrote, "someday maybe, there will exist a well informed, well considered, and fervent public conviction that the most deadly of all possible sins is the mutilation of a child's spirit". (9)

William Inge said "the proper time to influence the character of a child is about a hundred years before he is born." Kuan Tzu IV (3rd Century B.C.) stated: "If it is just for a year: sow seeds. If it is for ten years: plant trees. If it is for a hundred years: educate your people."

Public health workers in all areas need to continue with our most successful of all public health interventions, which is education. If we educate our people, we will have enlightened public policy. With enlightened public policy, we will have enlightened statutes, rules, and regulations. We will maintain our "character" into the future. Our future is based upon our families and our children.

grant-matching monies for states. These matching resources are used in over 27 states. Nearly half of the states have parent education programs, 15 states have prenatal and perinatal services for high risk women and infants, 22 states have homemaker services and 17 states have parent-aid support systems.

We will continue to strive for balance between intervention and prevention programs for those children and families which have been victims of abuse and/or neglect. We need to keep our eyes on primary prevention while dealing with the crises of the day. Child abuse and neglect has become a large industry,. Do we really want to put ourselves out of business? There are more and more conferences on "the traumatized child". There is a new journal: The Journal of Traumatic Stress, first published in 1988. (18) Trauma refers to "a blow", or a "sudden wound". Trauma generally applies to physical injuries or to dramatic psychological insults. How does one balance the concept of trauma versus the slow emersion in a chronically and pervasively neglecting family? If we do believe that neglect is the primary issue then perhaps we need to make every effort to have a "Journal of Neglect". Neglect certainly does not have the headlines, the professional support, and awareness that "trauma" has in our professional societies. We tend to deal with the crisis headline issues rather than the basic issues of everyday life.

We need to move toward injury prevention. We need to design out the problem if at all possible. We have good models with seatbelts, safety tops on medicine bottles, fire retardant clothes and reducing the temperature on hot water heaters below 120 degrees fahrenheit to prevent hot water burns. We need to move to concepts of "wholeness", which include health, safety, justice, intactness, and appropriate limits (boundaries). The negative terms of "incompleteness" are those related to disease, harm, injustice, injury, and evil. We need to create a "Circle of Safety" for our children. Our words are changing from accidents to injuries. The generic concept is one that deals with the concept of reducing harm from not only the family but also from the environment.

We need to attempt to identify those families, environments, and children who are at risk for injury. The word "risk" implies a "danger", a "rock"; "something that cuts". It is a "factor", "element" or "course" involving uncertain danger". As professionals we need to take risks and make risk assessments. We need to appreciate that "ratings or composite scores should never be used as the sole basis of casework decisions about a family, child, or

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SUMMARIZATION OF THE PROCEEDINGS FROM "FAMILY VIOLENCE: PUBLIC HEALTH SOCIAL WORK'S ROLE IN PREVENTION"

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The Public Health Social Work Institute focused on the above theme throughout all of the workshops and presentations. The seriousness of the topics have reflected the seriousness of the issue of family violence in today's society. Public Health Social Work's Role with Prevention of Family Violence is also seen throughout the Institute's activities.

Alicia Fairley, in her keynote address "Family Violence: A Contemporary Social Phenomenon," produced a sensitivity to the issue of violence for children and families. An increase in violence is seen to reduce the quality of life. In the past the issue was dealt with secretly. Now data is showing that violence and injury are the leading causes of death.

The Surgeon General's report on Violence and Public Health, 1985, gives the topic of violence a high priority on the Public Health Agenda. The family unit is seen as very important. Alicia notes that the strengths and stability of the family are being threatened. Family "spats" are now becoming violent. There is an increase in child abuse, incest, sibling abuse, and elder abuse both within the family and outside.

Family violence is seen as more complex than violence committed by an unknown. Data was offered to show the extent of the increase in spouse abuse, homicide and suicide, and the impact of that violence on the later generations.

Data from the F.B.I. Uniform Crime Reports of 1982 showed that 60 percent of homicides were committed by people known to one another. Often the family member providing the nurturing relationships is the same person committing the violence.

The National Crime Survey covering the years 1973-1981 provided data that there were 4.1 million victimizations by family members. Fifty-seven percent of all the crimes are by the spouse or ex-spouse. On the topic of self-protection, with 73 percent of attacks by relatives, the victims used passive resistance. Twenty-three percent used active resistance.

There are no simple answers to the family violence issue. Public Health must look at multi-dimensional factors including social, structural, and interactional factors. There have been dramatic changes in the way the home, school, and church are looked upon. The family has moved from extended to nuclear to single. Family involvement has decreased, schools are chaotic, and the church role is decreasing.

Public Health Social Work must take an active role in looking at Public Health policy, supporting reporting systems, and improving the collection of data. We need effective identification, treatment, and referral. We need to reexamine nonmedical problems related to violence. The mission is to SAVE Our Children, as children of today don't live past tomorrow.

In the first workshop, "Domestic Violence During Pregnancy", Mary Rizk describes wife battering/spousal abuse/wife beating as occurring among all socioeconomic classes, races, religions, and educational levels. The inadequate reporting by medical, legal, and law-enforcement officials, as well as the under-reporting by the victims themselves, make it difficult to determine the magnitude of the problem.

The focus of the presentation was secondary intervention for domestic violence during pregnancy. When the battered woman is pregnant, she can be considered a high risk maternity patient. Domestic violence with this population focuses on two victims--the wife/mother/mother-to-be, and the unborn fetus. Issues arise for the profession. Should the profession move in the direction of fetus protection; fetal custody? Should the state intervene to protect the unborn fetus?

The question of " why" during pregnancy was answered by discussion of what happens emotionally during the three trimesters for the woman and family. Pregnancy is more frequently linked with an increase in battering behavior. Pregnancy generates greater strain on the relationship, which may lead to frustration and violence. The husband appears jealous of the unborn baby and resents the intrusion on his relationship with his wife. Ninety percent of all domestic violence begins at pregnancy.

Eight recommendations were produced from the workshop:

1. A participant suggested that the national average of domestic violence is 16 percent. Therefore, professionals should look for 16 percent within their caseload.

2. Public Health Social Workers should align themselves with other service providers who interface with the family at risk, i.e., legal professionals, medical/health care providers, and other human service providers. We should work toward a multidisciplinary approach.

3. Develop flexibility in our approaches to the resistant victims. Make better use of our community resources.

4. Involve victimizers in treatment/rehabilitation.

5. Develop provisions for handling/addressing false accusations.

6. Family treatment and family assessment.

7. Assume an ethical responsibility to ask the right question, provide objective investigation, and design training for other professionals to do the same.

8. Provide case management, networking, identify community action mechanisms for protection of the fetus, protection of the mother, protection of the father, and protection of the family.

Becky Williams presented the workshop entitled "Helping Committees Build Effective Child Abuse Prevention Programs--The Arkansas Model".

The Arkansas experience described methods used for child abuse prevention. The history of the enactment of Children's Trust Fund Legislation lent itself to a discussion of the importance of a supportive political climate. The emphasis was placed on the local community for self-determination with the Trust Fund used as start up money for community level prevention.

Various methods for continuation of funding ranged from attaching surcharges to marriage license fees, to attaching a fee to birth registrations. In Arkansas local councils were formed--one per county. The councils included representatives from the Health Department, Children's Services, Department of Education, Law Enforcement, and citizens-at-large.

The Arkansas model also placed an emphasis on Public Awareness utilizing Press Conferences, Public Service Announcements, Balloon Releases, and receptions with political visibility. The generation of awareness at times can overcome the political climate.

Rhonda Brode, in her workshop "Public Health Social Work and Child Welfare Social Work: A Team Approach to Child Abuse Prevention", noted that a large percentage of Southwest Ohio's poor, unemployed, and at-risk population are located in the Dayton City area.

Social workers are seen as the primary gatekeepers and can uniquely answer why abuse occurs, when do we intervene, and how do we prevent its occurrence. The need exists for coordination of services within and among service delivery systems. A logical point to begin are with health and child welfare systems.

In her paper she delineates the role of the child welfare worker and that of the Medical or Public Health Social Worker. Rhonda describes a joint project entitled "First Time Around". The project involves the Miami Valley Hospital's Medical Social Services and Discharge Planning Department, the Montgomery County Children Service Board, the Montgomery County Combined Health District, and Womanline. The consortium provides parenting education, home visits, and peer support to parents with an emphasis on first time parents. The project is community-based, and is offered at three different sites to insure accessibility. The sessions are offered as an eight week series followed by a joint home visit by the County Children's Services Caseworker or the Hospital Social Worker and the District Public Health Nurse.

This early intervention by the consortium provides a comprehensive, collaborative approach to the problems of quality medical care, health education, parenting education, and emotional support. The programs's objective is to reduce the incidence of child abuse and neglect by focusing on the first time parent's parenting skills and their coping abilities.

Ruth Messinger Rockowitz's workshop was on "AIDS: Public Health Social Work's Role in Prevention". From the great state of New York, Ruth presented the results of surveys ranging from the payment for medical care to attitudes regarding the disease to the incidence of Pedicatric AIDS. An emphasis was placed on a need for a continuance of care for the aids patient including:

1. Inpatient
2. Home Health
3. Hospice
4. Longterm Care
5. Foster and Day Care for Children
6. Multidisciplinary Care Teams
7. Dental Care
8. Case Managenment
9. Health Education
10. Transportation
11. Volunteer Buddies
12. Housing Enrichment
13. Individual Care Plan

The Care Systems for the future must address not only primary and tertiary care for those with HIV+, ARC, or AIDS, but <u>must address Preventive Education</u> to everyone else.

Even though there is no magic bullet, progress is seen with the use of screening and diagnostic tests, possible treatment, and the elimination of transmission via blood transfusions.

The PHSW role is essential is dealing with AIDS. Twelve areas for the PHSW were enlisted:

1. Research
2. Distribution of Information
3. Dispelling of Myths
4. Provision of Comprehensive Social Services
5. Advocacy
6. Insurance of Confidentiality
7. Helping the Helpers
8. Training the Community
9. Insuring Legal Assistance
10. Identifying Community Educational Needs
11. Case Management
12. Networking with other Social Workers, and I may add
13. Networking with other disciplines

During the luncheon session of the first day, John Smey gave "An Historical Overview of Child Protective Services". Jack provided us with an historical perspective outlining how the rudiments of a child protective services system progressed and digressed over the years. The ongoing struggle appears to continue between and among the rights of parents, the rights of children, and the rights of the state to intervene. Along the way, the change was made from "rescuing" children to "changing" the family unit.

The first generation, as described, was the legal approach emphasizing prosecution vs. protection. In the second generation the push was for prevention efforts. Looking at social causes as well as personal causes was added to the legal enforcement approach. The third generation moved to social responsibility with efforts to increase family living standards. The 1960s brought mandatory reporting laws, the diagnosis of Battered Child Syndrome, and increased funding and staffing of Child Protective Systems. It also brought about a consensus that:

1. Punishment of parents is not an effective method
2. Bonding to parents was very important
3. Removal of the child does not terminate bonding and also increases concerns in regard to separation problems
4. Cost of services in one's own home is less than the cost for a foster home placement.

The fourth generation sees child abuse as a multidisciplinary problem with certain trends developing:

1. Government funds are emphasizing the short term quick fix.

2. An increase in criminal prosecution became an alternate to social services.
3. There is decreased financial support from the private areas.
4. Disciplines are competing for limited funding.

In the fifth generation, Jack described an ideal world where the child would be seen as a being rather than an object...where there would be a full consensus and commitment with the elimination of violence, and an elimination of abuse.

The second day brought us together in early morning with Debbie Stokes: "Child Maltreatment. A Joint Prevention Project Between Public Health and Child Welfare." The project described the coordinated efforts for early dientification and prevention. Five areas were emphasized:

1. Early screening of newborns one to four months
2. Cooperation on investigation strategies
3. Cooperation on planning treatment and follow-up
4. Continuing education on the interdisciplinary method
5. Consultation to nursing, social work, and medicine

The project maximized the interdisciplinary method, especially between Health Services and Child Welfare.

Part I of the project set up alternate systems of service delivery, two urban and two rural. The criteria for the four sites included consideration of geography, percentage of reports, success rate of services, and what was politically acceptable. Birth certificates are being used to identify the population. Newborn assessments ae conducted using the NCAST System and the Family Stress Check List. On those identifed as vulnerable, a coordinated case plan is completed with assistance in planning efforts. Follow-up if made by an often difficult-to-arrange six month home visit.

Part II of the project is Educational An interdisciplinary Committee will analyze the current school curriculum offered regarding child abuse and neglect. Other educational activities include seminars on child abuse and neglect. Current issues coming out of the project include:

1. Questions on the use of the birth certificate
2. What is early intervention?
3. Follow-up on vulnerable families is difficult
4. Confidentiality issues
5. Uniform interpretation of State policy
6. Need for research and urther studies
7. How effective are supportive studies
8. Need to look at duplication of services
9. Need to look at traditional delivery of services

"All children are our children" should be applied to policy and programs.

In the first workshop of the second day, Barbara Oehlberg presented "Parenting for Peaceful Families." The project as described was an outgrowth of the Ohio's Peace Education Network (OPEN). The project has developed to a point where it has been integrated into the Ohio Health Department. It has received both political backing and corporate backing in its efforts to strengthen families.
The next step above the non-violent family is the peaceful family, as proposed by Barbara.

The project integrates peace-making into families by delivering educational information and permitting families to take ownership of same. The education makes it possible for families to look at their belief systems and then to choose to change--to look at their parenting and make it possible by choice to change that parenting.

Written exercises during the session provided the participants with a values clarification method which was non-threatening and educational. Barbara pointed out that there is no one single way to parent, no absolute parenting method.

Howard Kroll's Workshop on "The Development and Application of a Psychosocial Assessment Instrument" was truly a workshop, engendering much constructive discussion. Basic information was provided regarding the process and issues involved in the conceptualization, development, and utilization of a clinical form for client assessment. The structure of the presentation covered the areas of:

1. Data
2. Format
3. Clinical Utilization
4. Training (in the use of the form)
5. Evaluation
6. Legal Issues

Samples of forms and their creation and development were used to raise questions and then to apply them to the participants settings.

Oliver Williams presented the workshop "The Impact of Non-Family Environments on the Social Learning and Attribution of Batterers and Non-batterers--Do We Promote or Prevent?"

I found this presentation the most difficult to depart from. Dr. Williams made use of videotapes which aroused everyone's emotions in relation to the impact of violence in the family. The experience of viewing the tapes cannot be adequately described in words in a summarization--you had to have been there.

Relating to the research being done, Dr. Williams described the phenomena in relation to social learning theory quite convincingly. Consideration was given to the subject's exposure and perception to violence from family and non-family sources. Emphasis was laid to look at the total picture. In the cycle of violence, batterers see the situation and respond with violence. Non-batterers see the situation and respond as a conflict situation. Batterers need to unlearn their behavior, and re-learn alternatives.

Jim Bozigar presnted the program "STARS: Service to Teenagers At Risk For Suicide." The Stars program was described in much detail in its efforts to address the teen population at risk for suicide.

The STAR Center of the Western Psychiatric Institute and Clinic:

1. Offers out patient clinical treatment.
2. Trains teachers and Mental Health Professionals to identify suicidal teens.
3. Assists schools and communities to increase their understanding and awareness of suicidal teens.
4. Evaluates treatment methods considered effective for suicidal teens.

Each of the four components of the STAR Program was described by Jim out of his extensive experience in this prevention program. The program is seen as creating a sense of wellness for the teen population at risk for suicide.

During lunch of the second day, Dr. Robert ten Bensel presented "Child Abuse: A National Perspective." Dr. ten Bensel offered a comprehensive description of child abuse and neglect giving a historical, national, and public health perspective. His two assumptions were that:

1. Children have special needs of nurturing, and
2. The family is the best place to nurture.

He went on to describe the four basic needs that are common human requirements, the two universal characteristics of language and the family unit; and the two taboos of incest and undeserved cruelty.

All of the issues raised regarding abuse of neglect were put into the context of the larger society. The United States is noted not to have a "family policy". It is the only country to execute children. It also has higher divorce rates. Current child protective service problems were addressed, as well as progress in those areas. Dr. ten Bensel sees the nation reaffirming the principles of parent's rights, children's rights, and the respect for the diversity of families.

Nationally it is a time for change within and outside the Child Protective System. The Child Protective Services system needs to move from substantial or unsubstantiated reports to a concept of "Children In Need of Services" or "a family in need of services".
Public Health Intervention needs to:

1. document the need
2. note the significance
3. determine intervention strategies
4. provide a data base
5. gain political support for programs.

He left us with many quotes indicating we must consider every family at risk. A quote I would like to repeat is from Erikson:

> "The most deadly of all possible sins is the mutilation of a child's spirit".

In conclusion, Juanita Evans updated the participants on upcoming events which brought us back to the realization of the great amount of work to be done in our home states. The Public Health Social Work Institute of 1988 is seen as producing the State of the Art for Public Health Social Work in the area of family violence.