In February 1966, the Committee on Infant and Preschool Child published a statement concerning the status of the problem of the battered child. The present Committee has reevaluated the statement in light of increased knowledge and experience over the past 6 years. The 1966 statement concerned itself primarily with two issues: (1) a historical review and definition of the battered child syndrome, and (2) discussion and recommendations concerning identification and protection of the abused child.

While a great deal of study and activity has taken place with regard to the problem of the battered child and there have been some positive results (e.g., every state in the union now has some form of reporting mechanism of the suspected or proven case of child abuse), the consensus of the Committee and its consultants is that the total problem has become magnified and is uncontrolled by present methods of management.

The Committee reaffirms and supports the following recommendations of the 1966 report:

1. Physicians should continue to be required to report suspected instances of child abuse immediately to the agency legally charged with the responsibility of investigating child abuse, preferably the county or state department of welfare or health or its local representatives, or to the nearest law enforcement agency.

2. The responsible agency must have ample personnel and resources to take action immediately on receipt of the report.

3. Reported cases should be evaluated promptly, and appropriate service should be provided for the child and family.

4. The child should be protected by the agency by continued hospitalization, supervision at home, or removal from home through family or juvenile court action.

5. The designated state agency should keep a central register of all such cases, with free access by appropriate people. Provisions should be made for the removal of case records from the register when it is found that abuse, in fact, did not occur.

6. The reporting physician or hospital should be granted immunity from suit.

We recognize that these recommendations, because of certain deficiencies in both content and implementation, have not gotten to the core of the problem and certainly have not influenced the overall incidence or even the overall prognosis of the battered child syndrome. We continue to anticipate an incidence of approximately 250 suspected cases of child abuse per million population in urban areas. New York City reported approximately 2,800 cases of suspected abuse in 1970, an incidence of 300 reports per million population.

Priorities must be established to allow for an expansion of the prevention, identification, and management aspects of the syndrome.

Specifically, the following five additional elements must be added to the recommendations of the 1966 report:

1. Valid predictive questionnaires or related techniques in identifying parents who have the potential to abuse should be obtained rather than relying on the after-the-fact presence of physical and/or x-ray findings in the abused child to institute legal or rehabilitative procedures.

2. Crisis management programs with easy accessibility for families needing immediate relief from an acutely overwhelming situation need to be developed. The concept of such centers or programs needs...
to be flexible and must be adaptable to differing community resources and cultural patterns. These crisis-oriented centers could vary from child care facilities where parents may leave their child in time of crisis to those which provide personal guidance and supportive services directly or by telephone service where parents could call for temporary help.†

3. Child abuse diagnostic and/or treatment centers must be established in larger urban areas to provide centralization of resources, expertise, and commitment to the prevention, protection, and rehabilitation of the abused child and his family. Individual agencies and treatment facilities involved with the abused child and his family frequently function in isolation without central direction and coordination. The Committee recommends a comprehensive, communitywide approach and concerned participation with centralized staff involving all needed disciplines (social, legal, medical, judicial, psychological, nursing, religious, and others as required) working together in a common physical facility readily available to the community to be served. Depending on the resources of a given city, this center could be attached to a health care facility or to a child protective service unit.‡

4. Increased responsibility by physicians and hospitals must be encouraged. Current practice absolves the physician and/or hospital from follow-up responsibilities after a case is reported to an appropriate agency. It is strongly recommended that each hospital seeing 20 or more instances of child abuse per year have a trained team available to serve as consultants, as coordinators, and as a follow-up resource to see that all aspects of management and rehabilitation have been adequately taken care of. ⁵,10

5. Day care services should be utilized whenever appropriate or feasible for the infant and preschool child returned to their homes. The day care centers utilized should have close liaison with the community child abuse management center responsible for the rehabilitation of the family. Larger centers should develop their own day care facilities as part of the comprehensive management and rehabilitation program.‡

6. Lay therapists and aides from the community are needed to provide the families with support and counsel on an individual or group basis. The centralized management or treatment center as well as the primary agency involved in family rehabilitation should be responsible for recruitment and training of these personnel. The lay therapist or foster grandmother has been shown to provide the type of support needed by many of the mothers to make the home safe for the child’s return.³ New programs using the abusive parents themselves in self-help groups are now developing and show promise of being effective.||

‡ There are a few crisis-type programs being developed throughout the country. Most of them provide only support through a telephone “hot line” and have not broadened into the flexible child and family centered programs that are to be encouraged is located at 2600 Nelson Ave., Redondo Beach, California.

‡ Currently, several model community-hospital child abuse treatment centers are being developed, such as those at the University of Colorado Medical Center, Denver; Children’s Memorial Hospital, Chicago; and Children’s Hospital Medical Center, Boston.

‡ A therapeutic Day-Care Center for abusive parents and their children is currently functioning in Boston. For information contact Miss Shirley Bean, Parent Center Project, Parent and Children’s Services, 329 Longwood Avenue, Boston, Massachusetts 02115.

|| A child abuse group therapy program is now functioning in Allentown, Pennsylvania, a self-help mother’s group called “Mothers Anonymous” is located at 2600 Nelson Avenue, Redondo Beach, California, and a parent aide program is underway at the University of Colorado Medical Center, Denver.

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REFERENCES
MALTREATMENT OF CHILDREN: THE BATTERED CHILD SYNDROME

Pediatrics 1972;50;160

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http://pediatrics.aappublications.org/content/50/1/160