Detecting Child Abuse by Studying the Parents

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Children have been abused by their parents and other adults from time immemorial. When children were considered chattel, the problem of child abuse was largely dormant. As the concept of child-as-person evolved during the nineteeneth and twentieth centuries, the groundwork was laid for increased public interest and concern.[1,2] The therapeutic optimism of the 1950s and the thrusts toward social programs and the rights of individuals in the 1960s provided an ideal atmosphere for change. Thus, when Kempe et al.[3] described the "battered child syndrome" in 1962, the U.S. Children's Bureau[4] drew up model legislation for reporting child abuse and, within four years, aroused legislators in every state had passed child abuse reporting laws. So great was the flurry of activity on the national, state, and local levels that by 1979, more than 1.1 million cases of child abuse were being reported annually—an eight-fold increase in reported cases in just 20 years.[5]

Child abuse is not only prevalent; it offends our sensibilities. Children are both physically and emotionally defenseless and the long-lasting effects of the physical and emotional trauma can be crippling. When such abuse is reasonably suspected, child protection agencies and, often, the courts launch an investigation. This investigation has two phases. First, the facts must be established. Did the abuse actually occur? If so, in many cases it is important to identify the abuser, seldom for criminal prosecution but to determine whether the abuser should have help and/or continued contact with the child. This is the adjudication phase. Second, if it has been determined that the abuse did occur, the investigating agency must evaluate the various options for handling the situation for the best possible outcome for the child. This is the disposition phase. In my opinion, unless the investigating agency or court has established actual abuse (or neglect), it should back off and not procede to the second phase; this would be unwarranted government intrusiveness.

Professionals and legislators have a variety of definitions of child abuse; they range from actual physical abuse to vague concepts of emotional abuse without any physical trauma whatsoever. In this article, I shall confine the term to nonaccidental physical injury of a child or sexual contact between

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an adult and a child. This definition conforms with what Goldstein et al.[6] refer to as "gross failures of parental care."

It is not always easy to detect whether child abuse has, indeed, occurred. Children seldom talk about the event either because they are too young or because they are exceedingly conflicted regarding their relationship with the abusing parent. The abusing parent and his/her spouse often attribute the injury to accidental causes. Frequently abuse can reasonably be inferred because the injury could not possibly have happened the way the parents describe or because there have been too many other incidents of unexplained injuries in the same family. The facts supporting these inferences can be developed by a knowledgeable pediatrician, radiologist, or pathologist and by a social worker who has access to the family's previous record. The help of a psychiatrist or psychologist is not needed to investigate these facts. However, when the evidence is ambiguous (and often, as a matter of routine), the courts and social agencies may turn for additional help or corroboration to the psychiatrist or psychologist (hereafter referred to as "the expert"). They seek an evaluation of the parents to determine whether they have personality features which are consistent with child abusers. This evaluation is considered along with all of the other findings in determining whether abuse did occur and, if so, who did it. It is my position in this paper that such a procedure is inappropriate: (1) the request made of the expert is inappropriate; (2) the expert who responds to the request is going far beyond his/her area of expertise; and (3) such study of the parents by the expert should not be allowed until and unless phase one—the adjudication phase—has been completed and a determination of child abuse has been made.

The Legal Issues

When child abuse has been alleged and the parents deny that it occurred, the matter must be decided in a family or juvenile court. Historically, these courts were established primarily to fulfill the State's parens patriae function—to provide help and protection to children because they cannot provide it for themselves.[7] Because of this, an effort is made to have the proceedings as informal as possible. Nonetheless, there are procedural rules; the participants are entitled to certain due process protections. These rules are generally less stringent in cases of child abuse than in delinquency cases. For example, the allegation that the child committed an offense must be proved beyond a reasonable doubt[8] while the allegations against parents which may lead to termination of parental rights need to be proved only by clear and convincing evidence[9] and where the allegation is child abuse rather than neglect, one court has stated that the decision may be made on the basis of the preponderance of the evidence.[10]

The informality of the family and juvenile courts cannot be measured only by the differences in the rules of procedure. Frequently, informal "pretrial conferences" are held in the judge's chambers. These conferences may disclose to the judge information (substantiated or unsubstantiated) which would be inadmissible in the more formal hearing.[7] In child abuse cases, rules of evidence have not been tightly drawn. And often, a clear-cut distinction between the adjudicatory phase and the disposition phase is not made; the "whole" case is presented as if there were only one phase.

In this article, I am concerned with the introduction of expert appraisals of the parents' personalities in the adjudication phase of child abuse hearings. At the very least, this concern demands that the phases be kept separate and that the trier of fact (the judge or referree) not participate in an informal pretrial conference which confuses the two phases.

The appraisals of the parents are in the nature of character rather than opinion evidence. In my experience, the expert rarely expresses the opinion that to a reasonable degree of medical certainty this is a case of child abuse or the parents abused the child. Instead, he or she describes the parents and indicates which "risk factors" are present; in essence, the expert either states or implies that this *kind* of person is likely to abuse his or her child. As Lempert and Salzburg[11] point out, this is circumstantial character evidence; it does not speak to the fact but to circumstances which seem to make the fact more likely. Indeed, in criminal proceedings, where circumstantial character evidence is usually barred, the parental aspects of the battered child syndrome have been disallowed.[12,13]

The admissibility of such circumstantial character evidence in the adjudication phase in family and juvenile courts varies from jurisdiction to jurisdiction; indeed, some jurisdictions do not even clearly state what the rules of evidence are in such courts.[14] Likewise, students of these courts are not all in agreement about whether such evidence should be admissible during the adjudication phase. On the one hand, Geddis et al.[15] state that in suspected cases of child abuse, tests of family relations "should be considered . . . as part of the preparation of court evidence." Fraser[16] has stated that expert examination of the parents can be "quite helpful" in determining culpability and even though it is circumstantial evidence, it should be admitted. On the other hand, the Model Acts drawn up by Sheridan and Beaser[17] suggest that such "study and report shall not be made prior to a finding with respect to the allegations . . ." Bourne[18] states that mental health professionals often wish to introduce data which implies but does not prove in the evidentiary sense. The ambiguity of the situation is well reflected in a recent publication of the Department of Health and Human Services.[19] Although the authors carefully separate the adjudication from the disposition phase, their discussion of the use in evidence of studies

of the parents fails to state whether it should be limited to one phase or used in both.

If the interest of the court is in the protection of the child and child abuse is so abhorrent, why should we not allow the widest array of evidence? When we raise the question of types and admissibility of evidence, are we merely nit-picking while a child may be in danger?

If protection of the child were the only important interest, we might answer these questions affirmatively. However, society has other, very basic, interests which also need protecting. A long line of cases has established the principle that the State must not interfere with the way parents bring up their children unless there is compelling reason to do so.[20,21] The parents have the right to discipline their children as they see fit.[1,22] The court in *Santosky v. Kramer*[9] emphasized that there must be attention to due process in proceedings which may lead to termination of parental rights because "freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment." These parental rights "do not evaporate simply because the parents have not been model parents." Because the distinction between deviant parenting and abusing parents is crucial, matters of evidence and proof should assume considerable importance. Furthermore, even in pursuit of its child protective interest, the court must attempt to be as nearly certain as possible that the abuse actually occurred because the standard of services available to the abused child are often so low that they, themselves, may be harmful. Newberger and Bourne[23] characterized some of these services as "punishment ... inflicted in the guise of help."

The Medicalization of Child Abuse

Even though expert study of the parents is character evidence, it differs from the usual kind of character evidence by presenting facts which need to be interpreted by the expert in order to make sense to the trier of fact. Generally, if we wish to impeach a witness' honesty, evidence of his/her previous untrustworthiness may be introduced. No special expert is needed to help the judge or jury decide whether the witness is to be believed. By contrast, the psychiatrist or psychologist testifies about observations and tests of the parents which, in themselves, would not point toward child abuse. These studies gain meaning only because they are part of a *syndrome*; one must be a medical expert in order to interpret the raw findings to the judge. Of course, one could point out that psychologists are not physicians; however, in the detection of child abusers, they are operating very much in the medical model—making a diagnosis of the "sick parent" part of the syndrome and frequently recommending a course of treatment. And, as we

shall shortly see, their power to do so and the prestige afforded them in the enterprise flows from the medicalization of the "syndrome." Now we must ask the question: Is the battered child syndrome or child abuse a medical syndrome?

The concept of battered child syndrome was publicly launched by Kempe et al. in 1962[3] and was immediately endorsed by the American Medical Association.[24] The concept was advanced by the U.S. Children's Bureau.[25] It has been accepted by the courts.[26,27] Indeed, the American Bar Association refers to it as a "medical diagnosis." However, others[2,23,28] have raised serious questions about whether such classification is appropriate.

It is instructive to inquire how child abuse became a syndrome. In 1946, Caffey, a pediatric radiologist, noted the concurrance of subdural hematoma and evidence of multiple previous long bone fractures. According to Pfohl[2] radiologists and pediatricians first believed that there were internal links between these signs—something residing in the child could tie the signs together in a syndrome. Only gradually did doctors become aware that the links were to be sought outside the child—in the child's social relations. As the doctors began to question parents more closely, they became aware that the explanations these parents gave for the injuries were discordant with the injuries themselves. The syndrome left the child and widened to include the explanation of the injuries, or rather the lack of explanation. At first, doctors imputed the discrepancy in the parents' stories to ignorance and lack of parental attention to accidents. Only later did they realize that many of these injuries were caused by parental mistreatment. At this point, the syndrome widened again to include "psychiatrically ill parents" who caused the injuries. Certain social forces within medicine worked toward the collaboration of radiologists with pediatricians and psychiatrists; these forces culminated in Kempe and his colleagues' coining the term battered child syndrome. The combination of physical signs, radiologic evidence, and psychosocial context into a "syndrome"—a medical illness—had some salutary effects. Although child abuse had been known for centuries, the prestige of the medical profession mobilizing around this newly discovered syndrome gave society the impetus it needed to start doing something about the situation. It also served to alert medical personnel in emergency rooms to the possibility of child abuse.

These historical events provide a guideline for our analysis. In true medical fashion, the radiologists first looked for links among the signs in pathology of the child. Had they found it (e.g., in the fragility of bone structure) there would have been no disagreement about the term syndrome. In the second stage, the syndrome widened to include not only the injuries but also their unexplained nature. Here began the confusion between a syndrome and its causes. In the third stage, the syndrome became the

injuries caused by family pathology. Sick children and their sick parents were all part of the syndrome. It is as if we were to call a combination of certain cases of chronic bronchitis and smoky factories "the medical condition of industrial-pollution syndrome." Even more relevantly, it is as if we were to call profuse bleeding from a jagged wound and the police capture of the attacker "the medical condition of the-Saturday-night-stabbing syndrome." While it makes good rhetoric, it is confused logic. Syndromes are generally confined to clusters of signs and symptoms of identified individuals; their causes may involve interaction with the environment, with other individuals, or with society, itself, as in the case of poverty and its effect on malnutrition. And while the syndromes are medical in nature, the extra-individual causes of these syndromes may drift away from the medical focus or area of expertise.

We can grant that the identification of the injuries is a medical matter. The inference of subdural hematoma from radiologic findings and physical examination is diagnosis in its strictest sense. Injuries not explained by the causes reported by parents, while not a syndrome, are still reasonably a medical matter. The trained physician can often state to a reasonable degree of medical certainty how the body reacts to certain types of trauma. These unexplained injuries constitute the battered child syndrome as understood by the American Bar Association.[27] However, most child agencies and courts distort the word syndrome even further by including parental attributes as part of the battered child syndrome.

Even if parental characteristics are not part of a syndrome, is there special psychiatric or psychologic expertise which enables us to state, with a reasonable degree of medical certainty, that certain features of parents are characteristic of child abusers? Is there a *child abuser* syndrome—a group of pathologic characteristics within the parents that are typical of child abusers? Or could we be looking for no syndrome at all but a group of attributes which define mean and nasty (rather than sick) parents?[29]

Accuracy of the Expertise

Two concepts are essential to the understanding of risk screening programs: sensitivity and specificity.[30] The sensitivity of a screening process is its ability to identify correctly people at high risk; a program which yields many false negatives—misses many abusers—has low sensitivity. Specificity refers to the ability of the process to pick out *only* the high risk persons; a program which yields many false positives, i.e., labels many innocent people as abusers, has low specificity. While I know of no studies which have tested the sensitivity and specificity of the experts' characterizations of parents, indirect evidence suggests that both may be low.

Reviews of the literature[31,32] reveal that a host of different "typical" characteristics have been described by various authors. Occasional studies have found parental attributes that are inconsistent with those found in other studies.[33] Some studies described clusters of attributes and yielded as many a four different types of abusers. This hodge-podge of data, largely derived from clinical observations and poorly controlled samples, led Zigler[34] to describe research in this area as "primitive and rudimentary." He warned about the danger of professionals' being swept up by the pressure for social action to the degree that they would confuse "myths with well validated facts."

I believe that this has happened in many clinical and legal settings. In reviewing several reports of parental assessments by experts specializing in child abuse and neglect cases, I have been impressed with the readiness to list attributes as "risk factors." It is as if the literature has spread out a cafeteria of attributes found in abusing parents and the evaluators seem to look over the menu and select those items which are relevant to the parents they see. Thus, one report listed the following "high risk factors": the parent's history of a rejecting mother figure who abused her physically and emotionally, conflicts relating to her maternal role, regressed intellectual functioning, and lack of creative outlets for her anxieties. In another report, the expert pointed to "major areas of concern that raise the potential for abuse and neglect." These were dependency on her husband, difficulty in expressing emotional warmth, and expectations of her child which were too high. Now, each of these attributes, indeed each of these combinations of attributes, can exist in many parents who do not abuse their children. In fact, Schneider et al.,[35] reporting on more controlled research, noted that "about 20% of the population of parents have child rearing attitudes and experiences that are so similar to known abusers as to make them indistinguishable from abusers ..." These "risk factors" have a low level of specificity. Technically, they are not even risk factors because studies showing the likelihood of people with these factors turning out to be abusers have not been done. Helfer[36] has pointed out that such predictors of physical abuse "will probably never be possible." The risk factors are really descriptors; they describe attributes often found in adjudicated child abusers. But they are also often found in nonabusers.

The experts are usually careful not to state that the parent is (or is probably) a child abuser. They refer to risk factors or features "consistent" with abusers. While they are correct within the jargon of the profession, how is the judge to interpret these findings when confronted with a difficult decision about a syndrome? As the court in *Sanders v. State*[13] said, "(The expert's statement that the parent) possessed many of the characteristics ... shared by the typical battering parent could lead a reasonable juror to no

other inference . . . than that this parent fit within the syndrome and had in fact murdered her baby." If the expert really does not believe that these attributes help to detect abusers, he/she should not present them during the adjudication phase; to do otherwise is dishonest. In my view, the responsibility for not confusing the issue falls on the expert, not the judge and not the attorneys.

Although early attempts to construct standardized tests that could discriminate between abusers and nonabusers were far too nonspecific to be useful (e.g., Paulsen et al.[37]), recently Milner and Wimberly[38,39] have been testing an instrument which promises very high specificity. It is conceivable that an instrument such as this one might replace the utterly haphazard detective work many experts currently use. However, Milner, himself, is very cautious. In a personal communication, he stated that much more testing must be done before the standardization might reach acceptable levels for adjudication purposes. Leventhal[40] has also urged caution in interpreting this type of research.

What is to be done in the meantime? Any severe injuries which are incompatible with the explanations offered by the parents or repeated severe injuries should be *prima facie* evidence of neglect, if not abuse. The testimony of pediatricians, radiologists, pathologists, etc. will assist the trier of fact in determining whether the injuries are compatible with the offered explanations. This testimony might also help exclude conditions not compatible with externally inflicted trauma (e.g., impetigo scars). Testimony involving psychiatric or psychologic study of the parents is irrelevant and should not be admitted. I submit that such study adds nothing but innuendo and prejudice. As Newberger and Daniel[41] have said, "Investigating the parents to determine culpability in child abuse cases has been characterized as 'clinically unhelpful, ethically absurd and intellectually unsound.' . . . The clinician may find himself playing a detective game for which he is professionally unprepared."

References

1. Thomas MP: Child abuse and neglect; historical overview, legal matrix and social perspectives. N Car L Rev 50:293–349, 1972
2. Pfohl ST: The discovery of child abuse. Soc Probs 24:310–323, 1977
3. Kempe CH, Silverman FN, Steele BF, Droegemuller W, Silver HK: The battered-child syndrome. J Am Med Assoc 181:17–24, 1962
4. U.S. Children's Bureau: The Abused Child—Principles and Suggested Language for Legislation on Reporting of the Physically Abused Child. Washington, DC: U.S. Dept. HEW, 1963
5. Besharov DJ: Child protection: past progress, present problems and future directions. Fam L Quart 17:151–172, 1983
6. Goldstein J, Freud A, Solnit AJ: Before the Best Interest of the Child. New York, The Free Press, 1979
7. Bortner MA: Inside a Juvenile Court: The Tarnished Ideal of Individualized Justice. New York, NYU Press, 1982, pp. 1. ff.
8. In re Winship 397 U.S. 358, 1970
9. *Santosky v. Kramer* 455 U.S. 745, 1982

10. Matter of Linda C 451 NYS 2d 268, 1982
11. Lempert RO, Salzburg A: Modern Approaches to Evidence. St. Paul, MN, West Publishing Co., 1977
12. *State v. Loeback* 310 N.W. 2d 58 (Minn.), 1981
13. *Sanders v. State* 303 S.E. 2d. 13 (Georgia), 1983
14. Davis SM: Rights of Juveniles: The Juvenile Justice System. 2nd ed. New York, Clark Boardman Co., 1983, sec. 5.5
15. Geddis DC, Turner IF, Eardley J: Diagnostic value of a psychological test in cases of suspected child abuse. Arch Dis Childhood 52:708–712, 1977
16. Fraser BG: A glance at the past, a gaze at the present, a glimpse of the future: a critical analysis of the development of child abuse reporting statutes. Chic-Kent L Rev 54:641–686, 1978
17. Sheridan WH, Beaser HL: Model Acts for Family Courts and State-Local Children's Programs. Washington, DC: U.S. Dept. HEW, 1975
18. Bourne R: The role of attorneys on child abuse teams. Chic-Kent L Rev 54:773–783, 1978
19. Landau HR, Salus MK, Stiffarm T, Kalb NL: Child Protection: The Role of the Courts. Washington, DC: U.S. Dept HHS, 1980
20. *Meyer v. Nebraska* 262 U.S. 390, 1923
21. *Pierce v. Society of Sisters* 268 U.S. 510, 1925
22. *Ingraham v. Wright* 430 U.S. 651, 662, 1976
23. Newberger EH, Bourne R: The medicalization and legalization of child abuse, in Family Violence: An International and Interdisciplinary Study. Edited by Eekelaar J, Katz SN, Toronto, Butterworths, 1978
24. Editorial: The battered-child syndrome. J Am Med Assoc 181:42, 1962
25. U.S. Children's Bureau: Child Abuse and Neglect: The Problem and Its Management (v.2). Washington DC: U.S. Dept. HEW, 1976
26. Harrigan CF: Evidentiary exceptions, in The Abused and Neglected Child. Edited by Landau HR, New York, Practicing Law Institute, 1982
27. American Bar Association: Recommendations for Improving Legal Intervention in Intrafamily Child Sexual Abuse Cases. Washington, DC: American Bar Association, 1982
28. Gellis RJ: Child abuse as psychopathology: a sociological critique and reformulation. Am J Orthopsychiat 43:611–621, 1973
29. Bursten B: Beyond Psychiatric Expertise. Springfield, IL, Charles C Thomas, 1984
30. Frankenberg W: Pediatric screening. Adv Pediatr 20:149–175, 1973
31. Spinetta JJ, Rigler D: The child-abusing parent: a psychological review. Psychol Bull 77:296–304, 1972
32. Starr RH: Child abuse. Am Psychol 34:872–878, 1979
33. Melnick B, Hurley JR: Distinctive personality attributes of child-abusing mothers. J Consult Clin Psychol 33:746–749, 1969
34. Zigler E: Controlling child abuse: an effort doomed to failure, in Newsletter of the Division on Developmental Psychology. Edited by Collins WA, Washington, DC, American Psychology Association, February, 1976
35. Schneider C, Hoffmeister JK, Helfer RE: A predictive screening questionnaire for potential problems in mother-child interaction, in Child Abuse and Neglect. Edited by Helfer RE, Kempe CH, Cambridge, MA, Ballinger Publishing Co., 1976
36. Helfer RE: Basic issues concerning prediction, in Child Abuse and Neglect. Edited by Helfer RE, Kempe CH, Cambridge, MA, Ballinger Publishing Co., 1976
37. Paulsen MJ, Afif AA, Schwemer GT, Bendel RB: Parent attitude research instrument (PARI): clinical versus statistical inferences in understanding abusive mothers. J Clin Psychol 33:848–854, 1977
38. Milner JS, Wimberly RC: An inventory for the identification of child abusers. J Clin Psychol 35:95–100, 1979
39. Milner JS, Wimberly RC: Prediction and explanation of child abuse. J Clin Psychol 36:875–885, 1980
40. Leventhal JM: Research strategies and methodologic standards in studies of risk factors for child abuse. Child Abuse Neglect 6:113–123, 1982
41. Newberger EH, Daniel J: Knowledge and epidomiology of child abuse: critical review of concepts. Pediatric Ann 5:140–145, 1976