

CHILD ABUSE IN KANSAS:
DEMOGRAPHIC FACTORS AND THE DOCTORS' RESPONSIBILITIES

by

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A MASTER'S THESIS

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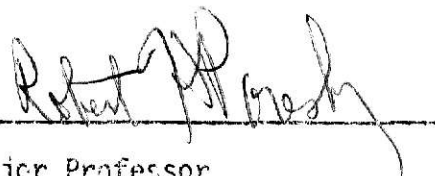
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CHAPTER I

PURPOSE AND SIGNIFICANCE

Child abuse is not a new phenomenon. It has its roots in the traditional and biological differences in physical makeup, levels of authority and status, between adults and children. Recent recognition and sanction of the rights of children, as well as research into the causative factors, incidence and treatment of abuse and neglect have brought the occurrence of child abuse into public awareness. Abusive and neglectful treatment of children is a daily fact of life for thousands of children every year in spite of societal repugnance and disbelief. Although not of epidemic proportions, child abuse and/or neglect has a permanent effect on their victims. Boisvert (1972) believes that only 10% of the victims totally recover from the consequences of abuse/neglect.

Since the earliest reported study of skeletal trauma due to maltreatment (Caffey, 1946), numerous researchers have investigated the causes, incidence, symptoms, treatment and prevention of child abuse from a number of orientations -- medical, legal, psychosocial, and economic. This type of information is vital to anyone interested in helping those families in which child abuse occurs, and to prevent any future incidents of child abuse.

The purpose of the present study is two-fold. Part I deals with an analysis of child abuse in Kansas, based upon a sample of cases reported in the Central Registry of Child Abuse. Not since 1964 has a study of the incidence of child abuse in Kansas been reported (Schloesser,

1964). In 1972 the Central Registry was established in which all reported cases of suspected child abuse in the state were to be recorded. Reports from local and regional Departments of Social and Rehabilitation Services were sent to the state Department of Social and Rehabilitation Services in Topeka. This statewide data collection provided uniformity of reports, status of follow-up procedures, identification of child abuse prone families, and the possibility of statistical analyses of the child abuse problem in the state of Kansas. The latter has been limited due to budgetary and time restrictions. The present project analyzed a sample of this recorded data as an initial attempt to describe the current incidence of child abuse in Kansas.

In the mid-1960's all states passed child abuse legislation requiring various professional groups and persons to report suspected instances of child abuse to the proper authorities, who were then required to confirm the actual existence of abuse if possible and to provide the necessary protective services. Special attention was paid to the physicians as one group most likely to see the victims of child abuse and neglect. The benefits and hazards of such legislation were voiced by many individuals and groups, and amendments have been made in the wording of many of the statutes. But the laws still require physician reporting of suspected child abuse. Although it has been estimated that doctors deal with 30% of the child abuse cases, only 9% of the reported cases are actually reported by physicians. A number of reasons for not reporting have been cited by physicians and other investigators, and will be discussed in the following chapter. Part II of the present study will deal with Kansas physician reporting

of child abuse to determine if the physicians are aware of the child abuse problem and the legislation, and what their attitudes toward the legislation are. The most recent Kansas legislation took effect July 1, 1975 requiring physicians, and many other professionals to report any suspected cases of child abuse to the Department of Social and Rehabilitation Services or the Juvenile Court. Failure to report constitutes a Class B misdemeanor.

The data collected will be available to the Department of Social and Rehabilitation Services and the medical profession as an indication of the statewide incidence of child abuse and of the direction which future educational and social efforts should take to alleviate the conditions associated with child abuse and neglect.

CHAPTER II

REVIEW OF LITERATURE

Historically, physical and mental abuse and neglect of children were frequent occurrences; infanticide, abandonment, maiming as an aid in begging, and the selling of children were the rule rather than the exception. In many cultures, the use of physical force in socialization and child rearing was permitted, even encouraged, and reaffirmed the basic inequality in the physical makeup and the social status of parents and their children. Such treatment was generally not considered wrong or undesirable.

There were brief periods in which public concern for maltreated children was evident. One of the better known incidents involved a child, Mary Ellen, maltreated by her adoptive parents in New York City in the mid-1800's. Friends, unable to rely on laws or agencies for help, called upon the Society for the Prevention of Cruelty to Animals, which made an immediate response to alleviate the problem. Shortly thereafter, the Society for the Prevention of Cruelty to Children was founded in New York (Ebeling, 1975; Fontana, 1973).

But child abuse was not recognized as a societal or a medical problem until 1946 when Caffey reported an unusual combination of X-ray findings. He had observed and studied several cases involving multiple fractures of the long bones of infants in various stages of healing associated with subdural hematomas (swelling or bleeding under the skull between the brain and its protective membrane) (Caffey, 1946). Though Caffey suspected that the conditions he observed were

traumatic in origin, he did not attempt to identify the sources. Subsequent intensive clinical studies of the cases by social workers, pediatricians and psychiatrists led to the suspicion and eventual confirmation that these unexplained injuries in children were often inflicted by their own parents and caretakers. Physical abuse of children came to be viewed as a widespread medical and social problem, which often resulted in serious damage to the physical well-being and emotional development of children and sometimes resulted in their death. Physicians became involved in the problem and developed procedures for identifying possible cases. Social workers realized their involvement in this area, and began the difficult work with the families of the abuse victims.

Since 1946, medical, legal, social work and psychological journals have repeatedly presented numerous case reports of traumatic injuries not explained by usual childhood diseases or accidents, substantiating the idea that there exists a widespread phenomenon which crosses the domain of many academic disciplines.

In 1962, Kempe and colleagues at the University of Colorado, coined the phrase "battered child syndrome" as a result of a study of 749 cases of child abuse reported by 71 hospitals and 77 district attorneys around the country. Many of the children within the sample had died or had been seriously injured, and the authors concluded that physical abuse was a major cause of death and maiming of children. Parents of the abused children were found to suffer from various types of personality disorders. The investigators also reported a reluctance on the part of physicians to accept or to investigate wilfull child

abuse (Kempe et al., 1962).

Societal pressure and concern has moved from its centuries old acceptance of the use of parental power to a new cultural sanction on recognizing and protecting the rights of children (Helfer & Pollock, 1967; Zalba, 1966). There still remains, however, some difficulty in differentiating between discipline and maltreatment/abuse. Many feel that a degree of discipline is needed for every child to direct his/her wide range of behaviors into socially acceptable patterns. Fontana suggested that 'abuse' is only the final phase of a maltreatment syndrome, which ranges from malnourishment and physical neglect to pre-meditated bodily injury resulting in permanent crippling or death (Fontana, 1963).

The definition of child abuse accepted for use in this study is that provided by Kansas law:

"Physical or mental abuse or neglect means the infliction of physical or mental injury or the causing of deterioration of a child and shall include failing to maintain reasonable care and treatment, sexual abuse, negligent treatment or maltreatment or exploiting a child to such an extent that the child's health, morals or emotional well-being is endangered..."
(Entire legislation in Appendix A)

This change in cultural emphasis on children's rights has led to a great deal of societal repugnance and disbelief in the occurrence of child abuse and neglect. Our society sees itself as an enlightened and rational one in which every child is guaranteed at least the bare minimum of care and protection (Elmer, 1960). Yet substantial evidence indicates that many children do indeed suffer neglect and/or abuse at the hands of others as a result of underlying personality disorders, pathological family relations (Gelles, 1973), environmental stresses

and/or the child's own characteristics which bring the abuse on himself (Gil, 1969; Spinetta & Rigler, 1972). Child abuse should be considered in any child exhibiting evidence of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, or in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma (Kempe, 1962). Connell (1963) suggested that physicians should consider child abuse as the etiology for a great number of injuries and symptoms:

"Be curious about:

Contrast between history and findings,
Hostile parents with rejected, neglected children,
Injuries causing metaphyseal 'corner' fractures,
Long bone periosteal proliferation, unexplained,
Differing ages of surprise skeletal damage,

Accident prone children, including poisoned, burned,
Bouncing baby skull fractures and subdural hematoma,
Unexplained convulsions, anemia, hematuria, jaundice, ileus,
Sudden death of patient or sibling,
Extraordinary inquisitiveness and concern by parents."
(p. 385)

In Kansas, 5262 cases of suspected child abuse and neglect were recorded in the Central Registry of Child Abuse, which is located in the Department of Social and Rehabilitation Services in Topeka, for the year 1975. Many investigators believe that the reported cases represent only the 'tip of the iceberg' of actual abuse cases (Gregg, 1968). Following a public survey in 1965, Gil (1973) suggested that as many as 2.53 - 4.07 million cases of child abuse occur every year, although later he stated that this estimate may have been a little high due to inaccuracies in collecting data. Kempe and

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NUMEROUS PAGES
WITH MULTIPLE
PENCIL AND/OR
PEN MARKS
THROUGHOUT THE
TEXT.**

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IMAGE AVAILABLE.**

Helper (1972) estimated there to be 60,000 - 100,000 cases of non-accidental injuries and neglect per year, while the most recent United States Department of Health, Education and Welfare estimates are in the range of 1 million children abused and neglected each year (HEW, 1975). The small number of reported cases is attributed to the varying definitions and interpretations of abuse, misinformation regarding the laws, failure to diagnose, suspect or report child abuse, and failure on the part of parents to seek aid for the abused child and themselves (Silver, 1968; Simons et al., 1966).

Most instances of child abuse occur in the absence of witnesses, and many fail to reach the attention of the proper authorities, so that a completely accurate analysis of the causes, incidence and nature of the child abuse problem is impossible. The scope of this study is not such to study the possible causes of abusive behavior, but rather to detail the reported incidence of child abuse in Kansas and to examine the role of the physician in the child abuse syndrome. Part I will investigate the incidence of child abuse in the state based on information available in the Department of Social and Rehabilitation Services Central Registry of Child Abuse. Part II will examine the Kansas physicians' awareness of child abuse and their attitudes toward reporting suspected cases of child abuse to the proper authorities.

Part I

Incidence of Child Abuse

One of the most extensive studies to date dealing with the incidence of child abuse was prepared by David Gil of Brandeis University under

the auspices of the U.S. Children's Bureau (Gil, 1969; Gil, 1973). He investigated all of the cases of abuse recorded in the central registries of the 48 states in 1967 and 1968: 5,993 cases in 1967 and 6,617 cases in 1968. This study provided valuable input to the existing knowledge of child abuse. Some of the data from Gil's study follow.

The number of children involved in the reported cases of suspected child abuse represented 1.2% of the entire national children's population in the year 1967 and 1.3% in the year 1968. The geographic distribution of child abuse corresponded to the density of population among the states, with the greatest numbers occurring in the areas of the greatest population density. The rates of child abuse remained stable throughout the year.

Slight variations in the sex and age distributions seemed to reflect the culturally determined child-rearing attitudes. Girls tend to be more conforming than boys during childhood and less physical force is used in rearing them. During adolescence, parental anxieties concerning their daughters' heterosexual relationships lead to increasing restrictions, intensified conflicts and increasing use of physical force to assert parental control. For boys, the patterns appear to be different. Physical force is used more frequently in childhood to assure conformity. During adolescence, the use of physical force in discipline of boys decreases as the physical strength of the boys increases and often surpasses that of their parents. Total numbers of boys and girls coincided with that of the national population, slightly more than half being boys. One quarter of the child abuse

cases fell into each of these four age groups: under two years, 2 - 6 years, 7 - 10 years, over 10 years. Previous studies had suggested that most abuse occurred prior to the age of three years, when the child lacks both the physical stamina to withstand attacks, and the ability to interact verbally and emotionally with his/her parents (Galdston, 1965; Gelles, 1973; Silver, 1968). The young child was often treated by his/her parents as an adult with all of the adult's capacities for deliberate, purposeful and organized behavior (Galdston, 1965). Gil suggested that these studies had been biased in the selection and composition of their study groups. They had been conducted in medical settings where, because of the function of the setting, most of the severely injured children are seen. Gil found that younger children tended to be more severely injured than older ones, and thus, were more likely to show up in the medical settings studied by the previous investigators.

Over one half (50%) had been victims of previous abuse, indicating that repetition of abuse of the same child in a family was frequent. Nearly one half (46%) lived with their father, and 87% lived with their mother. Both biological parents lived together in the home of the abused child in less than half of the cases (38%); in the other cases, the parents were single, divorced, widowed, deserted or remarried, or the child was living with a non-parent caretaker. These findings suggested an association between child abuse and deviance from the normative nuclear family structure. Other investigators have found a similar trend among the child abuse populations they have studied (Fontana, 1973; Galdston, 1965; Gelles, 1973; Gregg, 1968; Silver, 1968).

The average income of the families studied in the Gil project was low -- 38% earned less than \$5,000/year, and less than 4% earned more than \$10,000/year, compared to 25% of all American families who earned less than \$5,000 and 35% who earned more than \$10,000/year. Slightly more than one third of the families were receiving some form of public assistance (AFDC or other general welfare assistance) at the time of the suspected incident of child abuse. Nearly 60% had received aid from public assistance agencies during or prior to the study year. Other investigators suggest that this low income phenomenon portrayed in this study is inaccurate, and that if all cases of abuse were known, all social and economic classes would be fairly equally represented (Allen et al., 1969; Helfer & Pollock, 1967). Low income people secure aid from public agencies (ex., public health, welfare, legal services) which are often more responsive, and more knowledgeable in reporting their cases to the proper authorities, than are doctors or lawyers in private practice (Simons & Downs, 1968). Therefore, records of the incidence of child abuse in the low income population are more likely to be a matter of public record.

Many families in Gil's study (40%) had four or more children, which increased the financial pressures within the family unit. This percentage was nearly double that of the entire US family population. A slightly greater percentage of the children were abused by their mothers (48%) than by their fathers (39%). Thus, in a majority of the cases (87%) the perpetrator was a parent or parent substitute with whom the child had been living. Though in absolute numbers slightly more children were abused by their mothers than by their fathers, one

must remember that more than a third of the children were living in fatherless homes. Fathers or father substitutes were involved as the perpetrators in nearly two-thirds of the incidents occurring in homes that did have fathers or substitutes, while mothers or mother substitutes were involved in slightly less than half of the incidents occurring in homes that did have a mother or substitute. Therefore, the involvement rate of fathers was actually higher than that of the mothers.

The families appeared to be a highly mobile population, with nearly half of them living one year or less in the homes they occupied at the time of the reported incident, and about one quarter having lived in their present homes for 1 - 3 years.

The types of injuries sustained covered a wide range. The majority were bruises, contusions and lacerations, although burns and bone fractures were fairly frequent. Internal and head injuries were common, and most often the causes of death. Further investigations by Gil revealed that 90% of the fatalities reported in the mass media as due to physical abuse had not entered the official reporting systems. Several bizarre injuries were noted, including cigarette and radiator burns, severed limbs, flushing infant into sewer system, dismembering and cooking. Some cases of venereal disease were reported as were milder forms of abuse resulting from neglectful behavior. Forty percent of the children required hospitalization and 75% needed some form of medical treatment.

Help for the victim was initiated by various people. Nearly one quarter of the perpetrators themselves sought aid and in more than one third of the cases, members of the victim's household other than the

perpetrator initiated help. Thus, in over half of the reported cases the child's own family acted to obtain help once they noticed the results of the abuse.

A more complete and reliable analysis of the true extent of the child abuse syndrome should focus more attention on this medical and social problem, and encourage the development of the social and the educational machinery needed to alleviate the conditions triggering the onset of abusive behaviors (Bain, 1963; Gelles, 1973; Smith, Hanson & Noble, 1974).

Part II

Roles and Attitudes of Physicians

A strong, constant incentive to report every case of child abuse to the proper authorities is needed to obtain this kind of information on the incidence and nature of the child abuse syndrome. But the child victims can't or don't speak out, and neighbors are usually unwilling to assume the role of accuser (Fowler, 1963; Paulsen, 1966). Therefore, in 1963, the Children's Bureau and the American Humane Association prepared model legislative language and guidelines to encourage physicians to report cases of suspected child abuse. The theory behind these legislative suggestions was that doctors possess the expert skill and judgment for recognizing that serious injury has occurred by non-accidental means (Fowler, 1963). It was anticipated that the legal encouragement of reporting would focus on the child abuse problem, alert the medical profession to its existence and seriousness, and initiate action to provide better child protective services

(Bain, 1963). The American Medical Association objected to these guidelines for two major reasons: 1) Physicians were being singled out as the only professional group required to report when other groups were just as likely to observe cases of child abuse; and 2) Reporting of child abuse should be done at the doctor's discretion rather than as a mandatory act (Silver et al., 1967; J.A.M.A. editorial, 1964). In 1965, the Council of State Governments published a statutory model for child abuse legislation, as a compromise on the earlier guidelines (Paulsen, 1966). And in 1966, the American Academy of Pediatrics proposed its own legislative guidelines and suggestions (American Academy of Pediatrics: Committee on Infant and the Pre-School Child, 1966). By mid-1967 all but four states had child abuse statutes which: required or recommended that physicians and institutions were to report any instance in which there was reasonable cause to suspect child abuse; provided reporting procedures; and freed the reporter from civil and criminal liability for non-malicious reporting (Silver et al., 1969). Most of these laws also stated that neither the physician-patient nor the husband-wife privilege would be acceptable grounds for excluding evidence (Ferguson, 1964; Silver et al., 1969). Central child abuse registries were established in many states to facilitate the recognition of abusive families, to provide information for statistical analysis of child abuse factors, and to encourage uniform reporting procedures.

Mandatory reporting was to help to detect repetitive abuse, to relieve the doctor of the choice of whether or not to report a suspected case, and to relieve him of guilt feelings toward the parents

(Bain, 1963). More complete reporting was expected because of the clarification of the doctors' responsibilities, and the doctors' fear of liability would be diminished. The laws were intended to eliminate prejudice in management of the victims, and facilitate the detection of dangerous family situations (Reinhart et al., 1964).

Since 1967, modifications in the laws have been designed to better implement the procedures which would attain the original goals of a more complete analysis of this nationwide problem and the initiation of a more effective network of protective services. The most recent child abuse legislation in Kansas states:

"Every person licensed to practice the healing arts or dentistry, persons engaged in postgraduate training programs approved by the state board of healing arts, certified psychologists, licensed social workers,... and every licensed professional nurse or licensed practical nurse,... and every teacher, school administrator or other employee of a school,... or any law enforcement officer shall report ... and all other persons who have reason to believe that a child has had injury or injuries inflicted upon him or her as a result of physical or mental abuse or neglect may report, the matter promptly to the juvenile court ... or to the department of social and rehabilitation services..." (K.S.A. 1975, Supplement 38-717)
(Entire legislation in Appendix A)

However, physician reporting continues to be erratic for a number of reasons, some acceptable and understandable and others not. Often the doctor concentrates on the actual physical symptoms of one child in a family, failing to search for possible causes for the symptoms and ignoring the relationships between members of that family. Some may not be sure of their suspicions, and therefore they bury them (Fontana, 1973). Most persons do not want to become involved in the law, and physicians have the additional fear that publicity about their involvement in child abuse cases may decrease the number of

children brought to them for medical attention (Reinhart et al., 1964; Silver et al., 1967). Involving the police or other law personnel casts a premature criminal aura on the adult caretakers, encouraging them to avoid doctors who may bring them to the attention of the police (Corbett, 1964; Reinhart et al., 1964). Some doctors fail to understand the seriousness of the problem, are unaware of their own responsibility to report, don't want to antagonize the parents, or don't want to become personally entangled in a delicate and difficult situation (Fontana, 1973).

The law is inadequate if it only directs attention to the act of reporting and the protection of the reporter from liability without providing for the establishment of the needed protective services to investigate the reported instance of child abuse, to act for the child's welfare, and to prevent future occurrences of abuse. Appropriations to expand the child protective services haven't been enough (Laupus, 1966; Sayre et al., 1973; Silver et al., 1969), and few communities have established a network of protective services once a case of child abuse is reported. Cooperation and coordination between medical, welfare and legal authorities would improve their understanding and fulfillment of their different responsibilities (Fontana, 1973).

The law continues to emphasize the obligations of the physician in reporting suspected child abuse cases to the proper authorities. Gil (1967) found that three quarters of the abused children needed some type of medical attention, yet only 9% of the reported cases come from all physicians (Bain, 1963; Corbett, 1964; Gil, 1973; Schloesser, 1964; Zalba, 1966). The law has not had the intended impact even though

a misdemeanor charge for not reporting has been included in the laws of some states, including Kansas.

Doctors must be educated to recognize probable signs of child abuse as well as the diverse injuries resulting from normal early childhood accidents (Boisvert, 1972; Gregg, 1968). The doctor generally is the first to see the abused child after the abusive incident and therefore, is in a position to pass his findings on to the appropriate investigating authority. He is not responsible for providing the conclusive evidence of abuse or neglect, merely his suspicions. The victim is his patient so that the physician's responsibilities go further than immediate medical care to protection from repeated future abuse (American Academy of Pediatrics: Committee on Infant and Pre-School Child, 1966; Fowler, 1963; Fontana, 1964; Laupus, 1966).

But the victims of child abuse are usually brought to the doctor without warning when he/she is unable to give them the time or the emotional commitment that is needed (Kempe & Helfer, 1972). Thus, the physical exam must be performed meticulously without prejudging or condemning actions or persons who might have been the cause of the trauma (Gregg, 1968). Although the parents tend to protest any accusations of maltreatment and to defiantly defend their innocence, several investigators have concluded that in reality the parents desperately desire help for themselves, their children, and their families (Helfer & Pollock, 1967; Kempe and Helfer, 1972).

Often admission to the hospital provides the doctor with the time he/she needs to study both the surface and the internal symptoms of the child's trauma (Kempe & Helfer, 1972). He can also rely on a more

thorough examination by other hospital personnel (American Academy of Pediatrics: Committee on Infant and Pre-School Child, 1966; Silver, 1968). In these cases, many doctors prefer the anonymity of a large public institution to the individuality of private practice (Simons & Downs, 1968). Private doctors are less likely to be cognizant of their roles under the child abuse regulations and how to handle the procedural details of reporting which can result in less reporting of middle and upper class child abuse cases (Fowler, 1963; Simons & Downs, 1968). This indicates that a multi-disciplinary approach toward diagnosing possible child abuse might be a more effective and efficient means of case finding and reporting. It allows a sharing of the burden of responsibility by reducing the dependence on one individual's evaluation and judgment. It also encourages the use of a variety of diagnostic measures in determining the nature and precipitating causes of each individual case (Helfer & Pollock, 1967; Paull, Lawrence & Schimel, 1967). One such interdisciplinary approach has proven successful in increasing the number of cases determined to be the result of abusive and/or neglectful behavior, and in eliciting the cooperation of the various medical and social work personnel involved in the child abuse problem. A standing committee within the hospital made up of a senior pediatrician, hospital administrator, chief of psychiatric services, chief resident, another pediatrician and the director of the social services department, investigates the suspected cases, evaluates them and initiates the necessary protective measures. One doctor's reaction to this community approach was: "It is such a relief to have others with whom to share this awesome responsibility." (Paull, Lawrence & Schimel, 1967)

Some physicians indicated a fear of the direct or subtle legal, social or economic repercussions of the reporting act (Bain, 1963; Boisvert, 1972; Fontana, 1964; Galdston, 1965; House Report #744; Silver et al., 1969). Others don't consider the possibility of child abuse because they are not familiar with the syndrome (Allen et al., 1969; Bain, 1963). Much of the early research was reported in social work, legal or other specialized professional journals which doctors don't see (Silver, 1968). Limited attention is given to child abuse in medical training, so that physicians must rely on their own research or on postgraduate seminars and conferences (Fontana, 1964). Some physicians refuse to accept the concept of willful child abuse (Bain, 1963; Fontana, 1964; Kempe et al., 1962; Silver et al., 1969), while others concern themselves with immediate medical care and avoid any other considerations (Corbett, 1964; Reinhart et al., 1964). As stated above, some physicians are unfamiliar with some or all aspects of the law (Allen et al., 1969; Bain, 1963; Silver, 1968). There is some ambiguity and confusion as to the meaning and scope of many of the basic terms and concepts associated with the understanding and description of the varying degrees of neglect and abuse (Fowler, 1963; Silver et al., 1969; Silver, 1968). The responsibilities and limitations of the doctor, child welfare agency, child protective service, police, juvenile court and criminal court are not totally clear (Silver et al., 1969), and the expectation that social services would be developed and utilized to deal with child abuse victims and their families has not been fulfilled. Indeed, doctors often express a sense of futility regarding the ultimate management of cases which they do report --

either nothing is done to investigate the case or to protect the child and help his/her family, or the doctor is not involved in any way (Galdston, 1965; Silver, 1968; Simons & Downs, 1968).

Some doctors find it easier to deny the existence of child abuse than to deal with the anger that arises at the realization of willful parental abuse (Galdston, 1965; Kempe et al., 1962). Most physicians don't have the personality or the training to assume the role of 'police' or 'District Attorney' in determining the causative or precipitating factors leading to the physical symptoms of the abused child (Kempe et al., 1962). Yet professional people in all fields need to recognize, assess and deal with their feelings -- then their freedom of action in any sphere affecting the families and children involved will be greater (Elmer, 1960).

The second portion of this study was designed to investigate the Kansas doctors' knowledge of child abuse, their awareness of the reporting procedures, and their attitudes toward reporting under the new child abuse legislation.

CHAPTER III

PROCEDURE

Part I

To identify the possible correlates of child abuse, the 105 counties in Kansas were divided into three groups based on their 1975 population (County Assessor information). The "large" group consisted of those counties in Kansas with reported populations of more than 150,000. The "medium" counties were those with populations between 20,000 and 150,000, and the "small" counties were those with populations of less than 20,000 (See list in Appendix B). The population of children under the age of 18 years within each of these three county groups was determined from the last available census (1970 Bureau of Census). The distribution of the 5,262 suspected child abuse/neglect cases reported to the Kansas Department of Social and Rehabilitation Services Division of Services to Children and Youth during 1975 and recorded in their Central Registry of Child Abuse is given in Table I.

TABLE I

Thesis Sample, Child Population and Reported Suspected
Child Abuse/Neglect Cases in Kansas by County Size

County Size	Total 1970 Population of Children in Kansas	1975 Child Abuse/ Neglect	Rate/ 1,000	Total Sample
Large	326,860	2852	8	105
Medium	243,209	1503	6	107
Small	181,711	907	5	105
STATE TOTALS	752,280	5262	7	317

The number of suspected cases of child abuse/neglect recorded in the Central Registry of Child Abuse was approximately 7/1000 of the total population of children in each of the three county groups. In order to avoid biasing by the large number of cases from the "large" counties, an approximately equal number of cases were to be selected from each of the three county groups. A systematic stratified sample was drawn from the total child abuse/neglect population to obtain approximately 105 cases for each of the three county groups. The total sample size was 317 individual cases (Table I).

Written authorization was obtained from the Kansas Department of Social and Rehabilitation Services Division of Services to Children and Youth, in Topeka, Kansas, to use data from the Central Registry of Child Abuse. Permission was granted to use any information except for individual names. The following data was collected for the 317 sample cases (Table II), and coded onto computer sheets for statistical analysis.

TABLE II

Type of Data Collected for 317 Reported Suspected
Child Abuse/Neglect Cases in Kansas (1975)

1. County size
2. Date of report
3. Age of victim
4. Sex of victim
5. Number of siblings involved in the same incident
6. Public assistance status

7. Initial reporter of suspected child abuse/neglect case
 8. Caretaker of child at time of child abuse/neglect incident
 9. Suspected perpetrator of child abuse/neglect incident
 10. Type of child abuse/neglect
 11. Previous reports of child abuse/neglect
-

Part II

In order to determine the Kansas physicians' awareness of child abuse and their attitudes toward reporting suspected cases of child abuse, a proposal was submitted to the Kansas State University Committee on Research Involving Human Subjects (Appendix C). The proposal included a request that the investigator be allowed to distribute a mail questionnaire to a sample of Kansas physicians. The Committee approved the project when it was shown that the following regulations would be complied with:

1. "The rights and welfare of the subjects are adequately protected,
2. The risks to the subjects are outweighed by potential benefits,
3. The informed consent of subjects will be obtained by methods that are adequate and appropriate." (Handbook for Research, Development, Demonstration, or other Activities Involving Human Subjects by all personnel of Kansas State University)

The 1975 list of physician members of the Kansas Medical Society was used to obtain names and addresses of those physicians most likely to deal with child abuse cases at the primary care level (family practitioners and pediatricians). The number of these physicians in each of the three county groups used in Part I of this study was determined.

From the 550 family practitioners in Kansas a systematic stratified sample was drawn to provide a sample population of 94. As the number of family practitioners in each of the county groups was approximately equal, an equal number from each group was selected. The number of pediatricians was heavily concentrated in the "large" counties, and very low in the "small" counties. To assure some representation from all three county groups, varied systematic samples were drawn from these pediatricians to obtain a pediatrician sample of 16.

The total physician sample was 110 (Table III).

TABLE III

Total and Sample Populations of Family Practitioners
and Pediatricians in Kansas by County Size (1975)

County Size	Family Practitioners Population	Family Practitioners Sample	Pediatricians Population	Pediatricians Sample
Large	179	30	65	10
Medium	186	30	20	4
Small	<u>185</u>	<u>34</u>	<u>4</u>	<u>2</u>
STATE TOTALS	550	94	89	16

The director of the Kansas Medical Society was made aware of the purposes and design of this study. Due to his lack of direct control over the actual design of the project, and the use and interpretation of the results, he was unable to publicly co-sponsor this study, but did offer his support for the project.

A brief questionnaire, which had been designed and used by Larry B. Silver, M.D. (Silver et al., 1967) to assess the awareness

of Washington, D.C. physicians regarding child abuse and legal reporting procedures was the instrument used in the present study. Written permission was obtained from Dr. Silver to use the questionnaire. One question (#11) was added to help determine the county group representation of responses.

Along with the questionnaire, the 110 physicians in the sample were sent a letter explaining the purpose of the study and asking for their cooperation in completing the questionnaire. An informed consent form was included which physicians were asked to sign and return in acknowledgement of their voluntary participation in the project (See copies in Appendix D). After one month, a follow-up letter (Appendix E), the questionnaire and the informed consent form were sent to those physicians in the sample who had not yet returned a signed informed consent form.

CHAPTER IV

ANALYSIS OF RESULTS

Part I

Part I dealt with an analysis of the child abuse problem in the state of Kansas to determine the possible existence of factors related to child abuse which might be used as indicators or predictors of abusive environments. Statewide data on the incidence of child abuse/neglect based on a sample of 317 individual cases from 1975, is summarized in Tables IV - XV and Figure I.

The 317 individual cases recorded as the sample of the total suspected child abuse and neglect cases are categorized according to type of abuse and neglect in Table IV. Sixty-three percent of the children were victims of neglect; another twenty-four percent were physically abused. The remaining children in the sample suffered from mental abuse, or from a combination of the above types of abusive treatment.

TABLE IV

Sample of 317 Reported Suspected
Child Abuse/Neglect Cases in Kansas (1975)

Type of Abusive Treatment	Number of Cases	Percent
Neglect	201	63.41
Physical Abuse	77	24.29
Mental Abuse	4	1.26
Neglect & Physical Abuse	12	3.78
Neglect & Mental Abuse	2	0.63
Physical Abuse & Mental Abuse	16	5.05
Neglect, Physical Abuse & Mental Abuse	5	1.58
TOTAL	317	100.00

**THIS BOOK
CONTAINS
NUMEROUS PAGES
WITH DIAGRAMS
THAT ARE CROOKED
COMPARED TO THE
REST OF THE
INFORMATION ON
THE PAGE.**

**THIS IS AS
RECEIVED FROM
CUSTOMER.**

Figure I provides a detailed analysis of the age and sex distribution of the children in the sample of child abuse/neglect cases. Slight variations are observed but these did not reach significant levels. (A more complete analysis of the sex and age distributions within each of the four types of abuse and neglect categories can be found in Appendix F).

FIGURE I

Sex and Age Distribution of Sample of Reported Suspected Child Abuse/Neglect Cases in Kansas (1975)

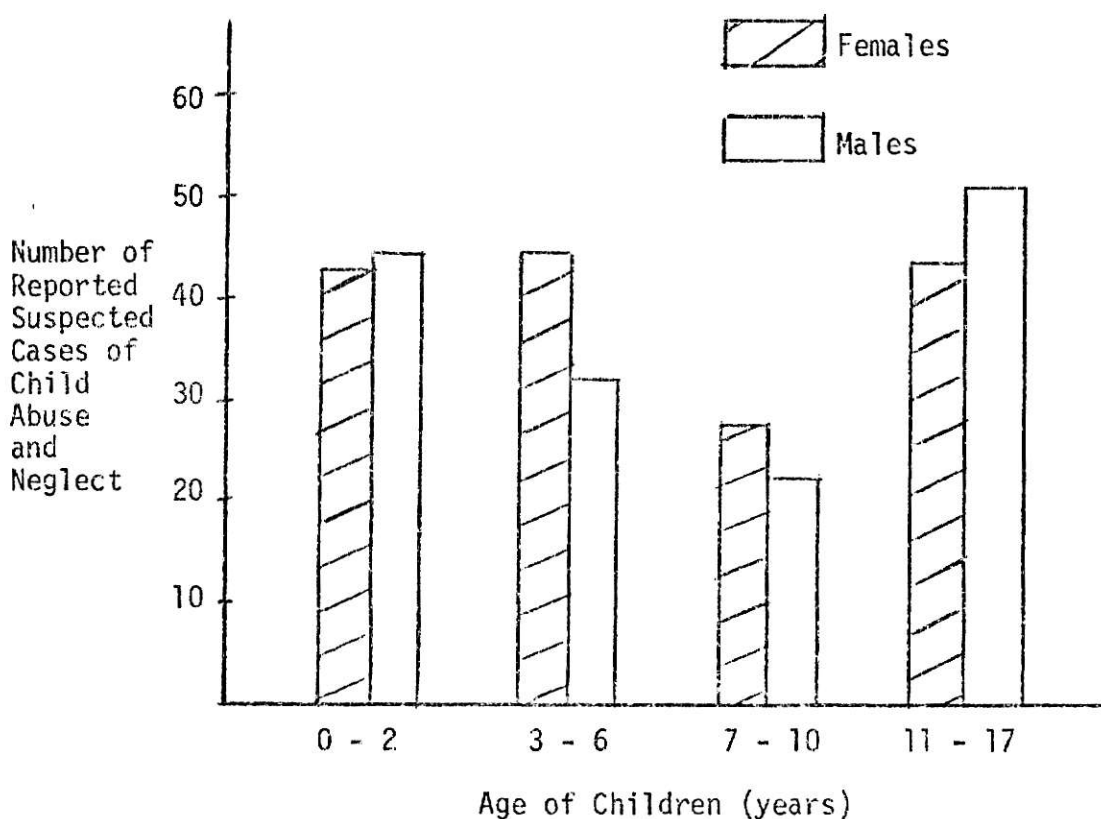


Table V provides an age comparison of the Kansas children's population with the 1975 child abuse/neglect sample population. The four age groups are consistent with previous studies (Gil, 1967). The younger children, below the age of six, made up a larger percentage of the abused population (52.36%) than would be expected from the percent of this age group in the statewide population (34.25%). The percentage of older children, over the age of six, in the abused population sample (47.64%) was less than that in the statewide population (65.75%). Statistical analysis of the actual populations indicated these differences to be highly significant ($\chi^2 = 60.1691$; $p < .001$).

TABLE V

Percentage Distribution of Kansas Children vs.
Sample of Reported Suspected Child Abuse/Neglect Cases

	Age Groups (in years)			
	0 - 2	3 - 6	7 - 10	11 - 17
Percent of Kansas Population	14.00	20.25	23.96	41.79
Percent of Child Abuse/Neglect Sample	27.44	24.92	17.36	30.28

Nearly equal numbers of males (156) and females (161) were represented in the child abuse/neglect sample. The statewide child population also includes nearly equal numbers of the two sexes of children, the difference being about 2% (Appendix G).

Table VI details the number of families in Kansas and in the sample of the abused population receiving some form of public assistance. Over five percent of all Kansas families received some public

assistance in 1975 (personal communication from Kansas Department of Social and Rehabilitation Services). Nearly twenty percent of the 1975 sample of abused children were members of families receiving some form of public assistance, either ADC or general welfare payments.

TABLE VI

Families Receiving Public Assistance in Kansas

	State of Kansas	Sample
Approximate percent of families receiving public assistance	5.5%	19.56%

Table VII lists the persons taking care of the child at the time of the suspected child abuse/neglect incident. The mother, alone or with a father figure, was present in the homes of 88% of the children in the sample population. The father/stepfather, alone or with a mother figure, was in the home of 50% of the sample of abused children.

TABLE VII

Caretaker of Child at Time of Reported Suspected Child Abuse/Neglect Incident

Caretaker	Number	Percent
Mother	132	41.64
Mother/Father	118	37.22
Mother/Stepfather	28	8.83
Father	12	3.79
Other*	27	8.52

*Including - stepmother/father; aunt; adopted parents; grandmother; grandparents; day care operator; foster parents; friends

Those persons suspected of perpetrating the reported incident of child abuse/neglect are described in Table VIII. At the time of the initial report, the perpetrator was unknown for 55% of the cases in the sample. Of the remaining 45% nearly one half were thought to be perpetrated by the mother of the victim, and nearly one quarter by the father.

TABLE VIII

Suspected Perpetrator* of Sample of Reported Suspected
Child Abuse/Neglect Cases in Kansas (1975)

Suspected Perpetrator	Number	Percent
Unknown	174	54.89
Mother	70	22.08
Father	34	10.73
Stepfather	15	4.73
Both Parents	13	4.10
Other**	11	3.47

*At the time of the initial report

**Including - mother's boyfriend; teacher; foster parent; adopted parent; grandparent; uncle

In seventy percent of the sample cases, one or more siblings of the victim were also reported as victims in the suspected incident of child abuse/neglect (Table IX).

TABLE IX

Sibling Involvement in Sample of Reported Suspected
Child Abuse/Neglect Cases in Kansas (1975)

	Number of Cases	Percent
Sibling(s) Involved	222	70.03
Sibling(s) Not Involved	<u>95</u>	<u>29.97</u>
TOTAL	317	100.00

A month by month analysis of the sample of child abuse incidents is presented in Table X. No significant variations were found.

TABLE X

Monthly Occurrence of the Sample of Reported Suspected
Child Abuse/Neglect Cases in Kansas (1975)

Month	Number
January	26
February	26
March	25
April	29
May	26
June	26
July	30
August	28
September	27
October	33
November	21
December	20

$\chi^2=5.2584$; df = 11; p7.90

The number of cases for which previous incidents of child abuse/neglect had been reported to the Central Registry of Child Abuse since

1972 are presented in Table XI. Nearly twenty percent of the children in the sample had been victims of suspected abuse or neglect prior to the present reported incident.

TABLE XI

Previous Reports of Child Abuse in Sample of Reported
Suspected Child Abuse/Neglect Cases in Kansas (1975)

Present Report	Previous Report	No Previous Report	Total
Neglect	36	165	201
Physical Abuse	15	62	77
Mental Abuse	1	3	4
Multiple Abuse	<u>6</u>	<u>29</u>	<u>35</u>
	TOTAL 58	259	317

The variety of persons who made the initial report of suspected child abuse/neglect to the Kansas Department of Social and Rehabilitation Services in 1975 is enumerated in Table XII. Relatives of the victim (excluding his/her parents) were the most frequent reporters of the child abuse incidents. Law personnel (primarily the police) and the neighbors of the victims were cited as the second and third most frequent reporters, while physicians ranked 13th on the list.

TABLE XII

Initial Reporter of Sample of Reported Suspected
Child Abuse/Neglect Cases in Kansas (1975)

Initial Reporter	Number	Percent
1. Relatives, excluding parents	57	17.98
2. Law personnel	35	11.04
3. Neighbor	33	10.41
4. Parents of victim	23	7.26
5. Unknown	22	6.94
6. Friend	19	5.99
7. Social worker	16	5.05
8. Juvenile court personnel	14	4.42
9. Hospital personnel	13	4.10
10. Anonymous	13	4.10
11. School nurse	10	3.16
12. School principal	9	2.84
13. Physician	8	2.52
14. Other*	45	14.20

*Including - victim, day care operator, school counselor, teacher, landlord, public health nurse, boyfriend, school superintendent, mental health personnel, janitor

The following three tables provide an analysis of the sample data for the three county sizes. Table XIII details the types of abuse reported in the three county groups. No significant variation associated with county size was found.

TABLE XIII

County Size vs. Type of Child Abuse/Neglect

County Size	Number of Cases				Total
	Neglect	Physical Abuse	Mental Abuse	Multiple Abuse	
Large	67	27	0	11	105
Medium	68	26	2	11	107
Small	<u>66</u>	<u>24</u>	<u>2</u>	<u>13</u>	<u>105</u>
TOTAL	201	77	4	35	317

$$\chi^2 = 2.4312; \text{ df} = 6; p > .75$$

Table XIV presents the number of males and females in the sample of abused children from each of the three county groups. A slightly larger number of females than males were reported in suspected cases of child abuse/neglect in the "medium" county group, but this difference was not significant.

TABLE XIV

County Size by Sex of Child Involved in Sample of Reported Suspected Child Abuse/Neglect Cases in Kansas (1975)

County Size	Sex		Total
	Male	Female	
Large	55	50	105
Medium	47	60	107
Small	54	51	105

$$\chi^2 = 1.8248; \text{ df} = 2; p > .20$$

Table XV details the age distribution by age groups within each of the three county groups of the sample. No significant variations are observed.

TABLE XV

County Size by Age of Child Involved in Sample of Reported
Suspected Child Abuse/Neglect Cases in Kansas (1975)

County Size	Age Groups (in years)				Total
	0 - 2	3 - 6	7 - 10	11 - 17	
Large	26	33	15	31	105
Medium	38	26	18	25	107
Small	<u>23</u>	<u>20</u>	<u>22</u>	<u>40</u>	<u>105</u>
TOTAL	87	79	55	96	317

$$\chi^2 = 11.2895; df = 6; p > .05$$

Part II

Part II of this study was designed to investigate the awareness of Kansas family practitioners and pediatricians regarding the child abuse problem and the reporting regulations and procedures in the state of Kansas. Questionnaires were sent to 110 physicians in this part of this study. Ten refused to participate, citing retirement, change of focus of their practice, death, or 'no time' as their reasons. The responses given by 73 physicians to the child abuse questionnaire are summarized in Table XVI.

TABLE XVI

Physician Responses to the Child Abuse Questionnaire

QUESTION 1: What is your type of practice?

	Number	Percent
a. Family Practice	61	84
b. Pediatrics	13	18
TOTAL	74*	100*

*One physician practices both family practice and pediatrics. His/her future responses are included with pediatrician responses.

QUESTION 2: When you see an injured child professionally, do you consider the possibility of child abuse?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Yes	58	97	13	100	71	97
b. No	2	3	0	0	2	3
TOTAL	60	100	13	100	73	100

QUESTION 3: Can you think, in retrospect, of recent cases in which the possibility of child abuse could have been considered but was not?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Yes	6	10	3	23	9	12
b. No	53	88	9	69	62	85
No response	1	2	1	8	2	3
TOTAL	60	100	13	100	73	100

QUESTION 4: In the course of an average month in your practice, what would you estimate the number of suspected cases of child abuse to be?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. None	47	78	4	31	51	70
b. 1 - 2	13	22	8	62	21	29
c. 3 - 5	-	-	1	7	1	1
d. 6 - 10	-	-	-	-	-	-
e. More than 10	-	-	-	-	-	-
TOTAL	60	100	13	100	73	100

QUESTION 5: When you suspect a case of battered child syndrome, to whom do you report the case?*

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
Correct response**	30	50	10	77	40	54
Incorrect response***	43	72	7	54	50	68
No response	4	7	-	-	4	5

*More than one response given by several physicians

**Social and Rehabilitation Services, Juvenile Court

***Police, hospital, head nurse, social worker, public health, mental health clinic, minister, psychiatrist

QUESTION 6: If you report a suspected case of child abuse, do you know what type of follow-up is initiated by that agency or person?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Yes	32	53	10	77	42	58
b. No	23	38	3	23	26	36
No response	5	9	-	-	5	6
TOTAL	60	100	13	100	73	100

QUESTION 7: Are there any occasions when you make the diagnosis of battered child syndrome but do not report the case?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Yes	5	8	1	8	6	8
b. No	52	87	12	92	64	88
No response	3	5	-	-	3	4
TOTAL	60	100	13	100	73	100

QUESTION 8: Assuming legal protection, would you report a case in which you suspect an abused child but did not have full evidence to confirm such a diagnosis?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Yes	48	80	12	92	60	82
b. No	6	10	-	-	6	8
No response	6	10	1	8	7	10
TOTAL	60	100	13	100	73	100

QUESTION 9: Assuming legal protection, what are the reasons you might not report a case in which evidence exists for a diagnosis of battered child syndrome?*

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Legal time lost	5	8	3	23	8	11
b. Implications to child's family	5	8	1	8	6	8
c. Insufficient diagnostic evidence	33	56	4	31	37	51
d. Other**	27	45	6	46	33	45

*More than one response given by several physicians

**Including - advise victim's parents of their alternatives, assume personal responsibility for helping parents, none (i.e., doctor would report any case), degree of injury not sufficient to be harmful, different definitions of child abuse, lack of faith in follow-up procedures

QUESTION 10: Where did you obtain your knowledge about the battered child syndrome?*

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Medical school	23	38	3	23	26	37
b. Special training	10	17	2	15	12	16
c. Medical journal	41	68	9	69	50	68
d. Lay press	8	13	1	8	9	12
e. Other**	16	27	7	54	23	32

*More than one response given by several physicians

**Including - experience, medical conference, seminar, residency training, internship, refresher courses, TV

QUESTION 11: What is the population of the county in which you live?

	Family Practice		Pediatrics		Total	
	Number	%	Number	%	Number	%
a. Small*	24	40	2	15	26	36
b. Medium**	21	35	5	39	26	36
c. Large***	14	23	6	46	20	27
No response	1	2	-	-	1	1
TOTAL	60	100	13	100	73	100

*Less than 20,000

**20,000 - 150,000

***More than 150,000

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

Sensational headlines of brutal child beatings, emaciated sickly children found locked in small closets, and sexual molestation of young boys and girls call forth feelings of horror, disbelief and outrage. We assume that the parents must be ill, or deviant for not loving their child and providing him/her with at least the bare minimum of adequate supervision and care. It is a common human tendency to attribute undesirable behaviors to people who are different from ourselves, such as those of different socioeconomic status, race or religion (Reinhart et al., 1964). Because we find them offensive, we don't want to help them to deal with the problems which cause them to abuse their children (Fontana, 1973). Maltreatment of infants and young children is hard to accept, even when it can be seen as an act stemming from a sense of helpless frustration at the unbearable stresses in the daily life of the perpetrator. Vivid case reports of the details of such occurrences which focus public attention on the more severe aspects of child abuse are hard to forget. Thus, two or three such reports tend to create the impression that such incidents are frequent, widespread and increasing.

According to nationwide statistics this is not the case. Reports of suspected child abuse incidents indicate that slightly more than one percent of all children are victims of abusive treatment (Gil, 1973). But "all attempts to minimize this ugly disease and reduce it to statistics, 'proving' it to be of small consequence, dangerously hamper

all efforts to find a cure for it and possibly even preclude a solution" (Fontana, 1973). Several investigators believe that these reported cases may only be the tip of the iceberg, and that as many as one million children are not receiving adequate care and supervision each year (HEW, 1975). The numbers and descriptions of suspected cases of child abuse do provide some valuable information which can be utilized by the many persons interested in alleviating the problems associated with child abuse. Central registries have been established in many states to gather this information. These central registries provide the most complete portrayal of the incidence and nature of child abuse/neglect in each of the states, assist professionals and courts to determine whether a child has been abused/neglected, and "keeps track" of abusive/neglectful parents who are prone to "hospital shopping" (Ebeling, 1975). The information in the central registries can be used for statistical analyses of the child abuse problem at a state and national level, as well as in the daily management and dispensation of child abuse cases.

Part I

Part I of the present study utilized the 1975 information in the Kansas Department of Social and Rehabilitation Services Central Registry of Child Abuse as an initial step in determining the incidence and nature of child abuse in this state.

The total number of cases recorded in the Registry for the year 1975 represented less than 1% of the children under the age of 18 in the state of Kansas. But the statistics fail to reflect the human

beings they represent which included 5,262 children who were the alleged victims of abusive and/or neglectful treatment. Nearly two-thirds of those children suffered from neglect by their caretakers who could, or would not provide sufficient food, love, shelter, clothing, medical care and/or supervision. The other children were victims of some form of physical abuse (beating, burning, poisoning, biting, battering, broken bones, etc.) or mental abuse (belittling, humiliating, witness to lascivious behaviors, etc.). It is usually the worst of these cases which are sensationalized in the public press, and remain in people's minds.

The sex of the abused children in Kansas followed the same distribution as the entire children's population in the state. Boys and girls were the reported victims of child abuse and neglect in approximately equal numbers in Kansas during 1975.

Previous studies had reported a greater percentage of child abuse in the younger age groups, but it was determined that these had been biased by the selection and composition of their study groups from hospital reports. Abused infants often end up in the hospital because they are unable to defend themselves, to fight back, or to withstand the effects of neglect. The older children have developed some of these capabilities and are less likely to be hospitalized following an attack or incident. However, the data in Kansas presents evidence similar to the earlier studies. A significantly greater percentage of children under the age of six were the reported victims of abuse and neglect than were those over the age of six. Using the available population data for the state of Kansas and the abused sample this

difference was found to be highly significant ($\chi^2 = 60.1691$; $df = 3$; $p < .001$).

Low income has also been cited as a factor closely related to the onset of child abuse. Some investigators have suggested that if all instances of child abuse were known this trend would no longer be found. Indeed it is only moderately evident in Kansas. Although only about six percent of the families throughout the state received some form of public assistance (ADC or general welfare assistance) during 1975, twenty percent of the children involved in a child abuse incident were from families receiving public assistance in 1975. Whether or not a family receives public assistance is not the most accurate estimation of their income level, but it can serve as an indication of their financial status. The data suggests that child abuse is not a phenomenon associated exclusively with low socioeconomic groups within the population, but includes children from all social and economic classes.

Another family characteristic analyzed in the present study was that of the victims' caretaker at the time of the child abuse incident. A great majority of the children (88%) were living with their mother, and of these slightly over half were also living with their father or a father substitute. Previous studies have found a high correlation between incidence of child abuse and marital discord, separation, divorce and single parenting (Galdston, 1965; Gelles, 1973; Gil, 1973; Smith, Hanson & Noble, 1974; Spinetta & Rigler, 1972). There was no direct measure of marital instability available in the data, but nearly two-thirds of the children were not living with both of their bio-

logical parents indicating some added support for this suggested correlation.

The perpetrator of half of the reported incidents were unknown, but the mother was suspected in nearly half of those cases in which a suspected perpetrator was listed. Follow-up contacts had not been completed to determine whether the mother was indeed the actual perpetrator in most cases. It has been suggested that the mother is often totally responsible for child rearing, household maintenance, and earning the income, whether a spouse is in the home or not. When unable to deal with all of the pressures of total responsibility, the mother exercises physical control over the one thing she has control over -- her children; the result of which is often child abuse (Gil, 1973). The father was suspected in about half as many cases, and a variety of others allegedly perpetrated the remaining cases.

The above data substantiates the finding of previous studies that the involvement rates of the fathers was higher than that of the mothers. Nearly 40% of the incidents occurring in homes with a father or father substitute were perpetrated by the father or substitute. In homes with a mother present, less than 30% were perpetrated by her. Absolute numbers of cases perpetrated by mothers and fathers do not provide this picture, but one must remember that fathers are not present in the homes of nearly half of the reported cases.

Many investigators have reported the tendency for one child to be singled out for abuse, usually the only child, the youngest child, the handicapped child, and/or the result of an unwanted pregnancy. The data in Kansas contradicts this observed trend in over 70% of the

cases. One or more siblings were also reportedly involved in incidents of both neglect and abuse, suggesting a problem within the family structure and pattern of interaction rather than an isolated incident of poor relations between one child and his/her parent.

Child abuse appears to prefer no season or time of year. Suggestions that there is a correlation between child abuse and time or year or the school calendar find no support in the data.

Nearly twenty percent of the cases reported in 1975 in Kansas involved children who had been reported abused or neglected since 1972. Because the Central Registry is relatively new, the total number of repeated incidents may be incomplete. Others have found a higher percentage of repeated abuse. Kempe (1962) suggested that sooner or later half of the abused children returned to an abusing parent would die of renewed abuse. Gil (1973) suggested that over 60% of the children have a history of prior abuse. Follow-up reports were not available to determine the outcome of most of the reported cases in Kansas -- whether abuse/neglect was confirmed, what services were provided, or whether the child remained in his/her home subject to possible future abusive treatment.

The child abuse legislation passed and amended several times since 1967 required a variety of professional persons to report cases of suspected child abuse to the proper authorities. By July, 1975 this included nearly everyone likely to come into contact with children. But the data suggests that over half of the initial reports come from friends or relatives of the victim, rather than from professionals. Physicians have been required to report since the first laws were

passed because they were most likely to see the child abuse/neglect victim, and would have the expert skill and judgment to recognize the symptoms. However, in Kansas the doctors reported very few cases (2.5%), ranking thirteenth on the list of reporters.

County size was found to be independent of the type of abuse reported across the state. Small, medium and large counties provided nearly equal proportions of the various types of abuse and neglect, suggesting that the density of the population does not affect the type of treatment children receive.

Age and sex of the abused children were also unaffected by county size effects. Children of both sexes and all ages were represented regardless of the population density of the area in which they lived.

This statistical analysis offers support to the hypothesis that limited significant demographic factors are available as predictors of likely child abuse prone environments or family situations. Both boys and girls of all ages from all over the state have been involved in all types of child abuse/neglect, although the proportion below the age of six years was significantly greater than those over the age of six. This data suggests that rather than trying to determine which specific factors are more likely to produce abuse prone people and then trying to alleviate them, efforts should be directed at improving the lives of all people. Better employment opportunities, more effective parent education, and increased availability of family oriented social services would be much more effective in eliminating the child abuse problem, as well as a number of other social problems, than would specialized programs for child abuse victims and their families. Family life

education projects, family planning programs, legalized abortions, more quality day care, and social services designed to help reduce environmental stresses on family life and to assist families and children who can't live together because of severe relationship and/or reality problems are some of the services being implemented to help in improving the quality of living and possibly decreasing the number of child abuse cases each year.

Part II

In 1967, Silver and his associates concluded, on the basis of responses to their questionnaire that "physicians are not sufficiently aware of the battered child syndrome or of community procedures for the management of cases of child abuse" (Silver et al., 1967). The same questionnaire was utilized in the present study to assess the awareness levels and attitudes of Kansas primary care physicians (family practitioners and pediatricians).

Nearly all of the physicians responding to the questionnaire reportedly considered the possibility of child abuse when seeing an injured child professionally, and only one in eight said they had failed to consider child abuse in a case that might have been child abuse. These responses indicate that these physicians are aware of the existence and nature of child abuse.

According to the physicians, child abuse is not a frequent occurrence. Less than one-third of them reported seeing 1 - 2 cases of child abuse in an average month of their practice; most doctors estimated there were no cases of child abuse in their average monthly practice.

More than half of the physicians didn't know the correct procedures to follow in reporting a case of suspected child abuse, but only one out of twelve doctors stated that he/she would not report a suspected case. The main reason cited for not reporting a case was that the evidence would be insufficient to warrant a diagnosis of child abuse or further investigation. The law states that any case in which child abuse or neglect is suspected must be reported, but physicians, and other professionals working with abused children are aware of the difficulty of proving that any physical trauma has been the result of abuse or neglect. Several physicians noted their frustration in "obvious" cases of abuse and neglect failing to be "legally" diagnosed as child abuse, and the child returned to his home without further protective services or support being provided.

Slightly over half of the doctors know what kind of follow-up is initiated once they have reported a case. Exclusion of the physician from follow-up services or investigations has been cited as another reason for not reporting a case; the doctor, treating only the physical symptoms, is generally left out of any action which might affect his/her patient's future physical well-being.

Medical schools are not cited as the most frequent sources of knowledge about the nature and treatment of child abuse and neglect. Instead, medical journals provide information on the problem for two-thirds of the physicians. A great number of researchers, since Caffey's landmark observations in 1946, have reported their findings regarding symptoms of child abuse, causative factors, incidence, legal and moral obligations of physicians, treatment and prevention of

child abuse, in various medical and other professional journals. A brief glimpse through Pediatrics in 1974 finds four articles and commentaries dealing with the subject of child abuse.

The responses to the questionnaire indicate a greater percentage of the physicians are aware of the existence of child abuse than Silver found in his 1967 study. Some physicians are still resistant to the possibility that there are indeed abusing parents and find it difficult to question the parents even in the face of obvious circumstantial evidence. Child abuse must be accepted as a clinical phenomenon by the physician before any legitimate expectations of reporting can be fulfilled. Increased educational efforts are needed in medical schools, postgraduate training, and professional journals. These efforts should be aimed at clarifying terms, concepts and responsibilities which are needed to help the physician know and feel comfortable in his/her role as the reporting physician (Silver et al., 1967).

An interdisciplinary approach to diagnosis of child abuse implemented by some communities offers possibly the best solution for the child, the physician and the community. The child abuse case is investigated by various hospital based professionals before any decisions are made as to reporting the case to the Central Registry or to diagnosis as child abuse. This alternative relieves the individual physician of the awesome legal, moral and social responsibilities of reporting and allows for a more complete diagnosis of each individual case. The interdisciplinary approach is viable in the larger urban communities in Kansas, but not in the rural counties where medical facilities and personnel may be limited. In either case, the lines of communication

between the physicians (groups or individuals) and the community agencies must be open and mutual to provide the most complete services for each child abuse victim and his/her family.

The establishment and implementation of a more complete network of social and protective services should be fully realized to deal with current child abuse cases, to prevent future occurrences of child abuse and to convince physicians that the child abuse case he/she reports will receive the attention it deserves.

Part III

Child abuse is not the major killer or maimer of children it was claimed to be in the sensational mass media stories. Such exaggerated claims reflect an emotional response to this destructive phenomenon which, understandably, touches sensitive spots with nearly every adult. Many adults may themselves be subject to aggressive impulses toward children in their care (Gil, 1973). But the incidence of child abuse needs to be put into a more balanced perspective. The true incidence rate will probably never be determined, but it appears that the scope of child abuse resulting in severe injury does not constitute an isolated major social problem. This is especially true when the numbers of child abuse cases are compared to the millions of children affected by poverty, racial discrimination, malnutrition and inadequate provisions for medical care and education (Gil, 1973).

But child abuse is a problem, and often associated with the other social problems cited above. A concentrated effort is needed to identify the problem (causes, symptoms, incidence), to educate the public

with the facts and not sensationalized myths, and to determine the best possible solutions. This can only be accomplished successfully through the cooperation of many people, especially medical personnel, social workers, legal personnel, and educators.

CHAPTER VI

SUMMARY

Analysis of a sample of 317 reported suspected cases of child abuse in Kansas during 1975 indicated that limited specific demographic factors could be used as predictors of child abuse triggering environments. Indeed the number of cases, less than 1% of the children in Kansas were involved, do not warrant emphasis on eliminating the particular problems affecting particular families. Instead, child abuse appears to occur in those environments associated with a host of other social problems -- poverty, illiteracy, malnutrition, racial discrimination and inadequate medical care. Future efforts should be directed at alleviating these conditions, and at general improvement of the quality of life for all persons. More employment opportunities, more quality day care, improved educational opportunities, nationalized health care are needed to provide the essentials of decent living for all. Presently, parent education projects, legalized abortions, family planning education, and limited numbers of family oriented social services are making initial steps in this direction. Expansion of these services is strongly recommended.

Physicians have been looked to as one professional group possessing the expert skill and judgment to determine the results of parental abuse in their children patients. Results of a survey suggest that increased attention to the incidence, nature, treatment and prevention of child abuse/neglect, and the legal responsibilities of physicians would benefit the child, the physician and the community. Medical

education, postgraduate training and medical journals should focus periodically on this syndrome which affects a number of children each year. Awareness of this problem would alert the medical profession to its existence, and enable them to deal with each case that arises so that the victim receives the best possible service and care. A multidisciplinary approach to the diagnosis of child abuse/neglect appears to be the most successful alternative. Relying on a variety of hospital personnel for the investigation of each case relieves the individuals of the awesome legal and moral responsibilities, and insures a complete diagnosis of the case.

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APPENDIXES

APPENDIX A
KANSAS CHILD ABUSE LEGISLATION

38-716. Reporting of certain physical or mental abuse of children; declaration of policy. It is the policy of this state to provide for the protection of children who have had physical or mental abuse or injury inflicted upon them and who, in the absence of appropriate reports and follow-up assistance concerning their condition and circumstances, may be further threatened by the conduct of those responsible for their care and protection. [L. 1965, ch. 386, § 1; L. 1972, ch. 164, § 1; July 1.]

38-717. Reporting of certain physical or mental abuse of children; reports. Every person licensed to practice the healing arts or dentistry, persons engaged in postgraduate training programs approved by the state board of healing arts, certified psychologists, licensed social workers, examining, attending or treating a child under the age eighteen (18), and every licensed professional nurse or licensed practical nurse, examining, attending or caring for a child in the absence of a person licensed to practice the healing arts, and every teacher, school administrator or other employee of a school which such child is attending, or any law enforcement officer having reason to believe that such child has had injury or injuries inflicted upon him or her as a result of physical

or mental abuse or neglect, shall report, and all other persons who have reason to believe that a child has had injury or injuries inflicted upon him or her as a result of physical or mental abuse or neglect may report, the matter promptly to the juvenile court of the county in which such examination or attendance is made, treatment is given, school is located or such abuse or neglect is extent or to the department of social rehabilitation services. Such report may be made orally by telephone and shall be followed by a written report if requested. When medical examination or treatment with respect to a child is pursuant to the performance of services by a member of the staff of a medical care facility or similar institution, such staff member shall immediately notify the superintendent, manager, or other person in charge of the institution who shall make such a report in writing forthwith. Every such report when required to be written shall contain the names and addresses of the child and his or her parents or other persons responsible for his or her care, if known, the child's age, the nature and extent of the child's injuries (including any evidence of previous injuries), and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the person or persons allegedly responsible therefor. [K. S. A. 38-717; L. 1974, ch. 175, § 8; L. 1975, ch. 231, § 1; July 1.]

38-718. Same; immunity from liability. Anyone participating without malice in the making of an oral or written report to the juvenile court or department of social and rehabilitation services relating to an injury or injuries inflicted upon a child under eighteen (18) years of age as a result of physical or mental abuse or neglect or in any follow-up activity to such a report shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report. [K. S. A. 38-718; L. 1975, ch. 231, § 2; July 1.]

38-719. Same; admissibility of evidence. In any proceeding resulting from a report made pursuant to this act or in any proceeding where such a report or any contents thereof are sought to be introduced in evidence, such report or contents or any other fact or facts related thereto or to the condition of the child who is the subject of the report shall not be excluded on the ground that the matter is or may be the subject of a physician-patient privilege or similar privilege or rule against disclosure. [L. 1965, ch. 386, § 4; April 21.]

38-720. Same; penalty for violation. Anyone knowingly and willfully violating the provisions of the Kansas child abuse and neglect reporting act shall be guilty of a class B misdemeanor. [K. S. A. 38-720; L. 1975, ch. 231, § 3; July 1.]

38-721. Reports of child abuse or neglect required; duties of the department of social and rehabilitation services. The juvenile judge, upon receipt of a report concerning an injury or injuries being inflicted upon any child as a result of physical or mental abuse or neglect, shall report the matter as soon as practicable to the department of social and rehabilitation services upon forms to be provided by the secretary. The department of social and rehabilitation services shall promptly initiate an investigation of the report to determine its accuracy and based upon a finding of abuse or neglect immediate steps shall be taken to protect the health and welfare of the abused or neglected child as well as that of any other child under the same care who may be in danger of abuse or neglect. The provisions of this section shall not be construed to affect in any way any power, duty or responsibility conferred or imposed upon the juvenile court under K. S. A. 38-816. [K. S. A. 38-721; L. 1974, ch. 175, § 9; L. 1975, ch. 231, § 4; July 1.]

38-722. Same; definitions. As used in the Kansas child abuse and neglect reporting act: (a) "Physical or mental abuse or neglect" means the infliction of physical or mental injury or the causing of deterioration of a child and shall include failing to maintain reasonable care and treatment, sexual abuse, negligent treatment or maltreatment or exploiting a child to such an extent that the child's health, morals or emotional well-being is endangered. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of such religious beliefs shall not be considered a negligent parent or guardian; however, this exception shall not preclude a court from ordering that medical services to provide to the child when the child's health so requires.

(b) "Child" means a person under the age of eighteen (18). [K. S. A. 38-722; L. 1975, ch. 231, § 5; July 1.]

38-723. Same; confidentiality of reports and records; exceptions. All records and reports concerning child abuse and neglect filed with the state department of social and rehabilitation services or a juvenile court are hereby declared to be confidential and shall not be disclosed, and it shall be a violation of the Kansas child abuse and neglect reporting act for any person, association, firm, corporation or other agency willfully or knowingly to permit or encourage the unauthorized dissemination of the contents of such records and reports except as otherwise provided by the Kansas child abuse and neglect reporting

act or under the following conditions: (a) Upon the order of any court of record after a determination by the court issuing the order that such records and reports are necessary for the conduct of proceedings before it and are otherwise admissible in evidence, except that such access shall be limited to in camera inspection unless the court determines that public disclosure of the information contained therein is necessary for the resolution of an issue then pending before it; and (b) the secretary of social and rehabilitation services or the judge of the court where the report is filed may authorize access to such records and reports to: (1) A person licensed to practice the healing arts who has before him or her a child whom he or she reasonably suspects may be abused or neglected; (2) an agency having the legal responsibility or authorization to care for, treat, or supervise a child who is the subject of a report or record; (3) a parent, guardian, or other person responsible for the welfare of a child named in a report or record, with protection for the identity of reporters and other appropriate persons; (4) a police or other law enforcement agency investigating a report known or suspected child abuse or neglect. [L. 1975, ch. 231, § 6; July 1.]

38-724. Citation of act. K. S. A. 38-716 to 38-724, inclusive, and amendments thereto, shall be known and may be cited as the Kansas child abuse and neglect reporting act. [L. 1975, ch. 231, § 7; July 1.]

APPENDIX B

Kansas County Groups Based on 1975 Populations

Large - more than 150,000

Johnson	241,781
Sedgwick	339,223
Shawnee	173,418
Wyandotte	187,833

Medium - 20,000 - 150,000

Atchison	21,288	Ellis	24,293	Lyon	31,133
Barton	36,102	Finney	23,323	McPherson	25,167
Butler	39,522	Ford	24,495	Miami	20,906
Cherokee	22,532	Franklin	20,591	Montgomery	42,741
Cowley	34,800	Geary	24,474	Reno	64,900
Crawford	38,127	Harvey	28,934	Riley	41,029
Dickinson	21,927	Labette	25,274	Saline	47,596
Douglas	63,833	Leavenworth	50,702	Sumner	24,165

Small - less than 20,000

Allen	15,455	Haskell	4,096	Pawnee	8,068
Anderson	8,539	Hodgman	2,744	Phillips	8,287
Barber	6,880	Jackson	11,288	Pottawatomie	13,035
Bourbon	15,470	Jefferson	12,816	Pratt	9,148
Brown	13,061	Jewell	6,006	Rawlins	4,301
Chase	3,554	Kearny	3,307	Republic	8,272
Chautauqua	5,051	Kingman	10,043	Rice	11,681
Cheyenne	4,005	Kiowa	4,030	Rooks	7,313
Clark	2,833	Lane	2,842	Rush	5,299
Clay	10,139	Lincoln	4,793	Russell	9,707
Cloud	14,072	Linn	8,364	Scott	6,453
Coffey	8,282	Logan	3,806	Seward	16,644
Comanche	2,839	Marion	16,209	Sheridan	3,856
Decatur	5,036	Marshall	13,919	Sherman	8,424
Doniphan	10,094	Meade	5,058	Smith	6,588
Edwards	4,507	Mitchell	8,115	Stafford	6,207
Elk	4,042	Morris	6,895	Stanton	2,523
Ellsworth	7,232	Morton	3,495	Stevens	4,865
Gove	4,000	Nemaha	12,104	Thomas	7,826
Graham	4,630	Neosho	17,782	Trego	4,564
Grant	7,055	Ness	4,653	Wabaunsee	6,746
Gray	4,943	Norton	7,213	Wallace	2,228
Greeley	2,210	Osage	13,368	Washington	9,319
Greenwood	9,154	Osborne	6,371	Wichita	3,697
Hamilton	3,076	Ottawa	6,419	Wilson	14,217
Harper	8,140			Woodson	4,796

**THIS BOOK
CONTAINS
NUMEROUS PAGES
WITH THE ORIGINAL
PRINTING BEING
SKEWED
DIFFERENTLY FROM
THE TOP OF THE
PAGE TO THE
BOTTOM.**

**THIS IS AS RECEIVED
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CUSTOMER.**

APPENDIX C

APPLICATION FOR APPROVAL TO USE HUMAN SUBJECTS

1. ACTIVITY OR PROJECT TITLE:

Child abuse and the physician in Kansas

2. PROPOSED SPONSOR (IF ANY):

3. PERSONNEL INVOLVED:

NAME	DEPARTMENT	PHONE
Robert H. Poresky, PhD THE PRINCIPAL INVESTIGATOR OR A RESPONSIBLE INDIVIDUAL*	Family & Child Devel.	532-5510
Margaret Keeley CO-WORKERS**		

4. ATTACH A COPY OF THE PROJECT PROPOSAL

A. RISK. ARE THE RISKS TO HUMAN SUBJECTS OUTWEIGHED BY THE BENEFITS TO THE SUBJECT? ☒ YES ☐ NO
ON WHAT PAGE OF THE PROPOSAL IS THIS INFORMATION OUTLINED? _____. IF THIS DESCRIPTION IS NOT OF SUFFICIENT DETAIL FOR THE COMMITTEE TO EVALUATE, ADD ADDITIONAL INFORMATION HERE.

There is minimal risk to the human subjects in the use of the questionnaire method to be used. There is no deception involved and the procedure cannot be instituted without consent of the subject. The subjects will be fully informed of the objectives and methods of the study. Results will be made available to them.

*MUST BE FACULTY - NOT A STUDENT
**MAY BE GRADUATE OR UNDERGRADUATE STUDENTS

B. INFORMED CONSENT. ON WHAT PAGE OF THE PROPOSAL IS THE PROCEDURE FOR SECURING INFORMED CONSENT OUTLINED?

_____. IF THE PROPOSAL DOES NOT INCLUDE ALL OF THE FOLLOWING, DISCUSS THEM BELOW: (1) a fair explanation of procedures to be followed including identification of experimental procedures, (2) description of discomforts and risks, (3) description of benefits, (4) disclosure of appropriate alternatives available, (5) an offer to answer inquiries, and (6) instructions that the subject is free to withdraw consent and participation at anytime.

1. The procedure is a written questionnaire which the person can refuse to answer
2. No discomforts or risks are anticipated
3. Benefits will be the results of the questionnaire
4. Alternative is not to participate
5. Inquiries will be answered
6. the subject is free to withdraw consent and participation at any time

C. EMERGENCIES. ON WHAT PAGE OF THE PROPOSAL ARE THE PROCEDURES FOR EMERGENCIES DISCUSSED? _____. HAVE YOU LISTED POSSIBLE EMERGENCIES WHICH MIGHT ARISE?
☐ YES ☒ NO. If further detail concerning anticipated emergencies or procedures for handling emergencies should be discussed, do so in the space provided below.

The questionnaire will be answered at the location of the subject. No emergencies arising out of the study are anticipated which would not be a part of the subject's usual activities.

D. PRIVACY. ON WHAT PAGE OF THE PROPOSAL DO YOU DISCUSS PROCEDURES FOR KEEPING RESEARCH DATA PRIVATE? _____. This should include procedures for maintaining anonymity of subjects. Supplemental information concerning privacy of data may be discussed below.

All material will be held confidential in accordance with American Psychological Association procedures for protecting the rights of subjects in research

5. STATEMENT OF AGREEMENT: The below named individual certifies that he/she has read and is willing to conduct these activities in accordance with the Handbook for Research, Development, Demonstration, or Other Activities Involving Human Subjects. Further, the below named individual certifies that any changes in procedures from those outlined above or in the attached proposal will be cleared through Committee 5075, The Committee on Research Involving Human Subjects.

Signed Robert P. Twiss Date 1/15/76
The Responsible Individual

Send application to: Dr. Page Twiss, Department of Geology,
Campus.

CHILD ABUSE AND THE PHYSICIAN IN KANSAS

PROJECT DESCRIPTION

The purpose of this project is to investigate the incidence of child abuse in the state of Kansas, as related to several demographic characteristics, and to determine the effects of the Kansas child abuse reporting law of 1975. Not since 1964 has any study of child abuse in Kansas been reported. The present study is the basis for a masters degree thesis in the department of Family and Child Development at Kansas State University.

The Social and Rehabilitation Services Division of Services to Children and Youth, in Topeka, has a central registry in which all cases of suspected child abuse are reported. Included in this registry are such demographic characteristics as county of residence, family status, sex and age of the abused children. These will be statistically analyzed for degree of correlation, and compared with other reported findings. Confidentiality of this information will be maintained through procedures established by the Social and Rehabilitation Services.

The amended child abuse reporting law in Kansas took effect on July 1, 1975. Physicians are required by this law to report any suspected cases of child abuse to the proper authorities; failure to report constitutes a class B misdemeanor. However, according to the literature in the field, physicians are responsible for reporting only a small percentage of the reported cases, even though they may actually see a much greater percentage in their professional practice.

In 1966, a questionnaire was sent to those physicians in the Washington, DC area who would most likely come in contact with abused children to: determine their knowledge of child abuse; their awareness of community procedures; and, their attitude toward reporting such cases. This same questionnaire will be used in the present study to obtain this information about child abuse knowledge in Kansas.

This data will indicate to the SRS and the medical profession the factors related to the incidence of child abuse around the state, and the level of awareness of child abuse among those physicians involved in primary care.



Department of Family and Child Development
Justin Hall
Manhattan, Kansas 66506

January 1976

Dear

Your assistance would be appreciated in a portion of our study of the battered child syndrome within the state of Kansas. In cooperation with the state department of Social and Rehabilitation Services, the study will investigate some of the factors related to child abuse. Among the factors to be studied are family size, type of home, economic status, age and sex of children, and parental status. We would also like to take a look at the role of the physician in the treatment and prevention of child abuse through the enclosed questionnaire. The questionnaire is quite short and should take less than five minutes of your time, but it will provide us with information about the doctors' understanding of child abuse which will be helpful in developing programs to help reduce the incidence of this syndrome. All responses to this questionnaire will be kept strictly confidential by the researcher.

The research project is being conducted in partial fulfillment of the Masters degree in Kansas State University's Department of Family and Child Development. Kansas State University requires that all projects involving data from human subjects provide evidence of informed consent. A separate sheet is included for this purpose.

Thank you for your cooperation.

Sincerely,

Margaret Kelley



Department of Family and Child Development
Justin Hall
Manhattan, Kansas 66506

An informed consent form is required for all studies involving human subjects at Kansas State University. Persons who take part in this study of child abuse in Kansas must sign this Consent Form, indicating that they are taking part on a voluntary basis and that they know what the study is about. Your answers to these ten questions will be useful in helping us to understand some of the factors involved in the physicians' responsibility in the reporting of suspected cases of child abuse. No names of individual persons will be included in the report; there will be no way of tracing responses to specific individuals, because this signed Consent Form will be separated from the questionnaire upon receipt by the researcher.

A report of the results of this research will be available at your request at the conclusion of the project, and we will be available to answer any questions.

I have read the above paragraphs and I am willing to take part in this study.

Signed _____ Date _____

CHILD ABUSE QUESTIONNAIRE

What is your type of practice?

- a. Family practice
- b. General practice
- c. Pediatrics

When you see an injured child professionally do you consider the possibility of child abuse?

- a. yes
- b. no

Can you think in retrospect of recent cases in which the possibility of child abuse could have been considered but was not?

- a. yes
- b. no

In the course of an average month in your practice what would you estimate the number of suspected cases of child abuse to be?

- a. 0 - 2
- b. 3 - 5
- c. 6 - 10
- d. more than 10

When you suspect a case of battered child syndrome, to whom do you report the case?

- | | |
|------------------------------|----------------------|
| a. Police department | f. Psychiatrist |
| b. Hospital medical director | g. Refer to hospital |
| c. Head nurse | h. Other _____ |
| d. Community medical society | |
| e. Social Service | |

If you report a suspected case of child abuse, do you know what type of follow-up is initiated by that agency or person?

- a. yes
- b. no

Are there occasions when you make the diagnosis of battered child syndrome but do not report the case?

- a. yes
- b. no

Assuming legal protection, would you report a case in which you suspected an abused child but did not have full evidence to confirm such a diagnosis?

- a. yes
- b. no

Assuming legal protection, what are the reasons you might not report a case in which evidence exists for a diagnosis of battered child syndrome?

- a. Legal time lost
- b. Implications to child's family
- c. Insufficient diagnostic evidence
- d. Other _____

. Where did you obtain your knowledge about the battered child syndrome?

- a. Medical school
- b. Special training
- c. Medical journal
- d. Lay press
- e. Other _____
- f. Not familiar with the battered child syndrome



February 9, 1976

Graduate School
Fairchild Hall
Manhattan, Kansas 66506
Phone: 913 532-6191

TO: Robert Poresky and Margaret Keeley
Family & Child Development
Justin Hall

FROM: John P. Murry, Chairperson
Committee on Research Involving Human Subjects

RE: Committee Review of Your Proposal Titled "Child Abuse and
the Physician in Kansas."

The Committee on Research Involving Human Subjects has reviewed the proposal identified above and has approved it unanimously.

This approval applies for this project only and only under the conditions and procedures described in the application. Any change in the protocol or conditions described in the proposal will require separate approval. This approval will be followed by surveillance procedures which will require periodic review of the project by consultation with the Responsible Individual and the examination of the appropriate records of the activity. Individual identification of human subjects in any publication is an "invasion of privacy" and requires a separate executed "informed consent."

Prior to initiation of activities involving human subjects, (unless specifically exempted) properly executed informed consent must be obtained from each subject or his/her authorized representative and such forms must be retained on file by the Responsible Individual for a minimum of five years after termination of the project.

Any unanticipated problems involving risk to human subjects or others should be reported immediately to the Director of the Student Health Center.



APPENDIX D
COVER LETTER, INFORMED CONSENT AND QUESTIONNAIRE
KANSAS STATE UNIVERSITY

Department of Family and Child Development
Justin Hall
Manhattan, Kansas 66506

February, 1976

Dear

Your assistance would be appreciated in a portion of our study of the battered child syndrome within the state of Kansas. In cooperation with the state department of Social and Rehabilitation Services, the study will investigate some of the factors related to child abuse. Among the factors to be studied are family size, type of home, economic status, age and sex of children, and parental status. We would also like to take a look at the role of the physician in the treatment and prevention of child abuse through the enclosed questionnaire. The questionnaire is quite short and should take less than five minutes of your time, but it will provide us with information about the doctors' understanding of child abuse which will be helpful in developing programs to help reduce the incidence of this syndrome. All responses to this questionnaire will be kept strictly confidential by the researcher.

The research project is being conducted in partial fulfillment of the Masters degree in Kansas State University's Department of Family and Child Development. Kansas State University requires that all projects involving data from human subjects provide evidence of informed consent. A separate sheet is included for this purpose.

Thank you for your cooperation.

Sincerely,

Robert H. Poresky, Ph.D.
Assistant Professor

Margaret Keeley
Graduate Student

An informed consent form is required for all studies involving human subjects at Kansas State University. Persons who take part in this study of child abuse in Kansas must sign this Consent Form, indicating that they are taking part on a voluntary basis and that they know what the study is about. Your answers to these ten questions will be useful in helping us to understand some of the factors involved in the physicians' responsibility in the reporting of suspected cases of child abuse. No names of individual persons will be included in the report; there will be no way of tracing responses to specific individuals, because this signed Consent Form and Questionnaire will be returned to the researcher in separate envelopes.

A report of the results of this research will be available at your request at the conclusion of the project, and we will be available to answer any questions.

I have read the above paragraphs and I am willing to take part in this study.

Signed _____ Date _____

CHILD ABUSE QUESTIONNAIRE

Circle the most appropriate answer to the following 11 questions.
Please do not include your name anywhere on the questionnaire.

1. What is your type of practice?
 - a. Family practice
 - b. Pediatrics
2. When you see an injured child professionally do you consider the possibility of child abuse?
 - a. Yes
 - b. No
3. Can you think, in retrospect, of recent cases in which the possibility of child abuse could have been considered but was not?
 - a. Yes
 - b. No
4. In the course of an average month in your practice what would you estimate the number of suspected cases of child abuse to be?
 - a. None
 - b. 1-2
 - c. 3-5
 - d. 6-10
 - e. More than 10
5. When you suspect a case of battered child syndrome, to whom do you report the case?

a. Police department b. Hospital medical director c. Head nurse d. Community medical society	e. Social and Rehabilitation Service f. Psychiatrist g. Refer to hospital h. Other _____
--	--
6. If you report a suspected case of child abuse, do you know what type of follow-up is initiated by that agency or person?
 - a. Yes
 - b. No
7. Are there occasions when you make the diagnosis of battered child syndrome but do not report the case?
 - a. Yes
 - b. No

(Over)

**THE PAGE
NUMBER ON THE
FOLLOWING PAGE
IS ILLEGIBLE DUE
TO BEING CUT OFF.**

**THIS IS AS
RECEIVED FROM
CUSTOMER.**

8. Assuming legal protection, would you report a case in which you suspect an abused child but did not have full evidence to confirm such a diagnosis?
- a. Yes
 - b. No
9. Assuming legal protection, what are the reasons you might not report a case in which evidence exists for a diagnosis of battered child syndrome?
- a. Legal time lost
 - b. Implications to child's family
 - c. Insufficient diagnostic evidence
 - d. Other _____
10. Where did you obtain your knowledge about the battered child syndrome?
- a. Medical school
 - b. Special training
 - c. Medical journal
 - d. Lay press
 - e. Other _____
11. What is the population of the county in which you live?
- a. Less than 20,000
 - b. 20,001 - 150,000
 - c. More than 150,000



Department of Family and Child Development
Justin Hall
Manhattan, Kansas 66506

April 1976

Dear :

In early March, you received a brief questionnaire seeking information on child abuse. The data so obtained would be used in a portion of a study of the battered child syndrome within the state of Kansas. We would now like to ask those who have not yet completed the questionnaire to take a short five minutes, to answer the eleven questions. Your answers, while kept strictly confidential, will better enable us to obtain significant results as to the Kansas doctors' understanding of child abuse.

Another copy of the questionnaire and the informed consent form, required of all Kansas State University projects involving data from human subjects, are enclosed. We hope that you will take the time soon to answer them and return them to us in the two self-addressed, stamped envelopes.

Thank you for your cooperation.

Sincerely,

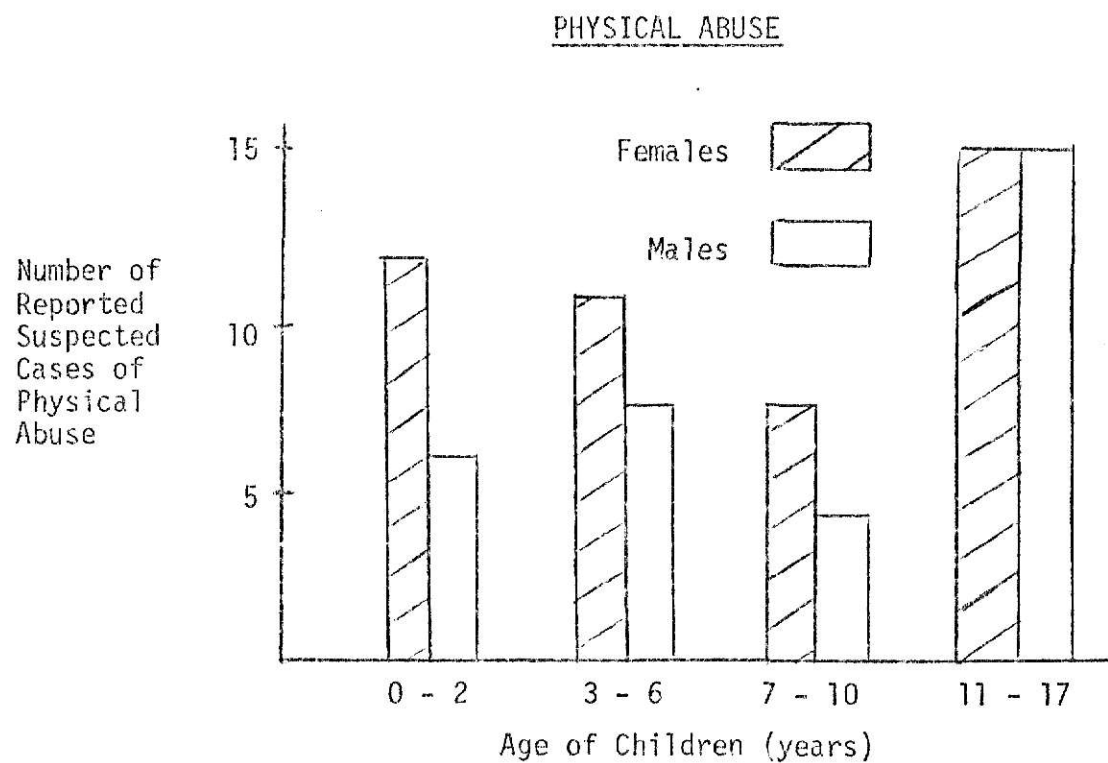
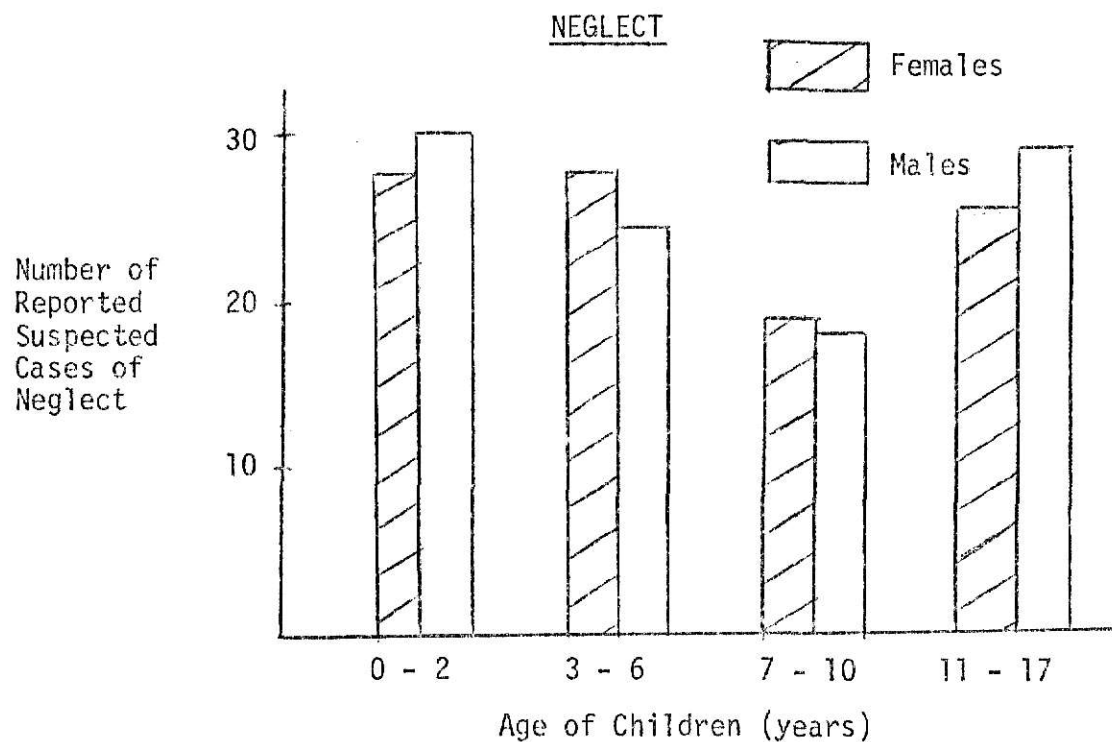
Robert H. Poresky, Ph.D.
Assistant Professor

Margaret Keeley
Graduate Student

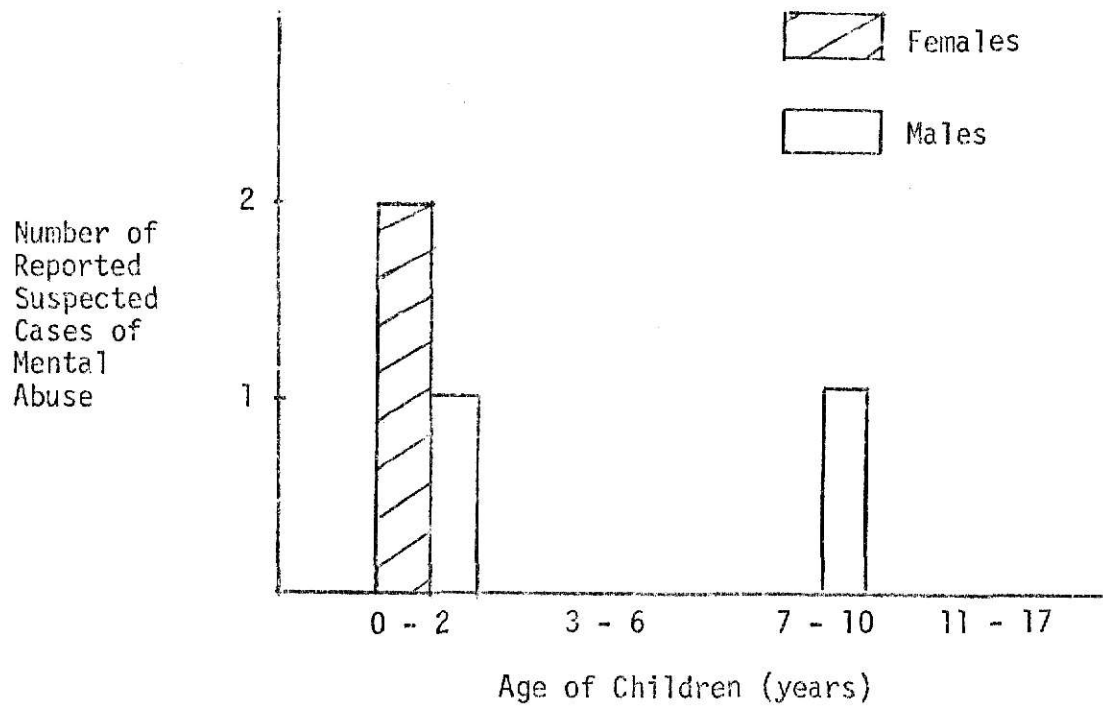
Enclosures

APPENDIX F

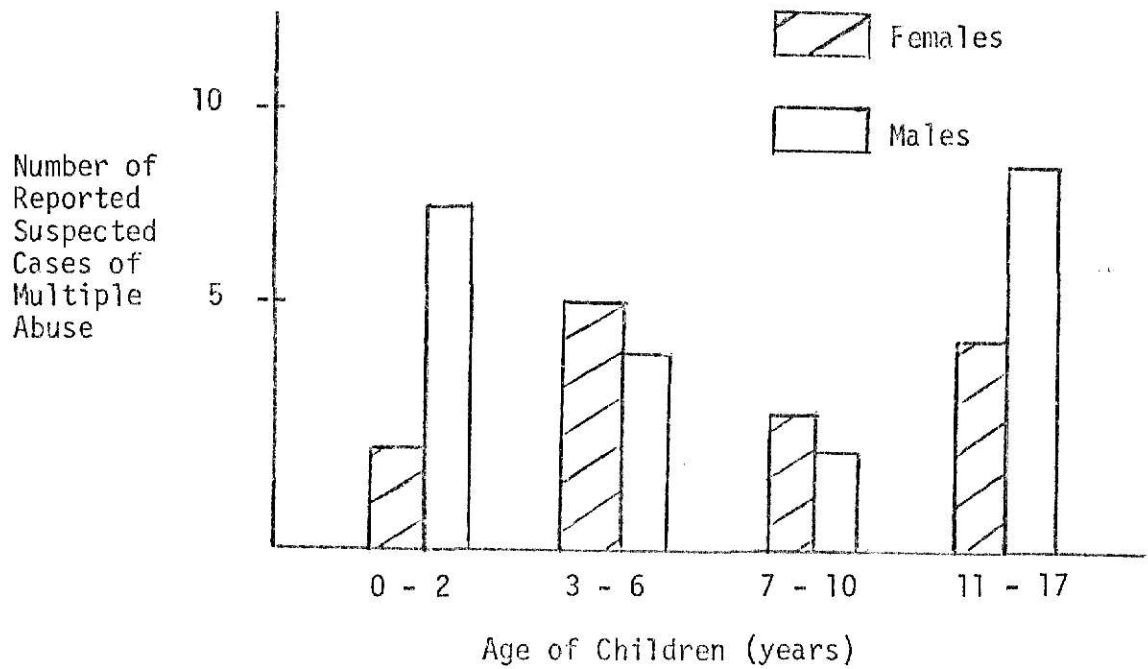
Sex and Age Distribution of Sample of Reported Suspected Child Abuse/Neglect Cases in Kansas (1975)



MENTAL ABUSE



MULTIPLE ABUSE



APPENDIX G

Percentage Distribution by Sex of Kansas Children and Sample Children

	Sex	Kansas Children	Sample Children
Female	♀	48.98%	50.79%
Male	♂	51.02%	49.21%

CHILD ABUSE IN KANSAS:
DEMOGRAPHIC FACTORS AND THE DOCTORS' RESPONSIBILITIES

by

MARGARET VAUGHAN KEELEY

B.A., St. Lawrence University, 1973

AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Family and Child Development

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1976

ABSTRACT

Recorded demographic factors of suspected child abuse cases in Kansas and the Kansas physicians' view of their responsibilities to abused children, their families and the law were the two foci of this study.

During 1975, 5262 suspected cases of child abuse/neglect were recorded in the Kansas Central Registry of Child Abuse. A systematic stratified sample of 317 cases was drawn to provide an approximately equal representation of child abuse cases from the low, medium and high density population areas across the state. Data collected on this sample indicated that child abuse affected at least 0.7% of all children under the age of 18 in Kansas during 1975, males and females equally. Children under the age of six were significantly more often the victims of suspected child abuse/neglect than were those over the age of six. Two thirds of the children suffered from neglect at the hands of their caretakers, and nearly one quarter were physically abused. A majority of the children were living with their mother at the time of the reported child abuse incident; nearly half of these were also living with their father or a father substitute. Of the parents living with the child victim, a greater proportion of the fathers than the mothers allegedly perpetrated the incidents. Approximately one in five children had been previously reported as the victims of abusive and/or neglectful treatment.

A sample of 94 Kansas family practitioners and 16 pediatricians were sent a questionnaire seeking to determine their awareness of child abuse in Kansas and their attitudes toward their legal respon-

sibilities. A majority of the physicians reported considering the possibility of child abuse when treating their children patients, but estimated they only saw between 0 and 1 abused child per month in their practice. Over half of the physicians were unaware of the correct reporting procedures defined by Kansas law and of the follow-up procedures initiated once a report had been made. Most doctors stated that they did, and would continue to report suspected cases of child abuse/neglect and listed a variety of authorities to whom they refer cases. In 1975, reports of suspected child abuse cases from physicians represented 2.5% of all cases recorded in the Kansas Central Registry of Child Abuse. Medical journals were cited as the most frequent source of information on child abuse; medical schools were cited by one third of the physicians as a source of information.

Recommendations for overall improvement of social conditions and more effective education regarding the incidence, nature, treatment and prevention of child abuse/neglect are noted.