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COMMENTARY

Observations on a Half Century of Research at the Kempe Center

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This issue of the *International Journal of Child Maltreatment Research, Policy and Practice* has a series of papers describing the current research programs at the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect in that center's 50th anniversary year. This commentary will provide personal observations on the center and its research from the perspective of one who has been close to and/or part of the center for 49 of its 50 years.

The Beginning: 1958–1972

C. Henry Kempe, MD, became the Chair of the Department of Pediatrics at the University of Colorado School of Medicine in 1956 at the age of 34. It was the start of a remarkable career. During his first 2 years in Colorado, he was the attending physician on the pediatric ward services at Colorado General Hospital (CGH) and Denver General Hospital (DGH). He was a virologist and known for his work in pediatric infectious disease, but he became frustrated with what he viewed as the intellectual dishonesty among medical staff in their ignoring of what he perceived to be obvious trauma to children. No one considered that the parents (or other caretakers) of the child might have inflicted injury or were severely neglecting the child who was not being fed. In a letter written to a friend, Kempe stated the following:

> I got into the problem of the battered child, not out of altruism, but first out of rage at the intellectual blocks I encountered when I went on ward service in 1957 and 1958. I saw child after child both at DGH and CGH with diagnoses that were absurd…'spontaneous subdural hematoma' (at age 8 months); 'Osteogenesis imperfecta tarda' (at age 3 years in previously well children);

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> 'spontaneous bruising of unknown etiology' and 'Failure to thrive of unknown etiology' in a child who gained 2 oz./day in the hospital despite 40 lab tests. (Kempe, 2012)
> "You could fairly say that I hate illogical diagnoses and I felt strongly that all this was denial from intern to resident to attending to specialist of an obvious trauma or neglect situation and that was not good for our intellectual honesty, nor did it do any good for the abused child, his siblings, or for his suffering parents, most of whom we could help."

Henry intuitively knew that to understand the problem, he needed the input of several colleagues trained in other disciplines. He described literally taking an adult psychiatrist, Brandt Steele, by the arm and pushing him into a room where a 7-month-old baby had both legs in traction and said, "talk to the mother and see if you can find out what happened." Two hours later, Brandt came out of the room, knew what happened, and as he later put it, "I was hooked" into wanting to work on the problem.

They formed one of the three first multidisciplinary child protection teams in the USA in 1958 (the others were in Pittsburgh and Los Angeles). It included pediatricians, adult and child psychiatrists, social workers, psychologists, a coordinator, and (later) a lawyer. That team has been meeting regularly for the past 64 years, reviewing cases that come into the acute hospital pediatric services. From the beginning, the members of this multidisciplinary team provided evaluation and assessment of the child and the family members and worked with the county to develop treatment plans and follow-up to see what the outcomes were. It should be noted that in those early days, physical abuse and neglect were the predominant cases, most were treatable, and the county departments, with the help of the family court system actually provided services that seemed to lead to good outcomes for most families. The principles of their practice in these beginning years were outlined in a book entitled *Helping the Battered Child and His Family* (Kempe & Helfer, 1972). I suspect very few practitioners today have read it.

The National Center: 1972–1981

The clinical experience of the professionals on the child protection team led to efforts to expand research and training for others throughout the USA and around the world. Henry sought resources for a national center to do so. In 1972, with funding from the then-new Robert Wood Johnson Foundation, the Commonwealth Fund, and the Carnegie Foundation, he founded the National Center for the Prevention and Treatment of Child Abuse and Neglect. In addition to opening a resource center and library for individuals needing references to work in this new field of study, the new center undertook a number of research efforts, such as the following:

1) A prediction and prevention study videotaped the interaction of parents and their newborns at the time of delivery and for the first feeding. These observations

made it clear that one could predict who was at risk for abuse and neglect and, further, that providing a home visitor to those at risk could prevent the abuse from happening (Gray et al., 1976).

2) The video technology was also used in a further study of the interactions between mothers and their children who had non-organic failure to thrive, demonstrating the impaired interaction and the mother's ability to learn in many cases (Haynes et al., 1983).
3) A therapeutic preschool for physically and sexually abused toddlers (3–4-year-olds) demonstrated that abused children with this experience had success in elementary school compared to untreated children who had academic and behavioral problems and ended up in special education (Gray et al., 2000).
4) A residential treatment program for abusive families was shown to be no better than outpatient treatment and was much more expensive.

Many of these programs were described in the January 2000 Special Issue of *Child Abuse & Neglect*, which described the first quarter century of work at "Henry Kempe's Center" (Hiatt, 2000).

Education was also a significant part of the center's mission, nationally and internationally. There were annual conferences that brought together hundreds of professionals in the growing field. Henry started the International Society for the Prevention and Treatment of Child Abuse and Neglect (ISPCAN) in 1977 and founded *Child Abuse & Neglect: The International Journal* that same year.

Henry worked with Senator Walter Mondale of Minnesota and Representative Patricia Schroeder of Colorado to draft federal legislation (the Child Abuse Prevention and Treatment Act (CAPTA) of 1974). CAPTA authorized the National Center on Child Abuse and Neglect (NCCAN). Henry's hope was that his center would be named specifically as that center and be given an appropriation to expand the field. The Nixon administration opposed the legislation at first, but when it looked as if it were going to pass, amended it to have the national center in Washington, DC, where it was embedded within the Children's Bureau in the welfare side of the Department of Health, Education, and Welfare bureaucracy. It passed in January 1974.

During the mid-1970s, sexual abuse became recognized as a significant but "hidden" pediatric problem, and the center turned its focus to sexual abuse. The preschool soon became filled with toddlers who had been sexually abused, and the treating mental health professionals began treating families where incest had been identified. The Kaiser Family Foundation funded the center for the work in sexual abuse through a separate not-for-profit foundation Henry set up called The Friends of the National Center.

Henry won the C. Anderson Aldrich award from the American Academy of Pediatrics in 1977. He was to give the award lecture at the annual meeting held in New York City in November but had a serious heart attack the night before. He was hospitalized in the Coronary Care Unit at Bellevue Hospital in New York for 6 weeks. He returned to Denver to recuperate and, in 1979, had unsuccessful bypass surgery in Denver. The surgery left him with another infarction and

a cerebral thrombosis which resulted in a slight speech impairment. In 1980, as I was leaving Denver for a Robert Wood Johnson Health Policy Fellowship in Washington, DC, Henry told me he was going to retire and move to Hawaii. He asked me to direct the center when I returned from sabbatical. I accepted.

Kempe National Center: 1981–1992

Henry left Denver in 1980. The center was administered by an executive committee consisting of the leadership of each of the programs, Brandt Steele and Don Bross (legal counsel). Henry asked me to visit him in Hawaii shortly after I returned from Washington and said, "Sorry I could not have left you with a bigger dowry!" There was $300,000 from Kaiser for the sexual abuse program, a small amount of state money for the child protection team, and nothing else. This was particularly distressing since a child psychiatrist and his family were arriving from England 6 weeks later for a 3-year stint at the center, and we had no means to pay him. Fortunately, before he arrived—and before anyone else had to leave—a local foundation gave the center a grant and a loan sufficient to cover the salaries of the remaining staff and new psychiatrist, David Jones, for 6 months. In January of 1983, the center began charging for its services, connected with other organizations to have their name on some of our programs (e.g., the Child Help Family Evaluation Program), and the friends ramped up their fundraising efforts, raising over $100,000 annually to support the preschool. In the spring of 1983, a local radio station raised $50,000 for the center during the week that a young child's body was found 3 months after he was murdered by his mother's boyfriend.

Other than the remaining National Institutes of Health funding for the failure to thrive study, the research in the decade of the 1980s was driven by clinical cases that we were seeing. In 1983, a 3-year-old girl was kidnapped, sexually abused, dropped into a mountain outhouse, and left to die. She was found 3 days later and subsequently identified her assailant in a lineup. This case was one of the first cases where we provided consultation to prosecutors and did videotape depositions for the court. It led to another child abuse consultation program, START, which contracted with six states to assist with difficult child abuse and neglect cases in their region. Notably, because the kidnapped child was not abused by any member of her family, the county department of social services said they were not going to be involved with the family. The significant trauma that the family experienced led us to start a group treatment program for families whose children were sexually abused by strangers (Grosz et al., 2000). Within weeks, the program was full, and group therapy was provided to the parents in one part of the center while the children were treated together in the preschool space. And, because the individual who kidnapped the girl had a long history of sexually abusing girls in the Denver area, it led to Gail Ryan's interest in learning more about adolescent perpetrators of sexual abuse. She started the National Adolescent Perpetrator network with 21 professionals who expressed interest at our annual national meeting in Keystone, CO, USA.

Henry died in Hawaii on March 7, 1984, and the Center was renamed the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and

Neglect. David Jones returned to the UK the following year, but not before doing important research on fictitious allegations of sexual abuse in Denver and on families with divorce-custody battles (Jones and McGraw, 1987, Jones and Seig, 1988). As was the case with the clinical observations of the earlier years, David's research basically underscored how complicated clinical child abuse work is and how, no matter how hard one tries, one might not actually know whether abuse happened or not (2 in 20 cases were so muddled that it was impossible to know whether abuse had occurred). This uncertainty is common in practice, of course, but there is no concerted effort to connect the families into either the health or education systems, where the families can be followed more closely.

In 1986, the Governor of Iowa invited us (with four other organizations) to evaluate their child protection system. There had been several child abuse fatalities, leading some to call for more resources for CPS. But there was a group named VOCAL—victims of child abuse laws—who were furious about the "Nazi CPS workers" who were removing children from their families for allegations of sexual abuse that could not be proven. The single most important outcome of this engagement was what we believed to be the first (and only to this date) survey of the families who had been reported to and involved with CPS the previous year. The results were published and showed that > 60% of the families served rated their experience with CPS helpful and said they were better off than they had been before their involvement (Fryer et al., 1990).

These and other programs at the center during these years were discussed in the previously mentioned special issue of *Child Abuse & Neglect* (Hiatt, 2000).

Final Thoughts

Some of the research conducted at the center over the years has been groundbreaking and effective. At the same time, the diffusion of the information has been spotty at best. Home visitation (demonstrated to be effective in the early 1970s) is a partial exception to this statement. Nurse-Family Partnership and Healthy Families America do provide home visiting services to several hundred thousand families a year in the USA. But when one realizes that there are over 3 million births a year, and there are few if any nursery protocols that monitor and record the interaction of the family at the birth, one wonders about the failure to effectively diffuse knowledge.

Furthermore, the lack of any data on the outcomes for children and families in the CPS systems nationally is appalling. There are a lot of data being tracked (e.g., recurrence, entry to foster care, how long to close a case), but none of this information lets the individual worker or agency know whether their practice has been helpful (or harmful) to the children and families they are serving in their communities. Interestingly, there are some researchers looking at outcomes, but it is not clear that the findings are changing the practice of the professionals in the agencies.

Fifty years in, one very obvious positive difference is that a multidisciplinary center that doing clinical work, research, education, and advocacy is no longer unique. There are now dozens of such programs in academic institutions and hundreds of multidisciplinary "advocacy" centers. Each works in its own unique setting,

and each probably has financial struggles. The challenge for all of us is that the infant and child mortality from physical abuse has not changed at all in the past 40–50 years, and the increasing recognition of the morbidity and later mortality in adolescents and adults who have experienced abuse and never received any help at all means that there will be a lot more for all of us to do in the next 50 years.

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