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THE CAUSES AND PREVENTION OF CHILD ABUSE

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PREFACE

In 1969 the Consultative Assembly of the Council of Europe adopted Recommendation 561 on the protection of minors against ill-treatment. The document recommended to the Committee of Ministers of the Council of Europe to take measures to make the competent authorities in the member states aware of the gravity of the problem and to work out proposals for its solution.

Subsequently, the Committee of Ministers asked the Governmental Social Committee to propose measures to foster public awareness of the problem of child abuse as well as to prevent or remedy it. The latter entrusted a consultant expert, Dr. Christine E Cooper, OBE, MA, MB, FRCP, DCH, Consultant Paediatrician, Department of Child Health, University of Newcastle-upon-Tyne, to conduct a study on the subject.

The Consultant Expert produced the present report, which contains a survey of the incidence of child abuse, the social and family background in which it generally occurs, its clinical aspects as well as the present trends. The report also contains the description of some methods to deal with the problem at the levels of detection, management and prevention.

Although the Assembly had also considered cases such as physical injury to adolescents, in particular sexual abuses, the report had to be limited to the study of abuse of relatively young children.

Acknowledging the importance of the subject and the value of the report, the Social Committee (later called the Steering Committee for Social Affairs) entrusted a Select Committee of Experts with the preparation of recommendations to the governments of member states mainly based on the report and embodied in a resolution.

Whereas this resolution is intended to give guidelines for action by governments, the opinions expressed in this report are not to be regarded as necessarily reflecting the policy of individual member governments or of the Committee of Ministers of the Council of Europe.

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CHAPTER 1

INTRODUCTION

Child abuse is a complex disorder of family life and research increasingly confirms that it is a total family problem and not simply a matter of parents losing their temper and punishing a child too severely. Moreover there is considerable evidence that the learned behaviour of abuse is transmitted on through generations of the same family. Published studies show the high death rate and the grave risk of permanent injury to the child. The condition is very common and may be increasing or else it is being increasingly recognised. No wonder that abuse and deprivation are emotive subjects and evoke strong feelings of opinion, often erroneous or ill-formed, in nearly all members of society, whether professional or laymen, and whether of good education or poor. It is of crucial importance, therefore, that all those taking an active part in organisations for the recognition, management and prevention of one of the most widespread, difficult and severe psycho-social problems of our time should not rely on their own feelings. Instead they should familiarise themselves with the literature and with the studies which have so far been published, most of them very recently, in order to gain a basic understanding of the extreme complexity of the problems of child abuse, neglect and deprivation. A study of child development and family attitudes, with the remarkable increase in knowledge acquired in the last thirty years, is also crucial to an understanding of child abuse.

The changing patterns of society and subtle political pressures no less than difficulties in family life all contribute to the evils of child abuse.

CHAPTER 2

HISTORICAL SURVEY

In legend and literature tales abound of children maltreated or murdered by their parents and in the Bible there are numerous examples of child murder, abuse and infanticide. The sacrifice of babies or children to appease the Gods, common in ancient times (for example, Jacob and Isaac in the Bible) probably still exists in the more remote cultures today together with symbolic and ritual killings. The father's absolute right to use and exploit his children in any way he chose existed throughout history.

Infanticide, the killing of the newborn or young infant, has been prevalent in history, and in ancient days it was the father's choice to kill a newborn who seemed weakly or was the wrong sex. In the middle ages infanticide was a form of population control, or was a means of dealing with illegitimacy, poverty or deformed babies. Greed for power among rulers led to single or sometimes to massive slaughtering of infants, and Pharoah's and Herod's acts are well known examples of this. Greed for money for nurslings or for burial fees also led to the death of young children. By the eighteenth century infanticide had become illegal and punishable by death, although if committed by the mother, a lighter sentence was given.

Abortion has also been used as a way of dealing with unwanted pregnancies.

Abandonment of children was another alternative to infanticide in dealing with poverty or illegitimacy. Foundling institutions sprang up for their care although many died from the overcrowded and insanitary conditions. In the third world today, hundreds of abandoned children are being reared in similar institutions although their ultimate fate as human beings must be a cause for speculation and concern. The use of children as chattels for hard labour and for bringing in money existed until a few decades ago in the western world, and is still prevalent in developing countries. Mutilation of children to arouse pity and to improve their takings as beggars has an ancient origin and is still practised in some areas of Africa and Asia.

The abuse of children as cheap labour during the industrial revolution in Europe was gradually recognised and abolished, but there are many parts of the world where children are still exposed to long hours of hard and unsuitable work. Selling children into slavery or prostitution was formerly the right of parents too.

A hundred years ago a change in society's callousness to children began. The case of 9 years old Mary Ellen, in New York, who was subjected to repeated severe cruelty and neglect by her parents, led in the USA to the first Society for the Prevention of Cruelty to Children, and to laws which began to regulate gross abuse of children. It is significant that a similar Society for the Prevention of Cruelty to Animals had existed there for several years and was the only means by which little Mary Ellen could be brought before the court and rescued.

In the past hundred years society has moved towards recognising gross forms of physical abuse or the murder of children. Medical recognition of subtle and puzzling injuries has been slower, although sporadically mentioned in medical treatises. The work of Tardieu in Paris in the 1850s and 1860s and of West in London in the 1880s paved the way for the modern recognition of child abuse.

In 1946 Caffey, an American radiologist, reported many children whose subdural haematomas (haemorrhages around the brain) were associated with fractures or other lesions of the long bones. Later on Caffey, and in 1955 Woolley, emphasised that these injuries were often wilfully inflicted and the news began to spread to the public and the mass media. Following Kempe's national study in the USA and his coining the term "the battered child syndrome" in 1962, medical and social agencies have begun to look more seriously at the causes and prevention of inflicted injuries on both sides of the Atlantic. In Denver, Colorado, Kempe and a team of collaborators have developed the field of recognition, management and prevention of child abuse and have alerted the world to this widespread evil.

Much of the abuse described earlier in this chapter was overt acceptable behaviour towards children at the time it occurred. This report concerns behaviour which is unacceptable to our society and therefore occurs secretly and is denied by its perpetrators.

Recent cases, such as those of Roxanne in New York City, 1969, and of Maria Colwell in Brighton, United Kingdom, 1973, have led to much public alarm and concern and to attempts to work out standard procedures and improved laws for the control of child abuse.

Perhaps societies should also be concerned that the abuse of children in another sphere is a pervasive influence in the world today where young children are taught to shoot and to kill and hatred of race or creed is inculcated in them from an early age.

CHAPTER 3

DEFINITION OF CHILD ABUSE

Child abuse exists in many forms as we have seen in the last chapter, and its control will depend on the limits a society puts on parental discipline and behaviour. For this purpose a definition is needed, and while many have been attempted in recent years none is completely satisfactory. The active form of abuse in which physical injury is inflicted, usually associated with verbal abuse, is called "battering". The passive form of abuse due to neglect and deprivation causing failure to grow and to develop properly intellectually, emotionally or socially, is called "the deprivation syndrome". The two may be quite distinct but in some families both occur together.

The sexual abuse of children should be included too for it is becoming more commonly recognised and it sometimes co-exists either with physical injury or with deprivation or with both. Since it is rarely looked for or talked about it is far too seldom diagnosed among all these severe family problems. Yet it has profound effects on the victims, especially when they come to be parents themselves.

1. Physical Injury

In 1970 Gil attempted a definition as follows:

> "Physical abuse of children is the intentional, non-accidental use of physical force, or intentional, non-accidental acts of omission, on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring or destroying that child."

This may seem sound conceptually but is not completely satisfactory for it may not always be possible to differentiate between intentional and accidental behaviour.

The infliction of physical injury upon children by their parents or guardians as a means of punishment or correction, or in anger or frustration at annoying behaviour, has hit the press headlines in recent years in several countries in the world, and is causing much concern to the public and to professionals alike. The "battered child syndrome" is now well-known.

The words "wilful" and "deliberate" are often used about the parents' violence and certainly some forms of sadistic cruelty should be so described. Often, however, these terms are inappropriate and the injuries are inflicted impulsively in fits of violent anger while feeling helplessly inadequate in coping with the child's behaviour. Many parents who abuse their children also love them and try to care for them well. Some do not, but find this hard to admit.

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Parents make shake, punch, beat, kick, fling or swing their baby or child repeatedly against a wall or floor, burn him with cigarettes, fire irons or other objects, scald him with boiling water or oil, burn him with fire, twist him, trample on him, throw him out of the window, poison, drown or smother him, and do all manner of other injuries to him. Our task is to try to understand why in order to protect the child and also to help the parents. First we must understand and work through our own anger and disgust or these feelings will impede the work we have to do with the family.

2. Deprivation

The passive form of abuse has received too little attention. Through neglect or want of concern and care, the child is not fed adequately or regularly, not kept properly clean or warm, not protected from harm, not played with or talked to, not fondled or loved. The child gradually fails to thrive in body, mind and spirit, and may succumb to injury or infection if not rescued from his miserable plight. In the more advanced stages, the child is apathetic, docile and inert. This syndrome has been called "the maternal rejection syndrome" or the "deprivation syndrome" or "deprivational dwarfism", and has only been recognised medically in recent years. It still goes unrecognised in many hospitals, clinics or child welfare agencies, but may co-exist with the active form of the battered child and in published reports some 10-30% of battered children are below the normal range in growth.

The psychological abuse of children is more difficult to define, and the public and professionals alike find it hard to agree where the limit of acceptable behaviour towards children should be drawn, and how far their development should be allowed to suffer.

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CHAPTER 4

THE DISCIPLINE AND PUNISHMENT OF CHILDREN

"Spare the rod and spoil the child" is a dictum that has been widely accepted by all cultures until today, although from time to time throughout human history a few, such as Plato in 400 BC or Roger Ascham in the sixteenth century, suggested alternatives such as playing or loving as more appropriate means of training children. The criteria for distinction between permissible discipline of children and maltreatment has varied throughout history and what are unacceptable practices in one culture may be common place in another even today.

One enlightened country, Norway, has within the last five years made the corporal punishment of children by their parents (or by anyone else) an offence, and Finland, by an amendment to the existing criminal law, has more or less achieved the same thing. It seems clear that in the western world nations are moving towards a code where the rights of the child will be equal with the rights of adults. Assault and battery on an adult carries heavy penalties in most countries but a similar assault on a defenceless child in the name of discipline may cause little comment.

Corporal punishment of children is one thing and nations in the western world are moving away from it, having prohibited it in schools and children's homes in many countries. It is to be hoped that, with succeeding generations, perhaps three or four, physical abuse of children will become a rare happening in these countries, and that other nations will soon follow this lead.

But what about psychological punishment? Under what circumstances does this become abuse?

Do we condemn parents who shut their children into cupboards for hours on end, who tie them up, who make tiny children stand in a corner in awkward positions holding very heavy weights on their heads? What do we feel about parents who do not speak to a child for hours or days, who allow him to eat only scraps from the floor, who shout at him, scare him, mesmerise and verbally torture him or who provide such an atmosphere of disapproval, criticism and hostility that the child's personality is warped and damaged? There are no visible marks or bruises in these children, no broken bones, no recognisable injury to the brain, but what about the spirit of the child? Evidence on this kind of parental behaviour is not readily acceptable in Juvenile Courts unless it damages the child physically.

The psychological damage resulting from this kind of abuse is probably more long-lasting and more damaging even than the physical injuries. People with violent behaviour tend to be the victims of violence. One study found that "remorseless physical brutality at the hands of the parents had been a constant experience" for first degree murderers in their childhoods. Each

time a child is punished by the use of violence he is being taught that the use of violence is a proper way to behave. Corporal punishment teaches a child that the deliberate infliction of pain as a form of persuasion and a means of controlling others is acceptable behaviour.

It is of the greatest public concern that children so treated are likely to become the abusing parents of tomorrow and that some of them will, in all probability, be among the murderers or perpetrators of violent crimes if they survive.

CHAPTER 5

THE INCIDENCE AND MORBIDITY OF CHILD ABUSE

"Child abuse is much more prevalent than is revealed by current statistics; substantial numbers of children are being abused or neglected without being brought to the attention of the appropriate authorities."

This quotation from the report of the New York State Assembly of the Select Committee on Child Abuse in April 1972 represents the general opinion of medical and social work agencies on both sides of the Atlantic. Even experienced practitioners in the field know that detection of the subtle, but no less important cases, may be difficult and time consuming. In addition there is a general reluctance on the part of many professionals, especially doctors, to bring families to the attention of the authorities even when abuse is obvious or strongly suspected.

It has been repeatedly seen that once practitioners in a particular area are made aware of the problem and alerted to methods of early recognition and to the fact that an organisation exists in the locality for management of the problems, the reported incidents increase alarmingly. In most countries child-care workers feel that only the tip of the iceberg of this difficult subject is at present being recognised.

Kempe, some years ago, estimated that abuse in pre-school children in the United States occurred at the rate of about 6 per 1,000 live births and in school children at about 40 per 100,000 school age children. Oliver, working in one county in the United Kingdom, found that maltreated cases topped 8 per 1,000 children under 12 years in 1973, a figure comparable with that of Light from Harvard, United States, in the same year, who estimated 1% of children under 18 years are victims each year. Chesser, in the United Kingdom as long ago as 1951, estimated 1% of children under 15 years are abused each year. Projections by Oliver reached a figure of not less than 4% of children under 12 years will be ill-treated at some time in their childhood and Chesser's comparable figure was 6 or 7%. When abuse is recognised it can often be shown that the child has been abused over months or years.

Re-injury of children after abuse is recognised and is beginning to be studied. The frighteningly high figures of around 20% were found in the recent National Society for the Prevention of Cruelty to Children, Great Britain, (NSPCC), figures from Manchester even in a 1-2 year period of follow-up in 1973-74 when services to help families were being increased and improved.

The risk of injury to the siblings is not often mentioned in the literature. Oliver quotes figures up to 72% in his series, and the NSPCC (1969) found 93% of subsequently born children were injured in 40 families where a first born was injured, and the overall rate of injury to siblings was 49% in 78 families.

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A small NSPCC study suggested that some 10% of minor injuries to young children in London are due to abuse and another 10% to gross neglect. Silverman has estimated that 10% of all fractures below the age of three years are likely to be due to abuse and many others to carelessness or neglect of the usual protective role of parents.

Mortality and long-term morbidity rates

The toll of death and permanent disability in abused children is frighteningly high. In reported groups of abused children the death rate has varied from 6-28%. Naturally it depends upon the criteria for diagnosis, the earlier this occurs and the more effective the management, the lower the death rate will be. It is clear that many children who are killed by inflicted injury do not appear on the statistics for homicide or even for accident. Some die of unknown or "mysterious" causes, some from poisoning where it is notoriously difficult to obtain a clear history, or from "cot death", and in others infection may play a part in the terminal stages and this then appears on the death certificate.

The rate of permanent sequelae is high in all studies published. Commonest are neurological defects resulting in varying degrees of cerebral palsy, mental subnormality, impaired vision, hyperactivity or clumsiness. Deformed joints and various severe scars also occur. Learning difficulties, speech disorders and behaviour problems are common later on although whether they result from the injury, or from the persisting adverse environment, may be hard to determine. From these figures it will be seen that child abuse is a common disorder, and that it is highly dangerous and damaging to children, physically, mentally and emotionally. Due to the nature of the problem, statistics are unreliable just as they are in other socially unacceptable forms of behaviour such as drug abuse, alcoholism, homosexuality and delinquency.

The writer feels that the time is now past when research, effort and money should be spent on studying incidence, since we know it is high. The use of limited money and personnel for research would be more profitably employed on studying schemes for prevention as these are urgently needed and will be far more worthwhile. Education for recognition of inflicted injury, for short- and long-term management schemes, and money for providing adequate substitute family care would all be well spent.

Failure to recognise serious neglect and emotional deprivation is a great problem of society too since this form of abuse is widespread and equally dangerous to the child's eventual adult status. There has never been a problem so well understood in terms of its dynamic outcome, and for which so little is done by using available knowledge. Further discussion of the long-term effects will be seen on page 19.

CHAPTER 6

THE AETIOLOGY OF ABUSE

Drs. Steele, Kempe and Helfer in the United States have highlighted the four crucial factors which are needed before abuse occurs. In general opinions in Europe and Australasia agree with their findings.

The four factors are:

i. the potential for abuse in parents or caretaker

ii. a child whom they see as deserving bashing

iii. a crisis or series of crises

iv. parents with no lifeline or friend to turn to in times of trouble.

1. Parental factors producing the potential for abuse

Subtle, more or less concealed, but profound disorders of personality in the parents have been the factors most often associated with child abuse. These lead to severe emotional problems, and child-like or distorted patterns of coping with children and with life.

The abnormal behaviour characteristics of these parents include:

- Much smacking of very young children.
- Undemonstrativeness with very young children.
- Carelessness over the whereabouts and well-being of young children.
- Demands of obedience from very young children.
- Formation of shallow sentimental attachments or emotionally exploiting relationships with their children.

Premature and other infants separated from their mothers at birth have a higher incidence of inflicted injury than others (Elner and Gregg, 1967; Skinner and Castle, 1969; Klaus and Kennell, 1970; Klein and Stern, 1971; Lynch, 1975) and mothers who are or have been ill or depressed more often injure their children. Drugs which impair self-control increase the risk to the children, especially certain tranquillisers often given to mothers, and these are as dangerous as alcohol in provoking outbursts of frustrated violence as Ounsted and others have shown.

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These parents are adept at modifying their accounts of their behaviour towards their children according to the attitudes of their listeners and they watch and listen for the slightest cues betraying these attitudes. They often react with anger and evasion to the simplest enquiries, using denial, withdrawal and projection of blame which have become second nature from earliest childhood. They have no model of normal family life on which to base their own behaviour and this makes treatment difficult.

In a number of the families the parents present an idealised picture of their own upbringing which, by reference to reports from welfare authorities or from schools, can be shown to be false. Blackie as well as Oliver and others, have discussed the deleterious effects on children of poor rearing by subnormal parents. In fact, shallow sentimental attachments or emotionally exploiting relationships with their children characterise parental behaviour in these families from generation to generation, and workers may confuse and mistake this abnormal behaviour for the adequate protective bonds of normal parents.

Although many parents and others who care for children feel like battering them why is it that so few do? Do we all have it in us to injure a child? The answer is probably "NO" because most people have experienced enough tender loving care themselves in infancy and the early years which has led to the development of trust, and have gradually learnt the built-in controls against the expression of violence.

Abusing parents usually come from disturbed families and broken homes where they were themselves subjected to harshness, rejection, deprivation or abuse, especially in the early years. The resulting personality disorder varies but basically it is a lack of trust, with poor self-confidence, low self-esteem and a pervading feeling of worthlessness. Sometimes these feelings are subconscious and they may be well hidden by a good education, charm or success in specific fields.

While child abuse may occur in families of any social class, it is essentially a problem of families with multiple social and emotional problems, and is transmitted down the generations by learning inappropriate child care and child rearing practices. Family kindreds with abuse and neglect in succeeding generations have been realistically described by Oliver and his colleagues. By assortive matings, in which deprived people are attracted to each other, abusing families are often linked with each other in brief marriages, cohabitations or transient associations.

Large size, youthfulness, instability, a gross excess of psychiatric and physical illness or disability, and criminality characterise the families in the series described by Oliver and by Smith and their collaborators, and similar findings have been shown in families studied in the various series of the NSPCC, especially those recently reported from Leeds and Manchester. Oliver has also shown that even with massive support from the health and social welfare services, few of such families improve to a realistic degree, where it could be said that the children are safe and even moderately well cared for.

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The marital relationship is usually poor as the young people from these backgrounds have no model of responsible, affectionate relationships on which to draw, and having severe personality disorders themselves cannot relate warmly or responsibly to a mate or to children.

Jealousy, sexual problems, drunkenness and wife beating, as well as severe discord over money, also occur significantly often in these families. Mothers often become increasingly dull and apathetic as the family problems mount up to intolerable levels. The families are commonly socially mobile having the unrealistic expectation that moving to a new house or a new area will solve their problems. Health and social service workers sometimes collude with these ideas.

In our society with its nuclear families, mothers may be alone with their young children all day long without companionship from their partner, who is at work, or from other friends or relatives. They look forward to companionship and conversation when their partner returns in the evening and when he retires behind a newspaper or television, feeling unequal to providing the friendliness she needs, moodiness, unhappiness and discord between them result. Such girls are especially prone to abuse their children since they have no adequate warmth or emotional comfort themselves. Lack of verbal communication commonly characterises many of these families.

The demarcation between parents who assault and those who neglect their children is not clear and some parents do both. In better educated families the child is often well cared for materially and yet physical abuse occurs.

In summary there appear to be four main types of abusive parents, although this is rather an over-simplification in some cases:

i. Habitually aggressive people with poor impulse control. In such cases alcohol makes the situation worse.

ii. People with very great dependency needs, often with varying degrees of depression, who look to the child, in vain, to fulfil those needs.

iii. People with rigid, obsessional, authoritarian personalities.

iv. People suffering from mental illness.

2. A child seen as bashable

Abusing parents have unreal expectations of their children, especially in their development, in their behaviour and their emotional responses. They look forward to receiving from their children what they did not receive in emotional rewards from their parents and naturally they are disappointed. They expect too much too soon, and hope their children will be good, kind, beautiful and clever beyond any reasonable expectation, to reflect them as good parents. They may expect a 6 months' old baby not to wet its nappy or a 15 months' old child not to spill food off the plate. Recently two young parents, teenagers, took their 6 weeks' old baby boy to see the Blackpool lights (a tourist attraction) and when the baby cried and was a nuisance and did not look at the lights he was beaten!

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Abusing parents often expect their very young children to be obedient, quiet and still, while the parents sleep or watch television, not realising the inability of this age group to comply with these requests. Such parents lack the ability to show gentleness, coaxing or to give the child time to understand and obey. Having lacked tender loving care themselves they are unable to provide it in adequate measure or sometimes at all. They do not respond to their baby's signals in appropriate ways and this may result in excessive crying, and eventually in demanding awkward behaviour in the child. Other children become withdrawn and unrewarding if constantly ignored and rebuffed.

Emotionally these parents expect their children to do something for them, to love them, comfort them when they are sad, and they see their baby as hostile or indifferent when he fails to live up to their expectations. This leads to anger and to abuse. Sometimes one can see inappropriate caretaking roles developing in young toddlers who pat the crying mother's cheek to comfort her, and this emotional exploitation of the parent/child relationship is typical in families where child abuse occurs.

Some families abuse several or all of their children in varying degrees, while others pick on one.

The child who is different or seen as different is at risk, and all doctors and other child-care workers should be alert to this. Sometimes the child is normal in any other setting, but cries or is disobedient and defiant at home. Alternatively the child may become too quiet and seem unrewarding. Sometimes his repeated injuries make him so. Premature babies and others who are cared for in special nurseries at birth, away from their mothers, are particularly vulnerable, and so is the child who is ill a good deal of the early months of life. Illness in the mother at this time also pre-disposes her to having problems with her baby as one might expect if she were less alert in responding to him. Crying babies, feeding problems and restless toddlers all occur, and a vicious circle arises when difficult infant behaviour received an impatient or inappropriate response. This type of vicious circle can be very hard to correct.

Illegitimacy, unwanted pregnancy, wrong sexed child and peculiar fantasies about the infant are also very common among abusing families, and so are low birth weight and other sick infants who are separated from their mothers as newborns.

The child may apparently be beautifully cared for, fed and clothed well, and the household may be immaculate. In other words the "mothercraft", a technical task, may be good, while it is the "mothering", the tender understanding and giving without restraint, which has gone away. The parents frequently say that the child they abuse is like them and reminds them of their own badness. The mother who abused an 11 months' old twin remarked that she could not stand his fidgety, cross behaviour and said "he is no good, he is just like me". The other twin was placid and loved.

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3. The crisis

Given the potential and the vulnerable child the crisis in the child is usually the precipitating factor which initiates the abuse. Crying, messing (with food, faeces or filth) and apparent disobedience or stubbornness are the commonest factors in the child, to spark off the attack. A household or marital crisis in addition will increase the risk for the child. Other adverse family and social factors will accentuate the parents' stress, and such problems as unemployment, overcrowding, poverty, frequent child-bearing, depression and despair all contribute stress to the potential abuser's vulnerable personality, although not in themselves the cause of abuse.

4. Having no life-line

These parents are isolated, friendless people who do not get to know their neighbours and who are often at odds with members of their own family too. They find it hard to ask for help when stressed with their children because unconsciously they feel it might show up their own inadequacies. Often they say they do not know their neighbours and "we keep ourselves to ourselves" is a common remark. They cannot trust, or believe that other people would be interested or want to help them, and they may have brusquely pushed off the neighbour's tentative offers of friendship or help, considering this interfering. These families are particularly resistant to seeing authority figures in any kind of friendly or helpful light and may close the door on health visitors, social workers and others. This inability of the families, especially the mothers, to use other people to help them when stressed with their children is a very significant feature of the family pathology.

The perpetrator - is it father or mother?

Usually both parents are deeply involved in the injury, one failing to protect while the other causes the blows. Sometimes both parents abuse a child at different times and it is rare for a non-abusing parent to be unaware of what is happening. The collusion which exists between the parents is a classic contribution to the problem, and makes diagnosis particularly difficult. A mother often leaves her child knowingly with an abusive father or consort while she works or shops or enjoys social activities. This indicates the profound breakdown of the mother's normal instinctual drives to protect the baby in this syndrome.

In published studies of families with child abuse about equal numbers of fathers and mothers are deemed to have illtreated their children. If the father is unemployed and at home with the child he is just as likely to be involved in hurting the child as the mother, especially if he has a violent temperament.

When young mothers are alone all day with their children, especially if they are suffering from over-crowding or poverty and perhaps a limited capacity for mothering and for making social contacts outside the home, it is they who are most likely to explode into violence when frustrated by a child's behaviour.

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It is unnecessary to go deeply into "who did what" when unravelling the family problems of battered children. The total family situation of damaged parental personalities, marital discord, the child who is seen as awkward and the social problems are the factors which have to be tackled.

Family planning

The attitudes of abusing parents towards family planning is generally unrealistic. Happily a few, usually the better educated, realise their own problems and have only the one child. Many abusing and neglectful parents repeatedly want another child as a status symbol in the community, but relate to it as to a doll which is subject to their own whims and moods. The child's own needs for loving attention and care are not met.

The mother is often fond of being pregnant, which is a time when she receives extra care and status in the family or community. The father or consort enjoys fathering children too, believing it to be a tangible sign of his manhood.

Many such parents repeatedly hope that the next child will love them and make up for the void they feel in their emotional life. Others conceive for selfish motives such as holding the marriage together, or obtaining a better house or a larger family allowance. Some have good intentions towards the children they conceive but are too unstable, inadequate and vacillating themselves to live up to the responsibilities of parenthood.

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CHAPTER 7

CLINICAL ASPECTS OF CHILD ABUSE

The diagnosis and management of child abuse is a matter for a specialist team in the same way as the diagnosis and management of many other conditions such as congenital heart disease, renal failure, etc. It is important to realise that THE CHILD'S INJURY IS A SYMPTOM OF A SICK FAMILY. The doctor may treat the injury but his failure to recognise the sick family may lead to the child's death or to permanent injury from another attack.

The attending doctor, for example, in family practice or orthopaedic or neuro-surgical specialities, cannot be expected to have the training and facilities in order to:

i. organise and conduct the time-consuming psycho-social investigations necessary in abusing families.

These complete diagnostic studies of parents, family and social environment are necessary for the next stage which is to:

ii. formulate and carry out a plan for protection of the child or children and rehabilitation of the family.

A team approach is needed from the start, and rehabilitation of the family will not necessarily mean returning the injured child to its parents. That will depend on the evaluation of the parents' problems and their response to intervention and help.

The physician who first sees a child with an injury however trivial has responsibility for considering abuse among other possible causes in every case, and especially if the child or other children in the household have had repeated accidents. The history of the injury and the nature of the family relationships and social circumstances will alert the doctor to the need for further studies. Since over 90% of abused infants and children have abnormal signs on their skin, often slight in themselves, physicians both at home and in hospital need to study these more thoroughly so as not to miss their significance.

If there is any suspicion of abuse the child should be admitted to a paediatric unit at once for initiation of the full family study. If possible the mother should be admitted too and other family members encouraged to visit freely. Refusal to allow admission may need to be reported to the child protection system so that removal of the child through the court may be considered. When severe life-threatening injuries are present and are obviously due to abuse the police should be involved at once, usually being called through the Department of Social Services. Concern for the safety of the other children or for the mother's safety may need immediate action in a few cases. The author has experience of two mothers who were murdered by violent consorts soon after the child was injured.

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At the end of this report some typical cases are described to highlight some of the minor injuries seen and missed by conscientious doctors, public health nurses and social workers in the recent past. Usually, when confronted with an injured child, the doctor has to consider four possibilities:

i. True accident (remembering that many, perhaps most, accidents are due to environmental or personal stress).

ii. Carelessness.

iii. Neglect.

iv. Inflicted injury, ie battering.

In order to distinguish carefully between these four possibilities the following four studies are needed:

i. The history of the injury.

ii. The physical signs in the child.

iii. Parental factors.

iv. Social factors.

After admission to a paediatric unit for diagnosis and management, the doctor will need to proceed to a team approach forthwith and this is discussed under management. Admission should not cut the child off from his parents or family since they should be able to visit the patient freely and where possible the mother should stay in with the child, if very young. This will prevent separation anxiety in the child, and staff observation of the mother/child relationship will assist diagnosis.

1. The history

This should be thoroughly taken on the first occasion and may reveal a delay in reporting the accident which is very typical of abusive parents. They become frightened after the assault and only later when bruises, swelling, pain or illness become apparent do they seek medical attention. There may be discrepant features between the history and the injuries. Sometimes the history is plausible but classical signs of abuse, such as bite marks or cigarette burns, are present. The history may change from day to day, be contradictory or unrealistic, or there may be no history of accident to a baby or young child in spite of his injuries. This latter is typical of abuse. Other children in the household may also have had puzzling injuries and it is always wise to check the records of neighbouring hospitals or clinics for injuries to all the children. When a register is kept in an area it is easier to check the family's previous history of injuries. It is important to remember that a minor accident they describe may have happened, but they omit the full story.

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2. The clinical features in the child

Experience of physically abused children over many years teaches doctors to be very meticulous in their examination and recording of all the abnormal signs in injured children and in looking for the discrepant history. Since 90-95% of children have tell-tale signs on their skin it is important for paediatricians and other doctors who see injured children to learn how to interpret them. The eyes must be carefully examined and the bones X-rayed for signs of injury and blood coagulation studies must be done if bruising is present, to exclude haemophilia and allied disorders. An outline chart of the injuries, and photographs in colour and black and white should be taken for record purposes.

Internal injuries to the chest and abdomen, poisoning, drowning, choking and "cot deaths" are other manifestations of inflicted injury, and when children from these conditions are seen, the family background should always be carefully looked at.

The clinical features in the child may be recognised in the following eight categories, and sometimes several are involved in one child. Another category, drowning, has been recognised, but it is rare.

i. The skin and mouth, which may show bruises, lacerations, weals or scars, especially around the head and face. Finger tip bruises of the face or trunk, and grasp marks on the limbs, should be looked for.

ii. Burns and scalds, especially minor ones which are often treated arbitrarily with little thought of causation by doctors and nurses. Cigarette burns, commonly in crops, and either fresh or healing, should be sought. Sometimes major heat injuries are deliberately inflicted by burning or scalding a child, and typical "dunking" injuries of a limb or the buttock area may occur.

iii. The bones and joints may show injuries with little external evidence, so all young children suspected of abuse should have their skull, limbs and chest X-rayed. Re-X-ray may be needed two weeks later in some cases to reveal the typical injuries of the periosteum. On looking at the X-rays of some babies and toddlers following abuse, doctors are often amazed to find multiple small bony injuries when clinically all the child has is a few bruises. Typically the bony injuries are of several different stages of healing indicating multiple assaults.

iv. Brain and eye injuries most often occur in babies from violent shaking of the crying child. They are bilateral and not associated with a fractured skull though limb fractures are often present. Other children are flung or swung against hard surfaces and then scalp swelling and skull fractures may accompany the brain haemorrhage.

v. Internal injuries to organs in the chest or abdomen may occur, often without any external bruising.

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vi. Poisoning is more common than is realised and the story that a child took the substance himself is not always true. The parents' attitudes and the severity of the child's symptoms may give clues together with the social background. In self-poisoning the child's symptoms are often rather mild because his interest in the tablets or fluid wanes before he has taken very much. When a child has severe symptoms of poisoning it is worth looking very carefully into the family background.

vii. Cot deaths (sudden infant death syndrome) may sometimes be due to abuse and this is very difficult to detect. Poisoning with unusual substances, smothering or the use of a plastic bag over the child's head may occur. The possibility of abuse should always be in the doctor's mind and a very careful search of the skin should be made for other minute signs of injury. Close attention to family problems and parental attitudes may alert physicians to the proper diagnosis.

viii. The failure-to-thrive baby, without organic disease. Varying degrees of stunted growth, slow development and behaviour problems occur and this syndrome is called the maternal rejection syndrome, emotional rejection syndrome or deprivation dwarfism.

Maternal rejection syndrome

This child lacks his mother's tender concern and he receives inadequate attention in feeding, warmth, cleanliness, affection, and stimulation by play and talking, leading to growth retardation and slow development. Some also have signs of inflicted injury such as bruises, black eyes, cigarette burns or fractures. The stage at which the mother's or family's indifference becomes abuse may be hard to define but by using infant growth charts many of these families could be detected at a much earlier stage. Other signs such as cold mottled limbs, pot belly, loose stools, appetite perversions, withdrawal and inability to play in the toddler or older child, should alert child-care workers to severe deprivation of maternal care and concern. The cheeks show wasting last and so it is imperative to see the child's body during home visits if neglect or deprivation is suspected. These stunted children look generally small, but they may not look thin. They have infantile proportions with legs too short for their age, usually resulting from very early deprivation. Immediate improvement in a paediatric unit with catch-up growth confirms the diagnosis. Soon the children become affection-seeking in a promiscuous way, attention seeking, greedy and selfish. They soon develop liveliness and seem superficially attractive but are intolerant of frustrations and develop temper tantrums and moodiness. Their slow development improves rapidly during their stay in hospital but speech disorders and learning problems at school occur in nearly all, in spite of subsequent good care.

These clinical findings point to a deep and long-standing emotionally wounding condition for the child who is liable to perpetuate the same behaviour when he or she becomes a parent. It is seldom possible to restore a close, caring and loving bond between mother and child. Permanent placement is needed with a warm substitute family which is able to tolerate the considerable behaviour problems the child may have while growing up. In spite of these difficulties most of the children do very well in foster or adoptive homes.

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Differential diagnosis of the injuries

It is important for the hospital paediatrician with his surgical, haematological and radiological colleagues to discuss the medical findings in great detail in considering the differential diagnosis. The doctors should record their individual opinions carefully in the records remembering that they may be needed for any subsequent court action.

3. Parental factors

These have already been described on page 10. When abuse is suspected in any young injured child, an appreciation of the attitudes and personalities of the parents is an important part of the diagnostic study. Their behaviour with the injured child and with the medical attendants sometimes gives clues to their feelings.

Kempe and Helfer suggested the five questions which the doctor should ask himself, answers to which, when taken with the history and the signs, will greatly reduce the number of doubtful cases. These are:

i. How do the parents see the child?
(as naughty, difficult and demanding, or alternatively as too quiet, dull, stupid, unrewarding?)

ii. What do they expect of his development?
(is it unreal and do they expect too much too soon?)

iii. How were the parents themselves reared?
(was there a broken home or a hostile, rejecting or depriving parent?)

iv. Was there a crisis?
(crying excessively, wetting, soiling, messing with food, etc?)

v. Do they have a lifeline?
(or are they shut in and friendless?)

4. Social factors

Over-crowding, housing problems, social mobility and other characteristics have already been discussed with the parental factors on page 11. While not the primary cause of the condition, a difficult social environment will accentuate the problems of these families.

During the study of the child and his family in the paediatric ward the parents, when visiting, should be kept informed of the child's daily progress, and will know the doctor's concern about the injuries. A well trained social worker should be supporting the family during the time of the crisis and will be beginning to formulate a psycho-social diagnosis. It is important that ALL the paediatric ward staff should understand the nature of child abuse and learn sympathetic attitudes towards the parents so that a caring and nurturing atmosphere for them is provided on the ward. This is the best way to help the child and his family and no-one should forget that the parents are equally in need of concern and help, but will not be able to accept this readily. Learning to manage these hostile, difficult people is one of the most taxing tasks in paediatrics.

CHAPTER 8

THE FAMILY DIAGNOSIS

DIAGNOSIS MUST COME BEFORE PLANS FOR MANAGEMENT, AND IT MUST BE COMPLETE.

Diagnosis is needed on:

the child

the parents

the family

Diagnosis on the child

This includes a knowledge of his growth, development, health, personality, educational levels, relationships with his parents, brothers and sisters, peer group, his injuries, the possible sequelae, his needs for special care, treatment, training or education.

Diagnosis on the parents

Each parent separately must be studied as a human being, in the light of his own background and childhood, and his strengths and weaknesses in health, education, personality, family relationships, and the ability to maintain steady employment. Most workers agree that some 10% of abusing parents are frankly mentally ill. Another 10-15% are incurably psychopathic, criminal or mentally dull and unable to cope with family life. The majority of parents, some 75% perhaps, both rich and poor, are people caught up in the terrible fourfold problem of: their past, each other, the child and the crisis. They are dependent, unhappy, inadequate, yearning people.

Diagnosis in the family

Abuse is a family problem and each member needs individual consideration, both in the immediate household and in the extended family. Recognition is needed of the way the parents relate to each other and to the children, the way the children relate to their parents and to each other, and the subtle roles that are developing for each individual, as they do in any family.

Then a study is needed of the family's ability to relate to others in the neighbourhood, in work, in social contacts and in community endeavours. The abusing family may be ostracised and neighbourhoods of such problem families develop. Oliver has shown clearly how family kindreds are involved in abusing and depriving their children, and he has emphasised the cost to the community in the excessive need for every kind of social and medical service, as well as the relative ineffectiveness of the usual "welfare" systems of help or control.

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These diagnostic studies take time, but are thoroughly worthwhile, so that realistic plans of management are made. The whole process may take several weeks, or even two or three months, and an interim plan of care for the child or children may be needed during the study.

Time and time again management plans are made for abused children which are not based on sound diagnosis, and this is the cause of many cases of recognised re-battering, 60-70% in some series, but more recently reduced to considerably lower figures. Not only should concern be felt about the family atmosphere which leads to physical harm to the child but all the attitudes to his care and development, so that he can prosper and develop his full potential intellectually, emotionally and socially, and not repeat the cycle of deprivation and abuse in the next generation.

CHAPTER 9

CONFIDENTIALITY

In all countries there are problems of conscience when a doctor is asked to reveal to a third party confidential information he has gained in the consulting room. The reporting laws in the United States have been designed to overcome the problem but even so it is clear that not all cases are reported. In the United Kingdom the Medical Defence Union, in its annual report for 1974, made it clear that it is the doctor's duty to discuss and disclose all the relevant information in order to ensure protection for the child. It is also protection for the parents since they too need help. A recent legal opinion in the United Kingdom can be quoted:

> "On the narrow legal issue about confidentiality, you can take it that in practical terms there is really no possibility of the parent of any injured child obtaining any remedy against the doctor who participated in consultations of this kind. The confidential relationship as between doctor and patient is, according to the law, not an absolute one and the doctor is entitled to break the confidence in certain circumstances; one of these is where he feels under a social obligation to do so. There is the additional point that in these cases the practioner also owes a duty of care to his patient, ie the child, and, by failing to participate in the consultation, he may be in breach of that duty of care."

In the Netherlands a national system seems to be working well. Ten confidential offices (with a physician, a social worker and a co-ordinator) cover the whole country, the families concerned are reported to them and they initiate the team intervention for diagnosis and management.

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CHAPTER 10

THE ROLE OF THE POLICE

In all countries where the subject of child abuse is being studied the role of the police is being questioned. It is noticeable that in the past ten years there is a subtle change in police attitudes in many areas of the world, as there is in the approaches of other professions too. The police are adopting a more understanding approach.

In Britain the police view is that:

- The police should be informed of suspected child abuse cases at an early stage and through accepted and adequately known reporting systems.

- Only trained and experienced officers with an understanding of these cases should be appointed to investigate them.

- The establishment of recognised and open consultations between all the disciplines concerned is desirable.

- The decision as to proceedings must remain with the police at a senior level in cases not dealt with by the Director of Public Prosecutions, but account should be taken of all the attendant circumstances, and police of senior rank should attend at case conferences and review committees.

In many areas this works well since a police officer of senior rank (superintendent) is the police liaison officer working with the medical and social services and attending consultations over child abuse cases. He (or she) is able to make his own decisions as to whether to visit the home and question members of the family. In cases of mild or moderate injury where the child is in a safe place, and the parents' personalities are not profoundly abnormal, and where the case conference reveals a sound plan through the court for the safety of the child, the police often remain in the background and keep a watching brief, provided they are fully informed, at all stages, of the progress of the case and the arrangements for protection of the child.

In more serious injuries or where the parents are violent, difficult, or known to be criminal, the police do interview the parents but do not seem any more or less successful in getting admissions of ill-treatment than other skilled workers in the medical and social services. False confessions of a father to protect a mother are not unknown. Since the problem is a family one, as described on page 14, and not that of one parent, interrogation to pinpoint and subsequently to punish the perpetrator seems of little use. When prosecution of the parents is successful, a suspended sentence and a probation order rather than a prison sentence may be one means of helping a parent towards better parenting of the family and of the injured child if he returns to the family.

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There is no doubt that doctors do not easily feel able to discuss confidential matters with the police. When they accept that their patient is an injured child, many will co-operate particularly if they feel confident that the police will maintain an understanding and helpful approach.

Where imprisonment of one or other parent ensues, there needs to be a more formal system of helping the family on discharge from prison. Conception of several more children is often a sequel and the abuse cycle may continue unabated if help is not provided.

More study and research is needed on the efficacy of the various police manoeuvres, as well as of the other aspects of management, in preventing further abuse in the family and in deterring others from abusing their children

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CHAPTER 11

MANAGEMENT

In all countries where abuse has been concerning health and child care workers for some time, similar trends in management are developing. It is important to recognise always the threat to the child's life and limb and even more to his developing personality. Varying systems of help and support are being developed in different places and in different countries. This is valuable since experiment and long-term action research are very much required. Above all knowledge is needed on which form of help is most beneficial to the child and to his family.

Management begins as soon as the parents or child seek help for the injuries and in general the first step should be a hospital investigation on the lines described. The need for sympathetic attitudes to the family cannot be over-stressed.

As soon as abuse is suspected it should be the paediatrician's duty to inform the Social Services Department or other Child Protection Agency. The family doctor and public health nurse should also be told of the child's admission. This should be done by telephone and should be followed up by a letter.

Where parents admit to abuse and inflicted injury and seek help themselves, the investigation of the child and his injuries might be done as an out-patient. It is seldom appropriate for the investigations to be made with the child in his own home since he remains very much at risk. A paediatric unit which maintains a close involvement with psychiatric and social services is an ideal place for the study to be carried out.

From the beginning, if abuse is seriously suspected, it is important for a team approach to be brought into operation, since no one professional discipline can provide all the information for the complex psycho-social enquiry which must now begin. Without it, mistakes in management will be made. In cases of serious neglect, police may need to be informed at an early date and it is preferable if this is done by the Department of Social Services or Child Protection Agency rather than by the medical team. The family should be told that this will happen and why. If approached sympathetically at this stage the parents may feel able to begin to talk about some of their problems.

The Therapeutic Team

The therapeutic team will consist of some of the following and the list is not exhaustive:

doctors:	a senior paediatrician the family doctor a child psychiatrist possibly other specialists involved with the child's treatment the ward doctor the school or clinic doctor

social workers:	the hospital social worker a senior social worker from the local authority any other social workers who may already be involved with the family, eg from a voluntary agency or probation
nurses:	the health visitor the public health nurse who knows the family the school nurse if the child is at school the ward sister the midwife (if patient is a young infant)
teachers:	the head teacher or kindergarten teacher the class teacher the ward teacher in hospital the play leader in hospital the education welfare office
psychologists:	an educational psychologist a clinical psychologist
lawyers:	the local authority or Child Protection Agency lawyer who may handle the case in the juvenile court
others:	probation officers other therapists or community staff

The police are not included in this list since few would regard them as therapists, but in a sense, and in some areas only, they can be considered in this light. More research is needed to understand the most appropriate role for the police in promoting the welfare of the child, the family and society. In all but cases of minor injury, police should be involved in the discussions (see page 24).

Magistrates and judges cannot be part of the team as they must remain impartial, but it is crucial to good management that they are well informed on all aspects of these complex problems of family life. The court can be a therapeutic place when the judge shows understanding for the parents as well as the need to protect the child.

It may seem that a formidable group of professionals are involved, but although most of them will need to contribute information, only a few will be closely associated with management. All relevant people for a particular family should be kept informed of the management plans and the child's progress in the family or elsewhere. The immediate team for a family will usually consist of a specially trained social worker, a nurse and a paediatrician. A child psychiatrist and psychologist should be easily available. A police officer and a lawyer will be involved at some stage in most cases.

Once they have been informed, appropriate members of the team should look at the information they already know about the family and be prepared to contribute this in writing to the hospital paediatrician who carries responsibilities for the child's health and development, and to the senior social worker who has responsibility for the welfare of the child and family. The safety and well-being of the child should be the first priority for all workers.

A week or two after the child's admission, a meeting of the key people in the above groups should be arranged as a case conference, to discuss the full family diagnosis and plans for management. Practical help for the family will already have been started, such as attention to the parents' health, or to housing problems, debts, marital conflict, etc.

The case conference

At the case conference seven major issues need to be settled and clearly agreed and understood by all members of the team. These are:

1. The nature of the underlying problems and the parents' personality traits, in order to assess (a) the risks of further abuse (b) the nurturing climate in the home.

2. Whether a legal order for protection of the child should be sought in the court.

3. Whether the child should return home and if so when? If not, what alternative care can be planned?

4. What special treatment or care should the child have?

5. What treatment and support does the family need, including psychotherapy, and how should it be given?

6. Who should be the primary workers with the child and his family?

7. When and by whom should the follow-up assessments of the child and his family be made?

1. The nature of the family problems

The severity of the injury is no guide to management, since if the abuse has been intercepted at an early stage, the severe injuries which might have occurred will not be seen. It is the family problems and the parents' personality traits, as well as a study of the wider family, which determine what must be done. These have to be VERY carefully studied by skilled medical and social work staff, sometimes with the help of other specialists.

2. The court order

In general when abuse has occurred, even if it is not severe, a Care or Wardship Order should be sought, or an equivalent, from the juvenile court (civil) for the child's future protection. The family's problems rather than the severity of the child's injury is the guide here. Voluntary agreements by these disturbed parents are not satisfactory because they often fail to honour them at a later date. It is in the nature of things that these parents have difficulty in managing relationships, and legal sanctions will often prevent or resolve some of the conflicts which arise. It is important for parents to see the legal sanctions as part of the total therapeutic procedure, and this takes time and preparation with the emphasis on the fact that the court's concern is the child's well-being now and in the future.

In the Netherlands, the confidential offices try to find solutions in case of abuse, avoiding as much as possible that the families are "marked" by a court order. The latter will only be used as a last step, when all other solutions are impossible or have failed.

3. The child's care

Whether or not the child returns home depends on the parents' attitudes. Sometimes they prefer him to remain away. In other cases, the parents' ability to talk about their problems and about the child's ill-treatment and to accept help will suggest that they are ready to resume his care. They should understand that the injury is only a signal of their unhelpful attitudes towards the child and that their feelings for him and ability to care for him must be discussed. They will need to learn new and improved ways of managing family crises or difficulties with the child.

Reassessment of the child and family in three months should give a strong indication of whether better progress has started. If the child is away from home his return should be considered not only from the point of view of re-injury but taking into account the parents' capacity to show warmth in an affectionate and stimulating environment, since this is crucial to promote the child's proper growth and development.

4. Treatment for the child

Most battered children need some treatment themselves, in order to develop trust and self-confidence from warm, caring individuals. When the child is returned to his family this is usually achieved by some day nursery or kindergarten placement. The child needs more adult time than do normal children and the staff should realise this and help the child accordingly. Some children may benefit from individual psycho-therapy or play-therapy. but since resources for this are scarce other forms of help for the child are being studied. Help and support for the parents must be continued or they will not be able to tolerate the child having special treatment.

Where the child is removed from the family for temporary fostering the foster parents will gradually help him to come out of his shell and to develop trust and promote learning. If possible they should co-operate with visiting of the child by the parents and help their visits to be mutually satisfying. This is a difficult task but many foster parents can undertake it well.

When the young child is permanently removed from the family a long-term foster home where adoption can later take place is the only valid care unless the child is considerably older and his roots and attachments are with the wider family.

5. Treatment for the parents

A number of the parents are untreatable and their child must be removed for good. The proportion of such parents is variously estimated as 20% to upwards of 50%. It may vary in different localities. These parents also need help and support and in their situation this will be directed towards helping them find other satisfactions in life than rearing children. Kempe has likened the relinquishment of children by their parents to divorce between spouses and this seems apt.

For the rest of the families practical help at the outset is very often needed with housing, debts, employment, health or various other matters.

Many forms of support systems for abusive parents and therapeutic interventions for families are being tried throughout the world, from individual psycho-therapy through group therapy, family therapy and case work help, to schemes for re-educating parents in hostel accommodation or in their own homes. Marriage guidance work, family planning or termination of pregnancy, and assistance in divorce plans are among the facilities needed. As successful as any other treatment seems to be the various schemes for providing family aides. These are warm motherly and fatherly figures to befriend the whole family but in particular the mother, on a visiting basis. They need not be professional people but best are those who grew up in a warm family circle themselves and who have had stable marriages and loving relationships with their growing or grown-up children. Such aides must be available on the telephone at any hour of the day or night seven days a week, and much time and energy, often with little reward, is needed from them. They can often cope only with one family at a time and these people give abundantly of themselves, to get the family functioning. As time goes on the parents' self-image can be seen to be improving, they see the child with some pleasure, they can manage crises more effectively and there is some degree of spontaneous love and enjoyment in the family circle.

Many of the mothers are dull by virtue of their own deprivation in early childhood as well as the overwhelming misery and frustration of life in the present. They need hope and with warmth and encouragement, and relief from much of the social pressures, and with the burdens of much of child-care removed from them at first, a number of families can improve. Most experienced workers find that a programme with short-term goals which the parents agree to, is helpful with these families.

In most societies adequate substitute care is not available for all the children who are deprived, neglected and abused, and so support systems in their own homes seem the only practical answer. A "crisis nursery" is needed where parents can leave their children at any hour of the day or night when they feel stressed, and until the crisis is over in hours or days.

Various forms of self-help groups are growing up in some areas, Parents Anonymous and others. These can be very helpful supports along with the other forms of treatment. Sometimes experienced workers in the field, both male and female, give some time to these endeavours.

It must be admitted that the best form of care and management for these families is not yet known, and further studies are in progress in many areas. CHILD ABUSE IS A FAMILY PROBLEM AND ACTION TAKEN FOR THE CHILD MUST INCLUDE THE WHOLE FAMILY. This must be emphasised at all stages of involvement and throughout all disciplines. Obviously prevention is the ideal aim.

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6. <u>The primary workers</u>

When a Care or Wardship Order is made the Social Services Department usually has a mandatory role to visit, and their social worker will be the main worker, together with a family aid or possibly the health visitor. Regular assessment of the child's progress will be made by the paediatrician. If progress is not satisfactory an opportunity should be made for the workers to meet and discuss further help, or possibly the removal of the child. Sometimes a probation officer, already involved with the family or a worker from a voluntary agency will take the main responsibility for the family support and for letting other members of the team know when things are deteriorating. The child psychiatrist may also be involved.

7. <u>Periodic review of family progress</u>

Plans for a formal assessment of the family in three to six months should be made, or an earlier date fixed if the situation warrants it. How long should the intensive care and observation continue? This will depend on progress, but "cure" is unlikely, so usually the child is at risk throughout his childhood, if not for physical abuse, then for harshness or indifference if stresses recur. Experience shows that long-term surveillance is needed in all the families, with concentrated support at times of crisis.

CHAPTER 12

LEGAL SYSTEMS AND LAWS RELATING TO CHILD ABUSE

In most countries the two systems of the law, criminal and civil, pertain to child abuse cases and the adversary system is used at the hearings.

CRIMINAL RESPONSIBILITY

The burden of proof

Criminal prosecution of the parents requires evidence of "proof beyond all reasonable doubt", whereas the standard of proof at the Juvenile Court for Child Protection Hearings is "the balance of probabilities". The collusion between the parents may make proof of who was the aggressor difficult to establish unless they can talk about it to one of the therapeutic team or to the police.

The spouses' compellability

The extent of one spouse's compellability to give evidence against the other is a major problem in criminal trials. In few countries or states is the spouse compellable, but where he or she is the evidence may come out more clearly. The English Criminal Law Revision Committee in its Eleventh Report (1972) considered these problems and recommended that each spouse be compellable

> "in the cases of offences of violence towards children under the age of 16 years and belonging to the same household as the accused".

The intention was to cover situations where the inequality of the relationship between victim and accused is fortified by the essential privateness of the family situation. If implemented this recommendation would not necessarily make the evidence given realiable, or overcome the risk of perjury, but it would give the court the chance to see and hear both parents and that would be an advantage in arriving at the truth.

Diminished responsibility

The question of using a defence of diminished responsibility due to neurotic stresses is another law reform which has been suggested. It would seem unwise to single out abusive parents for this differential treatment in the burden of proof.

Sentencing

Harding (1975) has suggested that it would be preferable to apply any special treatment, if at all, to sentencing. Social workers, probation officers, paediatricians and psychiatrists, in their reports to the court, should continue to be sensitive to the problems of abusive parents, and thus alert magistrates and judges to consider appropriate sentences which will often be of a non-custodial nature.

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The purpose of prosecution

Criminal prosecutions of abusive parents have been criticised for their unrelenting, impersonal censoring of parents without attempts to understand or remedy the true causes in order to promote family welfare in the future. If the parent is acquitted through failure of proof due to some legal manoeuvre by his lawyer, he may continue to deny his abusive actions, and the ill-treatment probably continues. If he is acquitted because the jury was persuaded the injuries were trivial, he feels vindicated in his "corrective" measures and the battering tendencies may be reinforced.

The parent found guilty and imprisoned is ostracised by fellow prisoners since child abuse is considered a despicable crime. His already damaged personality receives further stress, his morale on release is more wretched than ever, and the vicious circle of violence in the home is seen to continue unabated in many cases. If a custodial sentence is considered appropriate for the severely aggressive and psychopathic parents, perhaps it should be for a long term so that they are out of harm's way.

Probation may be the sentence for a guilty parent and it can provide opportunities for an experienced probation officer to understand and befriend a family and do some constructive work with the parents, in conjunction with the Child Protection Service and various community resources. Unfortunately probation may become a punitive, repressive, impersonal surveillance in some areas in the world, but this could be changed.

Punishing the parent

Although it is understandable that the public should cry out for punitive measures they are remarkably ineffective. Punishment for its own sake, valued by some, especially, it would seem, by the police, is of little value as a deterrent to others or to the same parent in the future. One might ask which parent should be punished - the one who causes the injuries or the one who allows them to happen? Rather should the true cause of the parents' conduct be sought, and help, if necessary with authority from the court, be offered for the family problems. At the same time the child may have to live away from the family because even with help for the parents not all homes can be made safe for the child. Many parents see removal of the child as punishment although that is not its purpose. Happier are the parents who can be brought to acknowledge that through no fault of their own they are unable to cope with the child, and society should greet with approval instead of disgust, those who relinquish their child or children after careful discussion and reflection.

In Britain the new Children Act 1975 gives the court powers to free a child for adoption after severe abuse, if the chance of his rehabilitation in the family seems very unlikely.

CHILD PROTECTION

Clearly it is better to use preventive measures than to wait until abuse has occurred but from the parents' point of view this produces a danger of infringement of their civil liberties. From society's point of view, therefore, a balance has to be struck. What is reasonable care and protection? What is cruel and unusual punishment? They are what the judge says they are at a point in time and it has been shown in the historical review how attitudes to children change in the course of time.

Individual freedom

In a democracy everyone feels guilty about intervention because in a "free society" people should be "left alone". It can be argued that people should be left totally alone unless they have a child in their care. Then many people think parents should not be left alone and indeed parents already accept some constraints. They must send their children to school, for example, or else they will be imprisoned, and they must put the child in an isolation hospital if it has a serious infectious disease. In some countries, there is no family allowances without evidence of a health examination. Most western societies accept other compromises too. For example, people who want to use gas or electricity for their appliances must also accept the man who reads the meter or they will have no light or heat.

The rights of children

Children enter society in most free countries when they go to school and from then on some degree of surveillance can be given. From birth to school age, however, there is no way to compel parents to have a child seen. They need not take him for periodic checks of health, growth and development, immunisation, vision or hearing tests, all essential services so that handicaps may be diagnosed and treated early. Studies which have been done all show that the parents of abused children are less frequent attenders for all these services.

What does society do to protect the rights of the child to such essential services? In France the child's health check is compulsory at the ages of one week, six weeks, six months and two years, and again periodically in school. It is important that growth and development is charted for the ready ascertainment of deviation from normal progress, especially where neglect and deprivation are concerned, and action must follow if the child fails to thrive.

Perhaps more countries will use a similar system to the French one which has caused little difficulty so far and which gains access to the child and his mother so that early nurturing problems could be recognised and help provided long before injuries occur. Successful prevention of injuries by this means has not yet happened in France or elsewhere although preventive programmes are now being tried.

Care and wardship orders

Many social agencies in the United States, Europe and Australasia are reluctant to initiate legal proceedings as a means of managing families who abuse their children. Some doctors are also reluctant to assist social agencies with legal proceedings and indeed in a proportion of the better educated families doctors collude with parents to prevent the abuse being recognised. Yet it must be admitted that doctors alone can seldom acquire all the necessary knowledge of the family, nor do they have all the skills for treatment.

Ensuring the child's protection through the equivalent of a Care Order or a Wardship Order does not necessarily prevent the child remaining in his family's care. This will depend on the diagnosis and prognosis. The Court Order does ensure access to him and assistance for the family, and the social

workers' skills in helping the parents are frequently facilited by the legal sanctions. All workers in the field of child abuse are familiar with the family where one child after another is injured, and some repeatedly, because it was felt that voluntary supervision was more appropriate than a Court Order. Voluntary agreements are seldom adequate since unstable parents abuse them, and many families may move to another area to avoid being traced.

Protecting the newborn child

With the increasing understanding of the psycho-pathology of abusing parents, it is possible to predict before birth that abuse may occur to a particular infant in the future. The climate of the courts is now favourable to the making of a Care or Wardship Order on the baby at birth so that it can be removed from the parents at once. This may seem an extreme measure but it is a necessary one for a few families where they have already abused a child or children and proved totally resistant to any change of behaviour. Family planning advice is particularly needed for such mothers, who often seek sterilisation when they can realistically face their predicament.

THE LAWYER IN CHILD ABUSE CASES

In this difficult and emotive field the lawyer involved needs training and experience in a number of matters including child psychology and development, child care, family behaviour and psychology, and he needs a considerable knowledge of the common clinical, social and psychological features of abused children and their families.

The lawyer acting for the Child Protection or Social Services

It is crucial for this lawyer to have a wide knowledge of the subject otherwise he is likely to be unsuccessful with his cases. If the doctors or social workers or other witnesses have had a difficult time during cross examination, he needs to be very astute in his re-examination of his witness to bring out again the salient features on which the case is based.

For this to be effective the lawyer must meet the witnesses to prepare the case thoroughly beforehand, and to acquaint himself with all the circumstances of the case which should be brought out in court.

So often the lawyers who are doing this work for local authorities or social work services are relatively young and inexperienced, and soon move to other work. Medical and social work teams may have to "educate" a succession of young lawyers in a short time.

The lawyer acting for the parent

All too often, regardless of the obvious evidence confirming child abuse, the parents' lawyer tries to "win his case" by legal manoeuvres in the juvenile court. Is this a "win" for the child who is at risk of being maimed or killed? The lawyer carries a heavy burden if he fails to give as much consideration to the welfare of the child as he does to the legal aspects. He should realise that it will not be in his clients' interests either if the child is re-injured by them or presents them with worrying problems of behaviour and development. A knowledge of the full treatment plan beforehand may help him to see the wisdom, in certain cases, of persuading his clients not to oppose the order being made. He may still put points in their favour to the court and he will naturally make certain that their legal rights and privileges are upheld.

The parents and the juvenile court

The court hearing is part of the therapeutic plan for the child and his family and as far as possible the parents should be brought to see this. They should understand that no-one is on trial or being prosecuted. It is a case of arranging the best facilities for the child's care to promote his well-being and development.

All the evidence about them from the various witnesses should, whenever possible, be discussed with them, either by the witness or by the principal caring member of the team. This will usually be the social worker or the paediatrician whose aim is to help them understand that the evidence is "for the family" and not against them. Professional workers often feel they will be unable to maintain a caring relationship with the parents if they also have to give evidence in court. Experience and training teaches that this is not the case with the majority of families, although the most damaged parents may be very hard to work with.

THE MAGISTRATE OR JUDGE

Until recently the "Bench" has had little knowledge of the complexities of the family problems in child abuse. Now with increasing knowledge the magistrate or judge may make all the difference to the acceptance by the parents of the order which is made.

The Bench can help them to understand that the order is not a punishment but that the child's accidents and injuries or standard of care are not acceptable, and that until they can demonstrate their ability to care for the child properly his return home cannot be considered. Compassionate but firm advice may help the parents to want to accept treatment. They should know that the child will be returned to them only with the combined recommendations of the therapeutic team, and this is the wish of the court for the good of the child and the whole family.

CHAPTER 13

REGISTERS AND REPORTING SYSTEMS

For a number of years doctors, health visitors and other professionals in many areas have recognised the need for reporting child abuse cases to a central register. The registers vary but they generally record key details about the child, his injury, his family and the names, addresses and telephone numbers of his medical attendants. Such a register has three functions:

i. Assisting diagnosis in a child with an injury or other suspicious "accident", by giving the attending doctor information about previous suspected or confirmed abusive incidents to the child or to others in the family or household.

ii. Monitoring the safety of children known to have suffered from abuse and who have returned home.

iii. The register can provide information on the nature and extent of abusive episodes to children in the area.

These functions can only be achieved if reporting to the register is complete and if the registers' director up-dates his information by regular reviews of the families concerned. In most areas of Britain registers are just starting, though some have been in action eight years or more. Time will yet tell all the benefits and difficulties of the system.

In the United States reporting laws were passed in all the states in the 1960s and the system has achieved a measure of success. At first only doctors had to report, but now any other professional and indeed all citizens must do so. All states now have reporting for neglect as well as for physical abuse. A number of doctors, mostly in private practice, still fail to report but probably the numbers are getting fewer. It has been realised that unless a satisfactory service for investigation and treatment of the child and his family exists following a report, professionals, especially doctors, are reluctant to make the report.

Some feel worried about the issue of confidentiality (discussed on page 23) but in the United States this has been largely overcome. The law frees the reporter from any liability unless the report is made maliciously. There have been no prosecutions for this in twelve years. In some areas general practitioners and community based paediatricians prefer to refer children to a hospital unit, for example with "easy bruisability" and the hospital doctors then do the report.

In the Netherlands a system of voluntary reporting is working well, the doctor or other professional reporting to a confidential office described above.

The advantages of voluntary or mandatory reporting laws for doctors and others dealing with an individual family are that he can tell the parents that he has no choice but is instructed to report puzzling accidents. He can emphasise it is not a case of "picking" on them, as it has to be done in every such case.

Fears that families will stay away from units or doctors who report these accidents have proved unfounded. It was felt that children might suffer by receiving no treatment for their injuries but this has been disproven by experience in the United States.

Of course reporting does not guarantee a good service to the abused child and his family, but such a service is more likely to follow, when reporting or notifying abuse cases becomes the agreed rule in any area, since people in authority will more easily recognise the need for such services.

It makes it easier for a doctor, or other professionals, to have no choice in the matter of reporting and probably it encourages the doctor to realise that he cannot and should not carry the case alone. The burden is too great and the risk to the child a terrible responsibility. When he is convinced that some effective help for the child and his family will follow the report, he will usually co-operate.

Concern is felt that unfounded accusations will be made but in the present climate of opinion all professionals err on the side of giving the family the benefit of the doubt. With diagnosis by a skilled team there should be few doubtful cases. The following are the recent comments of Kempe (1975) on this topic:

> "on which side is it worse to take a chance? Does it make sense to say that one wrongful court accusation against a family will be so bad as to be outweighed by the life of X (say 500) children? It does not. Parents can be upset and hurt at your having done so, and I can think of two families in the last twenty years; but that is nothing compared to the conscience, the bad feelings I have about perhaps eight or nine cases a year that we were failing to act on properly, year after year, whose deaths we caused by our failure to act. To this day we often err if you please on the side of 'belief' when in fact we really know better and take awful chances, I think wrongfully.
>
> So I think the community has to hold that the life of the child is paramount and that the wrongful accusation in good faith and with no malice has to be risked in a situation of this kind occasionally."

Kempe described the only two cases, apparently, in Denver in twelve years, out of several thousand cases,where it is known a wrong report was made. Both families remain good friends of the unit and one has become a foster family.

CHAPTER 14

THE ABUSED CHILD

Some of the factors which concern the child have already been discussed on pages 6, 7, 8-9, 12-13, 18-20, 21, 28-29. There is much we need to know about abused children and research on their future development is going on in many parts of the world but all of it is very recent. The most important question is: what kind of a person will the abused child grow up to be?

Clearly the abusive environment with varying degrees of hostility and rejection may be even more damaging than the injuries themselves in terms of subsequent development of the child.

The few studies so far published are not encouraging when the long term development of the abused child is concerned (Elmer 1967, 1975, Silver 1969, Norse 1973, Martin 1974, 1976).

Martin and others in Denver, Colorado, have reviewed the literature on the progress of abused children and Martin has studied fifty such children at a mean four and half years after the injury (1974 and 1976). He has described the high incidence of physical, intellectual and language problems in these children - for example 33% were functioning as retarded, 43% had neurological damage and 43% language delay.

Martin (1974), Elmer (1967) and others have indicated the large number (25-35%) of abused children with poor physical growth and nutrition. These undernourished children have a much worse prognosis in terms of mental ability and neurological function.

Martin's and Beesley's very important and thorough study (1976) of the subsequent personality characteristics of the fifty abused children will soon be published. Of these thirty-one were with their biological parents and the rest with foster parents (11) or adoptive parents (7) except for one grossly brain-damaged child. The ages ranged from one year ten months to thirteen years with a mean of six years five months.

Of the abusing parents twenty-one had received psychotherapy, fourteen received supportive intervention and fifteen no intervention. Only six of the latter group had their children with them at follow-up.

Three observers assessed the children, a developmental paediatrician, a clinical psychologist and a clinical social worker, using interviews with parents, reports from teachers and social workers and direct observations of the children's behaviour. They identified nine characteristics among the fifty children which were assessed independently by each observer and only when all three agreed was the child so categorised. The characteristics were:

	Number of children
Impaired ability for enjoyment	33
Behavioural problems (severe)	31
Low self-esteem	26
Withdrawal	12
Opposition	12
Hypervigilance	11
Compulsivity	11
Pseudo-adult behaviour	10
School learning problems	9

The authors point out that the type and severity of the physical assault does not corrolate with the child's psychiatric symptoms. The damage done by the abusing environment, even when no more physical injuries are recognised, results in these numerous characteristics of behaviour which makes peers, parents and teachers reject the children, so their self-esteem is damaged again and again in a vicious circle.

WHEN ONLY ONE SYMPTOM OF ABUSE IS CONSIDERED IE THE INJURY, IT IS EASY TO FALL INTO THE TRAP OF ASSUMING SUCCESS WITH INTERVENTION.

The associated factors which profoundly influenced the children's development were:

i. Home changes - 34% of the children had from three to eight moves up to the time of follow-up including moves from own home to foster home and back again, or from one foster home to another.

ii. Unstable home which existed for 32%, with poor household management, many family moves and chaotic social structure.

iii. Parental emotional disturbance was present in 72% of the parents, whose problems were severe enough to disturb, significantly their daily functioning.

iv. Punitive environment - 48% of the homes were classified as highly punitive with excessive physical punishment and/or obvious rejection or hostility towards the child.

v. Divorce or separation of the parents - 58% of the children at a mean age of six years five months had already experienced this.

It is more difficult and yet just as essential to eliminate these harmful associated factors in the abused child's family life as it is to stop the physical injuries, because they cause the inhibited intellectual capacity, emotional problems and eventually the vicious circle of the abused child growing up to be the abusing parent.

Martin and Beesley point to the need for the child to have direct help himself to deal with his own feelings and reactions to the violence in his family. He needs help in finding warm, satisfying relationships through which he may learn to trust, and help in learning to enjoy himself, and in developing autonomy and a feeling of self-worth.

The authors conclude with the comment:

> "The most striking impressions of the authors was that these abused children were not happy and had minimal ability to enjoy themselves in play or to interact socially as children ... Whether inhibited, compulsive, angry or socially pseudo-adult, they seemed unable to relax and enjoy themselves."

This is the most complete study of abused children so far, and the results merit attention, particularly when they emanate from the Denver unit where concern and endeavour to understand and treat these families has been such a pioneering force for many years.

Kempe has recently pointed out the need to look more closely at the behaviour of children in school, in hospital and elsewhere, since abused children will usually show their distorted behaviour in some way. This may lead on to the recognition of abuse not previously suspected. The child who is too compliant or lacks appropriate anxiety as well as children with excessive moodiness, fears and periods of tearfulness may be suspect.

Watchfulness and distrust are striking features of these children, who are trying to cope with the unreal demands and expectations of their parents. They may be more or less successful but at the expense of their own needs as developing human beings. Many children come to believe they really are stupid, naughty and difficult, and that they deserve to be punished.

Oliver (1974) and Blackie (1975) have stressed the importance of adverse child rearing methods diminishing the IQ especially when the mother is also dull.

Oliver emphasises that a number of features together, particularly three: excessive crying, over-active restless behaviour and the failure of the mother to attend health clinics for screening tests and immunisations, correlate highly with abusive families.

The collusion between parents and children so that the older children are secretive about the injuries and are evasive or lie as to their causation is not generally recognised by any of the medical, social and legal staff involved with these cases.

The fact that the child seems to cling to the parents does not exclude abuse. Many deprived or injured young children cling to their parents rather than showing them fear or distress. One reason may be that the parents may not be cold and hostile all the time, and are the only nurturing figures in the child's uncertain world, so he struggles to keep contact. Bowlby (1971) has shown that rebuffs from the mother only increase attachment behaviour. In other families subtle, harsh deconditioning of the child towards showing fear and distress has occurred but may be hard to detect.

The atmosphere of general family discord, often with violence between the parents, and in the neighbourhood, as well as assaults on children, creates anxiety and terror in the lives of many of these children which overwhelms them and damages their whole development, intellectual, emotional and social. Frequent separations and chaotic care often result and the parents use the children as pawns in the matrimonial conflict. Particular forms of emotional disturbance, affectionless psychopathy and indiscriminate friendliness, are characteristic of these children who, from an early age, are bandied about among various friends, relatives and welfare agencies, so that they often never know where they will be spending the night, and with whom, and have no opportunity to form a stable relationship.

The recent studies on family violence (Pizzey, 1974; Frommer and O'Shea, 1973, 1976; NSPCC, 1974; Gayford, 1975) highlight the dangers for the children who are likely to repeat the violence and disruption in their own lives when they become parents. They often marry early (Smith in Jobling 1973) and have large families, the children being born very close together, who again repeat the pattern unless rescued from their plight (Oliver 1974).

The girls from such violent families tend, more than the boys, to have neurotic symptoms of anxiety, fears, withdrawal, and physical symptoms such as nervous skin rashes, enuresis, etc. The boys are more likely to be aggressive and hyperactive.

When these children are received into care and removed from home social workers, paediatricians, child psychiatrists and psychologists have a heavy responsibility to promote their optimal care, which is no easy task. Supporting foster parents through spells of difficult behaviour can result in good improvement, which a child at last finds himself in a stable, warm and encouraging environment. Careful selection and training of foster parents is essential.

In most cases if a young child is removed from home for longer than 3-6 months there is further damage to the parent/child relationship, as the child becomes attached to his other caretakers. The parents' capacity to respond warmly to him suffers too. There is a need, therefore, to make permanent plans for the young child at an early stage and to work towards his early return to his family if he is to go to them at all. It is often found that the child remains in a nursery or foster home for many months or even a year or two or keeps changing his placement. This is very damaging for him and good practice will prevent such moves by regular assessment of the parents' response to help so that permanent plans can be made for the child at an early stage.

When the child is in short-term substitute care, preferably in a foster home, his parents should see him often, and should participate in his care by feeding or bathing him, rather than just playing with him or taking him for an outing.

Planning to return the child home means that the parents must work hard with their therapists in a short time to change some of their attitudes and behaviour and if they have not begun to improve with concentrated help in a few weeks the situation should be discussed with them again. They should fully understand the importance of time in a young child's world and if they cannot provide good parenting for him NOW it will be too late, because he will form psychological bonds with his substitute parents and to keep uprooting him does him irreparable harm.

It is therefore crucial that THE CHILD'S RIGHTS TO GROW AND DEVELOP NORMALLY SHOULD BE THE PARAMOUNT CONSIDERATION, and all workers should consider the whole picture in conjunction with the rest of the team in making plans for his welfare in the future.

CHAPTER 15

PREVENTION

It has to be admitted that although some progress has been made in the recognition and management of families who abuse their children research on prevention has hardly begun. This is the usual progress of events in a new medical condition. First comes recognition of the blatant forms of the condition and finding an effective treatment. Next there is a move towards recognising milder and milder cases and applying treatment "before it is too late". Then studies turn to prevention, always a less dramatic or glamorous enterprise but infinitely more worthwhile. Although child abuse is not entirely a medical problem progress from diagnosis towards prevention has followed this model.

First a broad view of prevention is needed which will encompass not only the child in his family but the changing patterns of the family in society.

The family and social change

Research on the sociological and psychological changes in the structure and integration of the family show that in Western societies with smaller family groups predominating, there are changing expectations of family life and progressive alienation of parents from children.

Freedom from continual child-bearing, mechanical aids in the home and better education have given mothers time to enjoy pursuits of their own and to enter the labour force, and at the same time to supplement the family income. A greater degree of luxury in living results and raises expectations further. The ubiquitous television set further alienates the family members by curtailing conversation, reducing opportunities for play and reading by children either individually or together, and particularly by reducing the chance of parents interacting with children through talking, arguments, playing games and enjoying family meals and discussion. It also reduces the parents' interactions with each other, and since these often involve discussing and planning for their children, television may subtly alter family cohesion.

The high rate of divorce in families with children causes further disruption in children's relationships with their parents. It is estimated in the United States that one child in six will lose a parent by divorce before he reaches his 18th birthday and in Britain and some other European countries similar trends are occurring. Relationships with step-parents may be more difficult than those with natural parents and these disrupted family situations may have a profound effect on children.

Consider the role of parent/child interaction in promoting the child's psychological development. The American psychologist, Bronfenbrenner, (1974), has set out two propositions in this connection which summarise the position:

> In the early years of life the psychological development of the child is enhanced through his involvement in progressively more complex, recurring patterns of interaction around a challenging activity with persons with whom the child has established a mutual and enduring emotional attachment.

> Any force or circumstance which interferes with the formation, maintenance, status or continuing development of the parent/child system in turn jeopardises the development of the child.

He goes on to say that the destructive forces are of two kinds. First externally imposed constraints such as poor health, bad housing, low income and mothers in full-time employment. Secondly, social forces and educational arrangements that diminish the status and motivation of parents as the most powerful potential agents for the development of their child.

The externally imposed constraints create patterns of disadvantage to children in any community.

Patterns of disadvantage

For children in any given community a number will suffer from factors leading to general depression of developmental potential and these have been termed the patterns of disadvantage. The study by Wedge and Prosser (1973) reports striking differences to children in the National Child Development Study covering all births during a week in March 1958 in England, Wales and Scotland. Disadvantage in this study was measured by three factors only:

> a large number of children (five or more) in the family or a one parent family;
>
> low income, defined as one needing National Supplementary Benefit in the past year;
>
> poor housing, defined as overcrowding and lacking a hot water supply.

At the age of 11 years, 36% of the children in this national cohort suffered from one or other of these three disadvantages and 6.2% suffered from all three.

These disadvantages in the children's environment showed in their growth, health and development. They were shorter, had more illnesses and absences from school, more accidents, and more impairment of hearing and speech. One in 14 of the 11-year-olds required special education. One in 20 were deemed educationally subnormal compared with one in 150 of the ordinary children not disadvantaged. At normal schools one in six, compared with one in 16 of the normal children, was receiving special help for educational backwardness. Again in normal schools one in four of the disadvantaged, but only one in 11 of the ordinary children, were considered maladjusted. The authors conclude that three approaches are needed to help children in the disadvantaged group, whose health, social attainment and physical environment was worse in almost every way than that of ordinary children. They suggest approaches through social work, through education and through re-distribution of material resources.

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Diminishing status and motivation of parents

Present educational systems tend to exclude parents yet there is abundant evidence that the influence of home is greater than school in the education and development of the child. Secondly, systems in early education which ignore the parents have little impact on the child, and most effective are those where parent and child participate together in the home or nursery school. The play-school movement in Britain recognises these principles but seldom applies to the disadvantaged families. In the United States and Britain a number of experimental early education programmes applied to these families confirmed the need to involve parents and when this was done substantial improvement in intellectual function occurred and spread on to the younger siblings.

The research reported by Halsey on the Education Priority Areas in Britain (1973) concluded:

> "... not only must parents understand schools, schools must also understand families and environments in which the children live."

or again, when arguing for a curriculum appropriate to the child's community:

> "Teachers need to be sensitive to the social and moral climate in which their children are growing up."

Changes in the curriculum which this would involve may take many years but as a policy teachers should look at it to arrange some innovations on their own.

Support systems for parents

Bronfenbrenner, having studied families in various countries in Europe and the United States, goes on to offer some recommendations in providing support systems for the parents in four major areas: in the world of work, at school, in the neighbourhood and in the home. He emphasises the need for flexible working hours and part-time employment for women, and closer links for parents with school. He advocates neighbourhood centres which would give mutual assistance and advice and be a focal point for organising acceptable parent intervention programmes. The problem here is always how to involve the inarticulate, disadvantaged families without diminishing their self-esteem, and more experiments are needed.

Bronfenbrenner outlines four ways in which parents in the home can be helped to enrich their experience with their children. The first would be "pre-child" parent education by better attention to medical care and nutrition before, during and after pregnancy, with improved environmental facilities in the housing and employment; also by exposing young people to babies and small children in various schemes to learn about early parenthood and the growth and development of babies before they have their own.

Secondly, the use of local residents trained as home-makers to help and relieve parents in disadvantaged areas, so they could have more time in activities with their children.

Thirdly, the power of television to facilitate the cognitive development of children is well-known and much better use of television for parents and children is needed. Mutual and simultaneous enjoyment of programmes by involving parents on the screen and in the home should be aimed at. It is also important to change the fairy tale perfection of family life, often presented in programmes or advertisements, into a constructive reality suggesting the challenges and rewards of being a parent in realistic every-day happenings.

Fourthly, research on the ecology of the family and the child is necessary, not only in situations where the child actually is, but including the wider impacts on family life such as work situations, transport, supermarkets, welfare and recreational facilities, etc. Studies would include changes which determine with whom and how the child spends his time, and various ways in which the child could understand and be involved in his parents' world of work in order to lessen the gaps and barriers between home and work so that work is seen more as a community endeavour.

Promoting optimal newborn care

Kempe, in Denver, Colorado, has described another form of prevention, by prediction of the vulnerable family by the sensitive use of questionnaires in antenatal clinics and by improved sensitive observation of developing mother/baby bonds in maternity units, and parent/baby relationships in the early weeks at home. Vulnerable families are offered extra services through home and clinic visits and telephone consultations too. The nurse or family aide who calls on the family needs extra sensitivity and empathy with young families. Her concern is first for the parents, especially the mother, for their feelings and their fatigue and anxiety over infant care as well as concern for the baby itself. Secondly, she offers practical help and support over the feeding, sleeping and daily care of the young infant, as well as practical tasks in the home. A reduction in severe nurturing problems has been shown to occur as well as fewer children being injured by their parents. Frommer and O'Shea (1973) also demonstrated the value of antenatal prediction and more schemes on these lines are needed as they are relatively simple and cheap.

The modern technology in maternity units is another factor which may interfere with the establishment of the intimate and inter-dependent relationship between mother and child and Spence as long ago as 1946 showed anxiety about this aspect of medical care. Dunn and Richards (1976) have shown that drugs during labour reach the baby and disturb his responses after birth for as long as a week or more making him sleepy and unresponsive and difficult to feed, and so altering the mother's responses too. Aleksandrowicz (1974) has reviewed the many reports of the drug effects on the newborn. Further researches into psychoprohpylaxis are needed to avoid this common hazard to the mother/child relationship. The work of Klaus and Kennel in Cleveland (1970) shows clearly that extended early contact between mothers and babies enhances their relationship and the effects of this are still evident two years later, in fewer health and behaviour disturbances and more interaction between mothers and their children. A critical look at all techniques and routines in maternity units is badly needed, and this should focus particularly on avoiding anything which interferes with the physical closeness and interaction between mothers and their infants.

SUMMARY

To summarise, preventive schemes can be considered under seven headings and the areas covered need to be integrated:

i. Education for both sexes in schools, youth groups, via the mass media, and in antenatal clinics concerning the growth and development of babies and young children, the responsibilities of parenthood, the early practical problems of parents and where to find help.

ii. Medical care in antenatal clinics, maternity units and for the family at home in the baby's early weeks should be geared to avoidance of separation of mothers and babies and to awareness of the attitudes, feelings and worries of young parents. Sensitive understanding and help as soon as problems arise must be easily available.

iii. The early detection of the child at risk from the overwhelming hostile reactions of his parents and recognition of the child who has already been injured, so that full assessment leading to protection of the child and help for his parents is instituted immediately.

iv. The evolution of multi-disciplinary teams to study these problems and help in their management.

v. The development of improved understanding of the use of legal systems in protecting children and families.

vi. Promoting improved understanding in the mass media so that they change their emphasis from horror stories and the hounding of abusive parents to indicating the complex issues involved. Showing ways in which help may be found would encourage abusing parents to reveal their problems earlier and to ask for help.

vii. Improvement in the health, education, environment and recreation of families through neighbourhood schemes as well as on a wider sociological and political front.

It has been shown that prevention has to be seen in broad perspective and this will involve sociologists, anthropologists, economists, social psychologists, town planners, politicians and many others. That should not prevent small studies and practical schemes being developed locally, and individual endeavour to improve the lot of parents and families by the sensitive understanding of their needs and by attention to details in planning the welfare and support systems in all communities.

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