THE USE AND ABUSE OF CHILDREN

By Dr. Peter Jones

Delivered at a Meeting of the Medico-Legal Society held on 16th August, 1975 at 8.30 pm at the Royal Australasian College of Surgeons, Spring Street, Melbourne. The Chairman of the Meeting was the President, Dr. Ainslie Meares.

"Maxima debetur puero reverentia . . ." Juvenal. Satires, 14:47.

Parenthood is a daunting experience, and there are times, I suspect, when most parents ask themselves why they ever had children at all. If answered, the replies would be almost as diverse as the questioners. The romantic would say that children are the literal embodiment of love, while the cynic would probably compile a list of reasons ranging from carelessness to dynastic aspirations. In fact, the reasons have varied greatly in time and place, as they still do in different parts of the world today, in the folklore of tribal communities, and in the so-called advanced "western" nations.

In the western world we can discount, if not entirely dismiss, such reasons for having children as: to provide and care for parents in their old age, as another pair of unpaid field-hands to work the farm, an additional wage-earner to the family work force, or even a welcome income tax deduction, were that not now an entirely impractical consideration when set against the incidental expenses.

A group of subconscious motivations should also be mentioned; for example, a deep instinctive drive to perpetuate the human race in general, or the patronymic in particular. There is also perhaps a tendency to conform with the community's expectations, or to obtain a "second chance" to achieve, at second-hand, unfulfilled ambitions; or more basically a need to demonstrate and prove fertility, virility or fecundity as the case may be. At a more conscious, and not necessarily more superficial level, there is the wish to experience the joys of parenthood; children can be fun. Psychologically there is a basic need to be needed, to create deep and lasting bonds of mutual understanding, respect and affection, with others; and with whom better than our own children. Who can, with complete insight and honesty, determine his or her own particular reason or reasons for having children? I suspect that our motivations would prove to be complex and multiple, probably based in the subconscious, with some more readily identifiable intentions forming the uppermost stratum.

I have included the "use" of children in my title; the purpose of having children, because illfounded reasons may contribute to the causes of maltreatment. When unrealistic expectations are, not surprisingly, unrealized, the parents' disappointment, anger and frustration lie at the root of some instances of maltreatment of children.

In presenting the data, I freely admit that my role is that of a rapporteur, for most of the social and psychiatric aspects involved are clearly outside my competence. For this information I am grateful to several of my colleagues, particularly to Miss Kath Dawe, sometime Senior Medical Social Worker at the Royal Children's Hospital, to Dr. Frank Bishop, who unfortunately cannot be here tonight, and to my wife, who is.

The abuse of children can be extended to cover a very broad spectrum of injury. A child can be "injured" in the sense that emotional and intellectual development can be impaired by withholding that interest, warmth, praise, and their accompanying stimulation, which are a necessary element in the growth and development of the personality, and the basis from which the growing child acquires a sense of worth, and the ability to form close and lasting interpersonal relationships.

In another part of the spectrum, there is indifference, expressed as carelessness or negligence, which may lead to truly accidental injuries, for example scalds in the kitchen, burns in the tool-shed, or accidental poisoning from the medicine cupboard. However, there is a break in the spectrum here; indifferent parents have given up; maltreating parents are still sufficiently concerned to be capable of anger when their attempts to make contact with or control their child are met with what they interpret as rejection, and they may react violently.

To most of us this is initially almost incomprehensible: the "battering" and "bashing" of infants and children; the terms commonly applied, and their emotive and pejorative content symbolise society's sense of outrage and, again initially, disinclination to believe that a parent could treat a child in such a fashion.

This disbelief played a large part in the reluctance of the medical profession to accept the evidence that some parents assault and sometimes kill their children. The first reference to the syndrome came from a radiologist, John Caffey, as recently as 1946, when he described a series of infants with multiple fractures of the limbs associated with head injuries. Significantly, he did not recognise the cause, or suggest that the injuries were the result of violence, but put forward the possibility of a disorder of bone, leading to unusual fragility.

Five years later, in 1951 Dr. Fred Silverman, who is both a

radiologist and a paediatrician, took the next step, and deserves the credit for the first concrete suggestion that "individuals responsible for the care of infants and children (who cannot give their own history) may deliberately injure the child and deny it". In the following five years, 1950-1955, a number of surveys revealed that injuries of this type were far more common and more widespread than previously suspected. The socio-economic factors and the psychopathology were also delineated in this period. One important study, by another paediatrician, Woolley, ruled out undue fragility of the bones as a factor, by the simple scientific expedient of removing affected infants from their home environment, and demonstrating that no fresh bone lesions developed in the ensuing weeks or months. Woolley was also the first to draw attention to the fact that in families with several children, one child, alone, often bore the brunt of the abuse and the injuries.

In 1962, Henry Kempe, Professor of Paediatrics in Denver, Colorado, wrote his classical article and coined the phrase (in its title) the *Battered-Child Syndrome*. He, too, noted the difficulty that doctors and others caring for children had, even in the face of strong circumstantial evidence, in believing that one or other, and sometimes both parents, were responsible for fractures, ruptured viscera and even death.

A search for evidence of maltreatment in history and literature reveals plenty of material. Smike in *Nicholas Nickelby* is the prototype of permanent mental retardation, and the first "battered" baby in literature. Bertrand Russell's mother described in letters to a friend his extremely severe chastisement, and her sense of enjoyment in dispensing it. The subtle brutality of Mr. Barrett of Wimpole Street is another case in point. Harsh Victorian fathers and headmasters were great ones for physical punishment, but there is a fairly broad line between battering babies and beating older children black and blue with a belt, a hazel switch, a riding crop or a school master's cane. Perhaps what sets these condoned primitive acts apart, is their ritualistic nature, in cold blood as it were, and with an avowed if misguided intent to correct and to train, and to punish the real if relatively trivial transgressions, of children for the most part presumed to be old enough to learn a Pavlovian lesson.

It is a paradox that cases of severe maltreatment seem to be increasing in number at a time when the use of corporal punishment is rapidly diminishing.

The fact that the majority of severely maltreated children are usually of an age when no such learning process can be expected, indicates an inherent loss of contact with reality by the parents.

The three organizations from which most maltreated children in Victoria are reported are the Social Welfare Department, the Royal Children's Hospital and Children's Protection Society. The Hospital, predictably, receives those with the most severe injuries, and the number of cases identified at or referred to the Royal Children's Hospital has increased steadily over the last five years. The annual incidence of cases in which parental injury is certain or strongly suspected is between one hundred to one hundred and fifty, two or three a week, and there are grounds for the belief that this may be only the tip of the iceberg.

It is not possible to say whether the increasing numbers represent increased prevalence, or better case-finding because of greater awareness and a higher index of suspicion.

The age group maximally affected is from birth to three years of age, with the highest incidence of severe injuries, in particular head injuries, in infants less than twelve months of age. No age group is exempt, although examples in children more than five years of age tend to be less common and the injuries less severe.

The child injured is somewhat more often a boy than a girl, in the ratio of three:two.

In ninety per cent of cases it is the mother who inflicts the injury, very probably because she is under greater and more constant strain than the father, who nevertheless often contributes to her stress by lack of consideration and support, by violent behaviour or alcoholism, or by prolonged absence from home, for example in gaol.

The distribution according to socio-economic status is skewed, because examples among the less educated, the less affluent and the poorly housed are more likely to be reported and hence more numerous. Our information is incomplete, but it will be obvious that in more affluent families, a maltreated child is more likely to be diagnosed and treated by the family doctor and/or a consultant paediatrician, neither of whom may be disposed to report the event. Public hospital patients therefore tend to predominate, but comprehensive studies in England and America have shown that maltreatment occurs at all socio-economic levels of society, and in Victoria several cases of maltreatment in doctors' children leave no doubt that children in any level of society may be physically injured.

The nature of injuries varies from one child to another.

Bruises, or their larger counterpart haematomas, almost anywhere on the body, but predominantly on the head and face, are by far the commonest evidence of injury, and so rarely found on the face in infancy, that their presence there is highly suggestive of maltreatment.

Fractures of almost any bone may occur: X-ray surveys in suspected cases frequently show several fractures, in several bones, and at various stages of healing.

Fractures of the skull are the most serious injuries, not only because they are potentially lethal, but also because a haemorrhage between the bone and the brain may be chronic and remain undetected, causing failure of growth, and more important, permanent mental retardation, reported to occur in as high as twenty-five per cent of maltreated children who suffer head injuries.

Space does not permit covering the whole range of bizarre and unusual parental injuries such as burns and scalds, but it is perhaps not widely known that excessively severe shaking can cause retinal haemorrhages and at least partial blindness. A row of separate small bruises, representing impressions of the finger tips, for example on inner aspects of both upper arms, is a tell-tale accompaniment of this form of injury.

Those with even a little experience of maltreated children work through the stages of disbelief, anger, revulsion, and desire for punitive action; none of these is in the long-term effective or productive, and none of them serves the best interests of maltreated children.

As Professor Reilly said in T. S. Eliot's *The Cocktail Party*: "All cases are unique and very similar to others", and although the circumstances of the parents are infinitely variable, some factors recur so often in case-histories that their relevance has been established; those can be summarized as follows:

Socio-economic factors. Those in poverty, in the isolation of high-rise housing, with no knowledge of how to contact sources of assistance and no psychological support from the husband, are particularly at risk.

The vulnerability of the nuclear family lies in the absence of helpful relatives close by, with no neighbourhood contacts, no one with whom parents can "talk out" their feelings.

Migrant families may be doubly isolated, not only by cultural and language barriers from their neighbours, but also because of threatened pride or hidden shame, by self-imposed isolation from their relatives or members of their own ethnic group in which the image of a fat (even overweight), smiling, healthy, happy baby (which theirs is not) is a deeply ingrained cultural stereotype.

Actual or fancied physical abnormality in the maltreated child. In most cases, but not invariably, one "special" child in a family is singled out for maltreatment because he or she is in someway "different". The reason may be visible; for example a birth mark, a minor deformity, mild spasticity, mental dullness or failure to thrive. These are

all potential sources of shame, guilt and anger for a parent unable to respond to a call for more than usual care and attention. In many cases the "perceived" defect is more subtle, but at least equally significant; the child may be a boy when a girl was wanted, or vice versa; the "husband" may not be the father; the appearance, the colour of the child's hair, or eyes, may continually revive memories of someone who was hostile to the parent when a child.

Premature babies or twins present additional problems, possibly in part because of separation from the mother in the vital post-partum period.

The unwanted child. Lack of education and information, and rigid family attitudes contribute to exnuptial births. Lack of access to advice on family planning, or its rejection on religious grounds, lack of co-operation or consideration on the part of the husband, or reliance on inefficient methods of birth control; these are all more likely in the under-privileged and the emotionally immature.

The emotional reverberations of an unwanted pregnancy carried through to become a continuing source of guilt, or resentment and hatred when transferred to a child, are matters for which those prepared to deny women's rights to birth control and/or abortion, must be prepared to accept responsibility.

The last of these selected contributory factors devolves from unrealistic expectations by the mother. Whether initially "wanted" or not, there may come a time, usually toward the end of the pregnancy, when a mother may begin to believe that at least the new baby will solve some of her problems by loving her unreservedly: that the baby will give her the affection and respect she failed to receive from her own parents or husband. The baby is seen unrealistically as potentially a constant source of satisfaction, and in her desperate need to be shown to be worthwhile and worthy of affection, there arises the unreasonable expectation that these rewards and pleasures will be supplied without any of the daily demands normally made by babies. When these demands are made, the mother perceives this as history repeating itself; here is yet another person who rejects her and makes her feel a failure; disappointment, resentment, anger and despair are the result. The unreality of the reaction is often clearly expressed: "I've told him again and again not to cry"; "I've begged him not to spill his food"; these sound reasonable enough, until they are applied to a six month old baby.

The team at the University of Colorado have summarized the causation as a group of four interrelated factors, found in the majority of their case histories:

A disturbed parent, capable of abusing a child—
because of the way he or she was reared;
who lacks support because the spouse is ineffectual, passive or selfish; and
has unrealistic expectations of parenthood.
A child who is different or special in some way.
A crisis or series of crises, major or minor, which make temporary but additional demands; desertion by the husband, the loss of a wallet, loss of employment, a transient illness in the child.
The absence of a "life-line"; someone, almost anyone, with whom the mother can talk uninhibitedly about her feelings; someone she can turn to for understanding when she feels she is losing control.
The psychopathology of the maltreating parent.

Some maltreating parents present a remarkably normal external appearance, and a reasonable level of competence or achievement in their everyday lives and occupations, to the extent that even well-informed investigators have reported that "less than one in ten maltreating parents are seriously disturbed". Clearly recognizable forms of psychosis are rare among maltreating parents and conversely, physical maltreatment of children is very rare in frankly psychotic parents.

The attack on the child is often made during or shortly after a crisis, when the parent is under severe psychic stress. The precipitating event may appear to be a very minor matter, for example, a crying baby, but this can be the final intolerable straw, or critical in the atomic sense, when imposed on a disturbed personality floundering in difficult circumstances.

One of the elements of the disturbed behaviour is "misperception" of the object of abuse: to an external observer a fretful, irritable or unco-operative infant; to the disturbed parent, a child who is "bad", hostile, unrewarding, and a reminder of the same attitudes displayed by a rejecting figure at whose hands the current parent, when a child, had suffered. The child is thus "misperceived" (in psychiatric terms a "part-object" perception) as the embodiment of a feared and hated parent, but now occupying the vulnerable form of a defenceless infant or child. The parent confronts this image from the past with full adult strength, and the explosive violence of the reaction is intensified by the depth and duration of previous feelings of rejection, anger, frustration and helplessness. The earlier inter-reaction is revived, but the roles have suddenly become reversed.

This interpretation is supported by the observation that maltreatment is frequently perpetuated from one generation to the next, the

battered child becoming an emotionally damaged and disturbed adult who in turn becomes a battering parent.

When the diagnosis of injury inflicted by a parent is suspected, or the risk of such an injury becomes apparent, the patient should be admitted to hospital; the medical social worker is immediately informed, investigations to confirm the diagnosis are commenced, and an initial consultation with a psychiatrist is arranged as a matter of urgency, ideally within an hour or so.

The processes of the law are first involved if the parents insist on removing their child from hospital before investigation and treatment have been completed, or arrangements for further care have been made. Neither the hospital nor the medical staff has a right to keep a child in hospital against a parent's wishes. In practice, attempts to remove the child nearly always cease when the parents are informed that this will be followed by notification to the police, and an application for a Care and Protection Order. When this fails to deter them, an urgent and potentially lethal situation is created and the police are usually notified immediately. Wherever possible, management of the child and parents proceeds without police assistance or a Care and Protection Order, for the application is not always successful, and the consequences of failure may be a further and sometimes lethal injury to the infant or child who has, as perceived by the parent, precipitated a police enquiry and an appearance in court.

Return of the child from hospital to the parents' care can be effected by the parents by appealing against the Care and Protection Order, or after consultation with the physician or surgeon in charge of the patient and the psychiatrist and medical social worker treating the parents. Supervisory home visits by a hospital or municipal social worker, or a district nurse, can be provided by a number of community or non-hospital agencies.

It is well recognised that occasionally the first but more often the subsequent presentation of a battered baby to hospital may be as "D.O.A.", dead on arrival, which may occur in up to five per cent of cases. Following the autopsy and inquest, one of the parents may be remanded for trial on an indictment for manslaughter or murder, or in the case of the mother of an infant less than six months of age, infanticide.

The breadth and depth of the problems of treatment, and how little has yet been achieved in solving them, is revealed by the fact that there is as yet no report which would substantiate the long-term value or benefit of medical or legal intervention on behalf of children injured in this way. More of them are surviving, but if the behavioural disturbance in the parents is severe, and when they are unwilling or

unable to be helped in any way, there may be no alternative but to remove the child from the family permanently, with the probability that the child will become a permanent inmate of an institution where, at present, no psychiatric treatment is provided, and until recently, no substitute parents, cottage home or simulated family circle was available for them.

Transfers from one institution to another are common and sometimes numerous. "Parents Anonymous", an organisation to assist maltreating parents with functions similar to Alcoholics Anonymous, was established in America in 1970 by a woman who was maltreated as a child, removed from her home, and an inmate of no less than one hundred and twenty-two institutions in the next eighteen years of her life.

A not unusual finding among battered children is that many of them, nevertheless, have an ambivalent attitude to their parents, a hostile/dependent relationship which, strangely, may include a fierce loyalty. Despite the risk to young children, for an older child the family and home may yet be preferable when compared with what society has so far offered in the way of alternative institutional care. For maltreated children more than five years of age it might be true to say "Better a bad family than no family at all". Although the problems of long-term management have not been solved, the knowledge already accumulated is of considerable value in recognising those children "at risk"; and in prevention.

There are several aspects of the abuse of children in which there is clearly a need for closer co-operation between the medical and legal professions, and there have been many suggestions as to how legal procedures might be improved. There is certainly scope for more information and a better understanding of the needs of children, by both professions. I would like to make some suggestions concerning three particular areas.

The first is in the early stages, at the point of suspicion. There is a need for an immediate hearing or an expeditious initial judicial procedure which would replace a police enquiry or a hearing in a court setting, both of which are likely to increase the parents' disturbed behaviour, to deflect their resentment on to an already maltreated child, and militate against the parents' co-operation in obtaining treatment for both the child, and themselves.

A "Medical Examiner" or a "Visiting Magistrate", who could at short notice be involved in the investigations and discussions leading to confirmation of the diagnosis, might be one solution. The person envisaged might, if thought fit, issue the equivalent of a court order, of limited duration if necessary, for example seven days in the first in-

stance, making the Medical Superintendent of the hospital, or the physician in charge, the legal guardian *pro tem.* The order could later, if necessary be extended for a period sufficient to arrange for a formal hearing in an appropriate setting, perhaps in a Family Court, empowered to declare the child a ward of the court.

In applying for a Care and Protection Order, the medical profession has no wish or intention to present evidence against a parent, but when the police are involved in obtaining evidence, they pass their information on to a senior officer for approval, and he may order that criminal proceedings be instituted against a parent. Such an indictment may then take precedence over the Application, and the parent may first be brought to trial in the Criminal Court. In one such recent case the medical evidence provided was rejected, the defendant found not guilty, and the subsequent Application was dismissed when it was submitted that there was no case to answer. This child's next admission was a "D.O.A.".

The second area involves legal action brought against the parent(s) for maltreatment. Might this not be an area for the Family Court? It has been suggested that the officers presiding and their staff should have special interest and training in the problems of families, and the psychological effects on, and the needs, of children.

Further, when a maltreated child may be made a Ward of the State, there should be provision for the child to be represented specifically, and if thought fit, be made the responsibility of a person with appropriate powers to ensure that the child shall receive essential medical and psychological treatment, education, and support. Where appropriate, the child might be returned to the care of the parents, on trial, under supervision, and with the proviso that the child could be again removed from their care if this did not reach minimum requirements, terminating the trial period without need for further legal proceedings.

It is estimated that five to ten per cent of maltreated children should not be returned to their parents, and that in perhaps two per cent of cases it may be necessary to separate the child from them permanently, leading, for example, to adoption rather than institutionalization. Properly constituted and staffed, a Family Court might have at its disposal officers who could combine the roles of social worker and home visitor, having some of the powers of a probation officer, and thus be able to ensure that the declaratory orders of the bench were properly carried into effect.

The third area concerns the interpretation of medical evidence in cases where a parent's actions have led to the death of a child. It is the opinion of most psychiatrists that the parent concerned commits the

act while in a state of temporary psychosis, likely to recur, perhaps infrequently, unless assistance and treatment are provided. In this light the act could be considered one committed during a period of diminished responsibility, in that at the material time the parent was not aware of the quality and consequences of the act. Should he or she not qualify for consideration according to the *McNaughton rules,* or whatever proceeds from or replaces them? It must be said that no generally accepted alternative to a prison sentence has yet been put forward. Perhaps an appropriate sentence would be a remand to a psychiatric hospital for detailed investigation, diagnosis and treatment, followed in suitable cases by release on probation, conditional on continued attendance for treatment. The current alternative, a prison sentence with virtually no treatment, is a remarkably primitive alternative. Imprisonment of a father-breadwinner or a mother-home-maker is a poor basis for attempts to rebuild and support a home and a family.

If this subject were to have a text, it would be two lines from *Juvenal*; the first, *Maxima debetur puero reverentia* ("The greatest concern is owed to children") is an exhortation for all who work in the field of child health and welfare. The line which follows: . . . *siquid turpe paras, nec tu puero contempseris annos*: ("if contemplating something bad, do not fail to consider their tender years"), applies to both the medical and legal professions in carrying out their responsibilities in this most difficult and, as yet, incompletely charted area.