General Practice Observed

Child abuse and general practice

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Summary

In a general practice of 9250 patients with 1841 children under 10 there were 12 cases of actual abuse during 1973-6. In March 1976 30 children were at risk. A preventive scheme was set up and the short-term outcome was good. There were no cases of serious abuse among the children at risk.

Introduction

Experience at the Park Hospital for Children[1-6] has made clear that any programme concerned with the problem of child abuse should aim at prediction and prevention and should include the primary health care team. Ultimately such teams, with the support of the hospital, should be able to take over most of the management. We describe one such team and its efforts in recent years to prevent child abuse.

Primary health care team and population served

There are four family doctors in one partnership working in a small town in Oxfordshire. Out of a total of 9250 patients, 1841 are under 10. Nurses, health visitors, and midwives form part of the team. The modern health centre from which the team works also houses the local social service office. Both social service and medical teams meet regularly in a joint common room.

The town has a population of 16 000. Housing is generally of a high standard but there are three mobile-home parks. There is also an Army camp and a Government research establishment, both of which supply tied housing. The main employers are the car industry, power station, Government research stations, armed services, and a canning factory. Most workers commute less than 20 miles (32 km).

The turnover of the practice list is about 9% a year, mainly among servicemen and first-home buyers in the private estates.

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Definition of terms

Actual abuse relates to injuries known to be inflicted. Either such abuse was admitted by the parents or their explanation of the injury was not consistent with medical evidence. This category also includes attempted suffocation, strangulation, drowning, and poisoning. Injuries may range from minor soft-tissue damage to the life-threatening.

Probable abuse indicates an injury to a child considered to be "at risk" that is not proved to be the result of assault.

Gross neglect indicates gross deprivation of adequate physical or emotional care, or both, that leads to failure to thrive or failure to meet the emotional or physical milestones of development.

At risk indicates a child in danger of abuse or neglect, or both, that is recognised by others or by the family itself. This category also includes outbursts of aggression not resulting in detectable injury. An example of such cases is parents who fear harming their child and seek help.

Actual abuse

Actual child abuse has been a significant problem in the practice. Twelve cases of actual abuse and gross neglect were known to the team between 1 January 1973 and 1 March 1976, a yearly prevalence of 2 per 1000 children under 10. The details of injuries and outcome are shown in the table. The management of actual abuse is not the concern of this paper. Once abuse has occurred there are procedures to be

Cases of abuse from 1 January 1973 to 29 February 1976

Case No	Sex and age	Injury	Outcome	Remarks
1	M 2½ y	Multiple bruising	Taken into institutional care. Moved out of area	Spastic and mental deficiency thought to be result of abuse at 4 m. Sibling (aged 2½ y) also taken into care
2	F 1½ y	Fractured femur	Taken into care. Later returned to family after psychotherapy. Moved	
3 (twins)	F 3 m	Facial bruises and scratches. Failure to thrive	Inpatient assessment at Park Hospital resulting in long-term care. Now in children's home	Abuse to child witnessed by doctor. Mother's two previous children adopted
4 (twins)	F 3 m			
5	M 5 m	Attempted suffocation	Returned to parents after 4 days in hospital. Moved out of area	Possibility of injury caused by child minder
6	F 1 y	Torn frenulum	No further injuries. In mother and baby group*	Retrospective diagnosis after request for help
7 (Siblings)	F 1 y	Multiple injuries	Children severely at risk. Parents resist all attempts to provide help	Rehoused in practice area with recent history of abuse
8 (Siblings)	M 3 y			
9	M 2½ y	Dislocated elbow	At home with parents. No further injuries	? Manipulation to obtain abortion
10	M 4 m	Baby thrown across room on to settee. Witnessed by doctor and social worker	Taken into voluntary care. With foster parents	Child rejected at birth. Twin still with mother
11	F 5 y	Multiple bruising	Taken into voluntary care	Single-parent family. Mother's cry for help
12	M 2 y	Gross failure to thrive. Well below 3rd centile	At home. Weight increasing. Participating in mother and baby group*	Probable battering before moved into area

*See text.

followed,[7-9] and other agencies inevitably are included. We feel that the major contribution a primary health care team can make is recognising early-warning signals in families with a high potential for abuse. The team is then in a unique position to help the families and work towards preventing actual abuse, We describe our attempts to do this.

Children at risk

We regard early recognition as essential if prevention is to be achieved. Thus a list of at-risk cases has been compiled. In every case the person identifying the problem felt that there was a need for extra help from the primary health care team. Some of the children were already on the social services at-risk register. Others came from families with the predictive factors outlined below. The families are discussed regularly by the team and information is updated. Such a system allows all members of the practice to be aware of these families, their problems, and the help being provided.

On 1 March 1976, 30 children in 22 families were considered to be at risk—that is, 16 per 1000 children under 10. The 22 families had a total of 43 children. In some families one child was clearly at risk while siblings were judged not to be.[3] Three children had been taken into voluntary care.

CHARACTERISTICS OF FAMILIES AND SOURCES OF RECOGNITION

All socioeconomic groups were represented by the 22 families, with one of them being in social class I, one in class II, six in class III, four in class IV, and three in class V. In addition one was a single-parent family and six (27%) were service families. Housing was generally less satisfactory than that of the rest of the population, with five families (23%) living in mobile homes and eight (36%) in tied housing (two in Government accommodation and six in service quarters). Of the remaining families one was an owner-occupier, six were in council housing, and two were in privately rented accommodation.

Ten cases were recognised by the general practitioner, four by the health visitor, two by the social services, two by other parents, and one by a hospital. In three cases the parents were self-referred.

The following examples show the extent and diversity of the problem.

(1) Four children from a well-known problem family where neglect and probable abuse had continued intermittently for years. Such a family belongs to a self-perpetuating subculture in which child abuse is common.[10 11]

(2) An adopted child rejected by an apparently stable middle-class family. Adoption breakdown may be a precursor of child abuse.

(3) A child whose father and mother were graduates. Here intellectual strain in the parents made the baby's intrusion dangerous. Intelligence is no protection against bonding failure.

(4) A child from an upper-class family bonded only to his nanny; crises occurred on her weekend off. Wealth does not prevent child abuse.

(5) A child whose parents had met in the local psychiatric hospital and assortive mating had occurred.[4] The mother was psychotic and the father a criminal psychopath.

(6) Several children with lonely young mothers, socially isolated because of a recent move into the Army camp.

Overcoming denial

All members of the practice team have had to overcome their denial that parents can harm their children. We believe that any parent, when under enough stress, can abuse their child. Each member of the team has had to acknowledge feelings of anger and violence in themselves that have often been denied.[12] Only when we have dealt with these feelings have we been able to accept the problem in others and approach the parents in a confident and non-punitive manner.

Prediction

Even before conception some couples have evoked concern about their suitability for parenthood. The family doctor is in a potentially stronger position than most for recognising these vulnerable parents because they or their families may have been known to the practice for years.[13] Complete antenatal care includes psychological preparation for parenthood. Unrealistic expectations and ambivalent feelings and fears about the child should be looked for in both parents.

There is an increased incidence of difficult pregnancy, abnormal labour and delivery, and neonatal complications in subsequently abused children as compared with siblings.[3] Observations of the mother's early interaction with her baby are useful for predicting future difficulties.[6 14] We have found the postnatal period at home to be a valuable time for establishing good links with a young family. We have tried to be accessible and to understand emotional needs as well as practical and medical problems. Parents must be able to trust the team and feel that their worries and fears will be treated sympathetically yet seriously. Later, simple uncritical questions like "How are you coping?" "Are you enjoying your baby?" or "Are you getting out with your husband?" have provided opportunities for unhappy parents to share their problems.

Parents who abuse are under stress. At any stage stress may produce medical symptoms that bring the family to the practice's attention. Virtually every condition has been presented, from ear infection to dyspareunia. Problems of the child's sleeping, eating, excreting, and behaviour have been used frequently as a presenting problem. Often the families have reacted in an inappropriate way or appeared at an inopportune moment. Recently some of these at-risk families have presented with sexual difficulties or minor psychological disturbance. The agitated, depressed mother is particularly worrying because it is so easy to treat only her symptoms, missing her underlying problems in coping with a young family. In fact, the drugs prescribed for her anxiety and depression may release inhibitions leading to aggressive outbursts.[15]

A characteristic of many of these families has been to make frequent emergency appointments, see different doctors in the practice, attend the accident department, and call out the health visitor. Requests for help with social problems often come at awkward times. For example, one patient walked into the doctor's kitchen at Sunday lunchtime and demanded a letter for rehousing. Another woman rang up the social services duty officer at 2 am asking how to obtain a divorce. We have noticed, however, a few vulnerable families who make little or no demands on the practice and reject all offers of help. They tend to be isolated and antagonistic to all approaches.

By recognising the potential for child abuse at an early stage, we hope to avert many of the problems associated with the accusation and stigma of "baby battering." This enables us to deal with the problem in an open and non-punitive manner before the patient's self-respect and the family's integrity are lost. The team is beginning to be seen locally as approachable and sympathetic towards the problem. The evolution of a management programme has raised the morale of all members of the practice team and led to an optimistic and constructive approach.

Management of at-risk cases

The whole family needs treatment. In most cases this can be provided while the child remains in the care of his parents. For the occasional child at risk, however, separation may be necessary.

IMMEDIATE ACTION

These families seldom present when there is time for prolonged discussion. Recognition and acknowledgment of the problem, however, may be achieved during an ordinary surgery consultation. Once the parents realise that their predicament is understood a lifeline has been provided. Then a longer consultation is planned during which a detailed history may be taken, a more accurate assessment made, and a therapeutic relationship established.

DIAGNOSTIC INTERVIEW

The diagnostic interview may be arranged by any member of the practice team, and it has been helpful to have the health visitor, doctor, and social worker present. The first part of the interview is devoted to formal history-taking and includes both parents' family backgrounds. We have found that this serves the dual purpose of providing valuable biographical information while at the same time gaining the family's confidence.

The second part of the interview is used for defining the problems and making a treatment plan, which is likely to be different for each family.

TREATMENT SUGGESTIONS

Twenty-four-hour lifeline—All members of the practice must be aware of the families at risk, even if they are not directly concerned with them. It has been possible to encourage the families to establish links with the whole practice and to use the doctor on duty if a crisis occurs when the primary therapist is absent.

Therapeutic relationship—This is provided by the team; the doctor or health visitor acts as the primary therapist and sees the family either at home or in the health centre. In some cases both husband and wife are seen regularly. In others, the mother attends a therapeutic group with an attached playgroup, which has been established recently in the practice. This will be described elsewhere.

Child care—The child is seen regularly either at home or in a clinic. Most parents of children at risk have rich fantasies and unrealistic expectations of their child's capabilities and development. These must be gradually and gently brought nearer to reality, which may take weeks or months.

Practical help—We have found the most useful form of practical help to be the provision of a playgroup/nursery place. Help with transport, baby-sitting, domestic arrangements, social activities, and, in extreme cases, housing has alleviated family stress and reduced the risks to the child. We try to maintain an honest and realistic approach to these problems to avoid raising false hopes and expectations.

Referral to other agencies—Informal discussion with members of the social services is often as important as a formal referral. Even after referral the responsibility for the case is shared. In some cases, psychiatric or paediatric specialist services, or both, are necessary. Each member of the primary health care team has a continuing contribution to make to assessment and management.

OUTCOME

It is too soon to know how much such an approach will reduce the prevalence of actual abuse. We know that two of the 30 at-risk children have suffered minor inflicted injuries—a bruise and a red slap mark on the face. Both of these would have passed unnoticed without the extra attention the families were receiving.

We are confident that all the families have benefited from our intervention, particularly those mothers and children attending the therapeutic group. Children have been seen to make outstanding progress in all aspects of their development.

Conclusion

Child abuse is the result of a process with origins years, sometimes generations, before the event. The process is complex and different for every family. Factors in the parents' biographies, social problems, and ill health are all included. Identification of the syndrome needs recognition of the continuing process rather than diagnosis of an isolated medical event.

Most abusing families are known to the family doctor—firstly, because there is increased actual ill health and, secondly, because medical symptoms are often used as a way of seeking help. If the family doctor regards each consultation as part of the family dynamics and not as a single isolated event he has the unique opportunity for recognising early predictors of child abuse.

Early recognition of the problem is itself a step towards prevention. Reluctance to make the diagnosis could increase the risk. We have shown that the primary health care team can attempt to treat the problem of child abuse in the community and work towards prevention with the back-up of specialist services.

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Statistics at Square One

XX—Correlation (concluded)

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The regression equation

Correlation between two variables means that when one of them changes by a certain amount the other changes on the average by a certain amount. For instance, in Dr Green's children (Part XIX) greater height is associated on the average with greater anatomical dead space. If y represents the dependent variable and x the independent variable, this relationship is described as the regression of y on x. The relationship can be represented by a simple equation called the regression equation. In this context "regression" (the term is a historical anomaly) simply means that the average value of y is a "function" of x, that is, it changes with x.

The regression equation representing how much y changes with any given change of x can be used to construct a *regression line* on a scatter diagram, and in the simplest case this is assumed

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