Emotional Problems in Childhood and Adolescence

Neglect, Cruelty, and Battering

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An anonymous annotation recently stated "It should be axiomatic that *any* injury (other than a road traffic accident) to a child under 2 *must* be considered to be an instance of the battered-baby syndrome."¹ This is, fortunately, obviously incorrect, even if a more recent estimate that 500 children die each year from battering is nearer the truth.² The very word "battering," and the term "battering parent," add to the already considerable difficulties of determining which injured children have been damaged by their families. So do exaggerated estimates of the size of the problem and alarmist claims that it is on the increase. Up to a point publicity and catch phrases have been effective in drawing attention to a problem which certainly has been underestimated. Now that research is in progress it could only be helpful if the emotional temperature were lowered. Our understanding has been increasing faster in the last 15 years since Caffey³ described the periosteal changes and other injuries seen on x-ray films of children who had been swung fiercely by their ankles or their wrists.

From work done independently in different parts of the world and in different social situations⁴⁻⁶ we know that much of this deadly or potential deadly damage can be prevented. Also that most families which have produced or permitted grave physical or emotional injury and neglect can recover and achieve their ambition of nurturing thriving children. We have learnt too that the suspicious, over-simplified, and potentially accusatory approach epitomized in my first quotation makes recovery more difficult and further injury more likely. We have learnt it in the process of discovering that the opposite approach of sympathetic and concerned, but controlled, curiosity is essential if recurring tragedy is to be avoided.

Clues in Diagnosis

All doctors have a strong incentive to diagnose a disorder which may be fatal yet is eminently treatable. With families in which children get hurt there is the additional incentive that it is not a self-limiting problem. Failure to provide appropriate help for such a family leads to the situation going from bad to worse. Even the death of a child brings no resolution despite the fact that there may appear to be one child who is the scapegoat. A child is much more likely to suffer, and die, from injury in a family where other children have been abused. So the diagnosis must be made, if possible. Yet it is one with which even the most experienced and sympa-

thetic general practitioner needs help. And so we come to the question of what might such a doctor notice and start wondering about.

The first possibility is that of an unusual or severe injury, especially if the parents delay seeking advice and offer contradictory explanations or one which does not seem to make sense. Or there may be a sequence of minor injuries to one child, of the kind that would lead a healthy parent to ensure that there was no repetition (for example, burns and falls). Another possibility is a contrast between parental attention to clothes and cleanliness in the child and its failure to gain weight. Again, a doctor may be alerted by the extreme defensive sensitivity of some parents who react to attitudes which doctors may not even know that they are taking.

All these signs are more readily seen by those with experience of normal reactions to the responsibilities of parenthood from the birth of the first baby onwards. But still they are much harder to perceive than a simple list suggests, a fact which stems from the emotional impact on us all of parents who actually endanger their children. Related to this difficulty in seeing what is there to be seen is the difficulty of deciding what to do if the diagnosis is suspected. We may quite unconsciously avoid such a decision by failing to observe what the family tries to draw to our attention. Such a lack of perception explains most cases of doctors' failure to seek help. Misplaced sympathy (sometimes concealing fear and rage) may lead to the erroneous decision to do nothing more than treat the child's lesions or accept the proffered explanation of a baby's death from injury.

None of us can help having been babies once—babies, and then children, who inevitably looked up to their parents as infallibly good and yet potentially frighteningly, as well as righteously, opposed to misdemeanor. These attitudes persist and recur in all of us to some extent, particularly where parental failure is concerned. Even as adults we are appalled and enraged and terrified by grown-ups who fail in their admired parental duties. We try to defend ourselves from such shocks by ignorance. And when we do see we may keep our antagonism hidden from ourselves because we want to be the good concerned grown-ups. But these adults whose personalities are so disordered that they can or do hurt their children are dangerously sensitive to the conscious or unconscious attitude that they are bad parents, bad people who never even aimed at producing a family group and from whom the child must be quickly rescued, while they are punished. Fortunately the parents are equally exquisitely sensitive to the attitude that the family is a living group, with a need and a right to grow; a group in which a damaged or dead child is a disaster for all concerned.

Personality Disorder

How does the parents' personality disorder develop? It may evolve from their being reared in emotionally abusing situations themselves; situations which, like the disorder they later

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develop, are not confined to any social class. Unwanted, unloved, neglected, frequently moved from home to relatives or residential care, witnesses of parental quarrels and violence, sometimes even physically abused themselves, the parents remember these situations only partly consciously and try to forget, and overcome, by starting their own families young and with the intention of treating their own children better. These early situations have left the parents very unsure of their own worth, very vulnerable to the opinions of others, and unduly reliant on external proof that all is well—hence their tendency to clothe and feed their children particularly well and their susceptibility to disturbance when things go wrong, or appear to do so. Thus they may perceive the wetting or soiling of even a normal infant as a rejection and an accusation of failure, and other such events include illness or unhappiness in the child or just its inevitable childish failure to fulfil the role of loving child to the tragic parent who has never had consistent experience of such affection or care.

After general agreement had been reached about the occurrence of this type of parental personality disorder, attempts were made to devise a questionnaire for use with all mothers of young children, in the hope of picking out those who might harm (or allow their husbands to harm) a baby. In my opinion such schemes can be worse than useless if they tempt doctors too strongly to rely on them rather than struggle to achieve the alteration of attitude which is so essential. Moreover, the use of forms, or any official type of approach, tends to reinforce the parents' sense of being unappreciated objects who are not treated as fellow human beings. For they are, and need to know they are seen as, human beings with a lifelong problem which has tragically worsened under the strain or parental responsibility.

Hospital Admission

Of course, if a child has a serious injury that must be concentrated upon first and foremost. Provided the doctor's initial attitude is that he needs the hospital's help with this suffering child, there is usually no difficulty in getting the parents' agreement to admission. Then there is time for relief, reflection, and investigation. Unless there is parental psychosis, two children in a family are not simultaneously at risk, so one can safely leave the other children at home. Psychosis is very rarely the cause of maltreatment of children, but its existence must be diagnosed because it is not susceptible to the same treatment as the more common personality problems which lead to an unsafe home. So a psychiatrist's help is needed.

In the more psychiatrically aware culture of the U.S.A., Kempe (a paediatrician) had no particular difficulty in getting the parents of injured children to co-operate with his colleagues in the department of adult psychiatry. We have had similar success in getting and maintaining parental co-operation when it is the child who is officially referred for a psychiatric opinion. There is no lower age limit for referrals to a department of child psychiatry and parents are always included in the investigation of a problem. Our youngest patient so far, was brought to us three months before she began her extrauterine existence, but I still have a bitter memory of failing to get a mother in early pregnancy referred to us rather than being sent to prison for neglecting a baby.

PSYCHIATRIC INVESTIGATION

Psychiatric investigation of a family will pick up psychoses and those depressive retardations which have led some

workers to the erroneous view that parental mental deficiency is an important cause of child abuse. Psychiatric investigation will lead to an assessment of each parent's personality and of their interaction. But it will seldom yield a quick answer as to who actually dealt the blow or whose cigarette end caused the recurrent burns. Such answers may not be forthcoming even after years of work with a family. But we are not seeking such answers; indeed, it is positively unhelpful to do so because it increases the parents' fear and suspicion in a way which is likely to make them refuse their co-operation. Similarly, punishment plays no part in curing the problem or preventing recurrences, so investigation by the police—particularly if it leads to a criminal charge and imprisonment—can be dangerously inappropriate. On the other hand, a juvenile court may be of great help, concerned as it is for the welfare of the child in its family as a whole.

This not to say that children must always remain with their families unless taken into hospital already injured. They may need to go into care temporarily, or on a convalescent holiday, while work is beginning or proceeding with the family. Such a decision is most appropriately undertaken by a department of psychiatry, especially a department of child psychiatry, but help can first be sought from the National Society for the Prevention of Cruelty to Children (especially for families within reach of their research unit) or the social services department of the local authority. Resort to the police in the first instance should be made only in the direst emergency.

A decision must be made whether someone already involved should carry on the benign supervision which is required or whether a new person—for example, a social worker or health visitor—should be introduced. In our present situation of shortage of psychiatric personnel, it is fortunate that most of these parents do not need interpretative psychotherapy. But they must have concerned and sustained interest from someone who can, without blaming or condoning, convey an understanding of the need to keep the child safe and well. This person may be trained or untrained, but must be aware too of the need for respectful co-operation between all concerned. Such co-operation is an important part of the treatment. It relieves personnel of some anxiety, though some will be inevitable where a child's life is at stake. Co-operation between personnel serves to reassure parents that the adult dissension of their childhood is not continuing. If at least two people know of the parents' problems, and are known to the parents, the family upset when a worker goes away will be relieved. For these families need to depend on a professional worker because they could not depend on their own parents and cannot now depend on each other alone. Yet once a family is known, which normally needs intensive investigation at first (including several home visits by a social worker), the care they need is long term rather than intensive. Though the presence of thriving infants is very good therapy for this type of family disorder, some outside help will probably need to be available so long as babies are being born into the family.

I hope that in the short space available I have been able to throw some new light on one of mankind's perennial problems and stimulate some thought. I hope it will be clearer why many of us working in the field are not being sentimental when we eschew police intervention in most families—also why I do not favour a change in the law relating to the problem of babies and children injured within their families. A central register of "batterers" and their victims could only make it more difficult to convince the whole family that our aim is relief, not retribution. Moreover, the relevant section of The Children and Young Persons Act 1969⁷ gives ample scope for all action necessary if the parents' co-operation cannot be gained. Among the reasons for which a child can be taken into care, is the category "if his proper development is being avoidably prevented or neglected, or his health is being avoidably impaired or neglected or he is being ill-treated." There is also a clause

in which the probability of recurrence of a previous condition—for example, in a family where one child has already died in a similar situation—can lead to preventive action.

Of course, these clauses will not be invoked by a magistrate unless convincing evidence can be offered of a family's inability safely to care for the child. Such evidence can only be acquired by patient, sympathetic, and intensive investigation. This investigation can in itself be therapeutic—so can the plan of care based upon it. This is why it is important to seek out, use, and demand an increasing supply of the social workers and psychiatrists, whose co-operation has been so clinically rewarding and productive of so much understanding already.

References

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- ⁶ Isaacs, Susanna, *Lancet*, 1968, 1, 37 (correction p. 98).
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European Counterparts

Two Research Institutes—London and Rome

FROM A SPECIAL CORRESPONDENT

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The Istituto Superiore di Sanita in Rome and the London School of Hygiene and Tropical Medicine are two of Europe's important biomedical institutions. Both have a wide diversity of function, taking in research and public health work; both possess special problems of administration related to these functions; and both have a newly appointed young energetic director who is himself in part a product of his institution. There are further points of resemblance: each is situated in the university district of the capital city, flanked by faculty buildings and close to a university hospital. While both institutions have a history going back about 100 years and incorporate other famous institutions, both are essentially modern, and owe much of their present status to generous bequests from the Rockefeller Foundation made to them in the early 1930's.

The Istituto is the principal public health authority for all Italy. It carries out most of the functions of a food and drug administration; it acts as an advisory body, to both the State and international organizations; and it is a distinguished post-graduate research centre where some 200 scientists from all over the world pursue their work in basic and applied research entirely undisturbed and under exceptionally favourable conditions. While it may appear to have many activities in dissimilar fields, all have in common the protection of the public health.

As I watched the Istituto's director, Professor Francesco Pocchiari, being driven up to his office at 8.20 a.m. I reflected that this is not the way Dr. C. E. Gordon-Smith arrives at the dean's office at the London School of Hygiene and Tropical Medicine; crowded London Transport has to do for him. But the Istituto belongs to the State, and the director is appointed by the government and is answerable directly to the Minister of Health himself. "Does this complicate your life?" I asked Professor Pocchiari. "It makes it interesting, but tricky to survive" was the humorous answer, which might raise a British smile, though I doubt if many of us could tolerate, let alone produce good work from, such a bureaucratic situation. Professor Pocchiari's budget, which amounts to about \$8m a year, comes directly from the Ministry of Health and he alone is responsible for disbursing it for administration and research. Money for administration he must allocate on an annual basis,

but that for research he can budget for on a quinquennial basis to facilitate research programmes. Neither he, nor anyone else on the staff, is allowed to look for money for research from other sources, and this is a problem. Asking for more money officially was never permitted except under very special conditions. His predecessor at the Istituto, Domenico Marotta, got around this difficulty by creating a non-profit financial foundation. This permitted a wide expansion of the research facilities, attracting many great names in science to work at the Istituto, and making it a world-recognized centre of scientific brilliance. Nevertheless, at the same time this special financial arrangement substantially contributed to the severe criticism of Marotta in the last years of his directorship.

Types of Staff

All members of the staff—which now consists of about 900 persons—are civil servants; over 200 are university graduates in science or medicine and many of these hold, in addition, teaching appointments in Italian universities. These university connexions allow for a valuable cross-fertilization of ideas, but they also inevitably lead to many of the brighter stars transferring to the university firmament. This took place especially after the retirement of Marotta, who left no obvious successor. At that time a number of his most senior people went to university chairs. Of the 250 laboratory technicians about 100 possess diplomas of various kinds. Each of the ten departments has a library and the staff of librarians numbers 16; the administrative staff numbers more than 150. Nearly half the personnel, including most of the graduates, belong to trades unions. This means that strikes are not unknown at the Istituto, and on one occasion about 18 months ago one developed into a walk out and lock-out owing to disagreement about terms and conditions of service.

The London School of Hygiene has 10 departments. Of the 450 staff, about 150 are academics or research assistants. The professorships and readerships are university appointments. Laboratory technicians number 120, of whom 55 are supported by grants. There are 10 librarians, including three professionals, but in contrast to the huge administrative staff of the State-owned Istituto, at the school there are only 24 people who fall into this category—"and I am one of them" says the dean. He is in fact chairman of the school council and as dean is executive to the board of management. As a part—though autonomous—of London University, the school receives more than