CHILD ABUSE: Professional Paralysis

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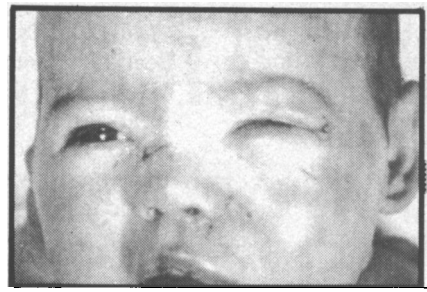

In this composite case study, the names and some details have been altered to protect the innocent, and the guilty.

Sue was nineteen years old and three months pregnant when she came into contact with a hospital. She had successfully concealed the pregnancy and claimed that she had only just realised her predicament. Referred to the social worker, by the time she got around to saying that she wanted an abortion it was too late. Adoption was explored, and she finally agreed, only to later change her mind. As the weeks went by, Sue, and her boyfriend, made no preparations for the birth, and neither of them talked about the expected child with any pleasure. The social worker discovered that both Sue and her boyfriend came from deprived backgrounds. Sue had been beaten and sexually assaulted by her father and was eventually made a State Ward after her father had died and her mother had claimed she was uncontrollable. Her boyfriend had had a history of psychiatric treatment and a criminal record for petty offences.

Sue had had two previous pregnancies; one was terminated and the result of the other was a boy who became a State Ward after Sue abandoned him. Both Sue and her boyfriend were drug and alcohol dependent, and could barely look after themselves. When Sue came to hospital to have the child she told her social worker that her boyfriend had walked out a few weeks before. The baby was born easily and there were initially no problems with him. However, Sue didn't appear to care when told that he was a boy, and she avoided eye contact with the child, and in spite of much prompting by the nursing staff failed to say anything positive about him at all. In fact she repeatedly asked the doctors if there was anything wrong with him, claiming that his head was misshapen.

Sue continually had to be pushed into feeding him, holding him. The nurses all noted and reported that Sue would be much happier if she didn't have to have anything to do with the baby, and she still claimed that his head was "too large" or "too badly shaped".

Although she commenced breast feeding, after a couple of days Sue complained that her breasts were too painful and refused to breast feed any longer.

After a great deal of encouragement she decided that she would call the baby Shane. She appeared to find little Shane rather distasteful and would only change him if bullied into doing so. She said Shane smelt. There were soon problems with Shane's feeding, and he lost weight rapidly and the nurses noted that it was because Sue had no patience with him.

On several occasions they reported that she was angry with Shane, and one nurse saw her raise her fist to him in anger although he was barely five days old. During all this the social worker and the doctors remained benignly optimistic, reassuring the nursing staff that Sue would soon "come round" and that "all would be well".

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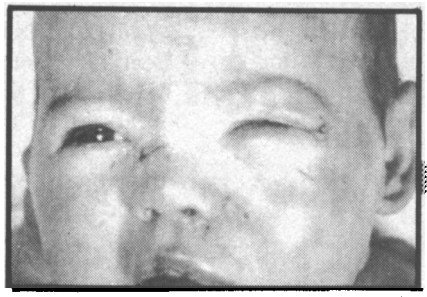


Because of his poor weight gain it was planned to keep Shane in hospital a little longer but, before any discussions were held or plans were made, Sue discharged herself. She was not seen for two days; when she did turn up at the hospital she demanded to take Shane home. When she saw him, however, she appeared to lose interest in this idea and went home alone, promising to visit next day.

This time there was a four day gap in visiting; and after that it was a week before she returned and took Shane against medical advice.

Shane was next seen at the local children's hospital where Sue complained that he was feeding poorly. On examination he was grubby, smelly and had severe nappy rash. Sue did not hold him during his medical treatment until virtually told to by the doctor, and then it was a mechanical response, lacking in warmth.

There were frequent visits to the hospital during the next few weeks with many complaints, mainly about his crying and his poor sleeping. Different doctors saw Shane each time, the more observant noting the rough handling. One of the nurses reported mother's apparent anger with Shane in the waiting room. There was no referral to the Social Work Department.

When Shane was three months old a social worker from the local council visited and noted a bruise on Shane's face. There was a new boyfriend, Peter, whom Sue said drank a lot. Shane was smelly and the cot was dirty. The social worker contacted the Infant Welfare Centre Sister who in turn visited. She recorded a bruise around Shane's eye. The social worker had not said anything about the bruise she had seen earlier.

Both the Infant Welfare Centre Sister and the social worker visited irregularly. More bruises were noted, and the social worker became rather concerned. Mother's explanation that Shane was restless in his cot at night was seen to be satisfactory, however.

It was around this time that Sue complained to the local G.P. that Shane and his crying were driving her mad. The G.P. applied reassurance and a diagnosis of neurosis.

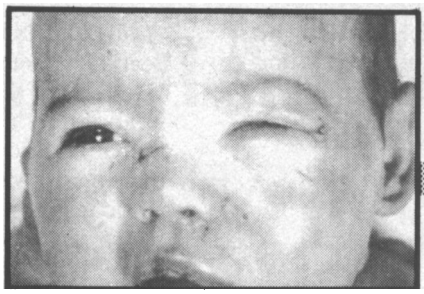
When Shane was 5 months old he attended the children's hospital with a fractured arm. Mother claimed that she dropped him. The fracture did not need plaster immobilisation, a simple bandage sufficed, and admission was not seen as necessary. No social assessment was requested, child abuse was not considered as a diagnosis. The Infant Welfare Centre Sister went on holiday and the social worker no longer visited. Shane was uncomfortable in his bandage and cried. Sue took it off. Shane cried. Sue became angry. Peter the boyfriend walked out. Sue punched Shane again and again.

When he next attended hospital he was dead.

The purpose of this composite case study was to highlight possible points of intervention in a case of child abuse, (Kempe and Kempe 1978) and to demonstrate that, at those points, co-operation between professionals and co-ordination of services are of the utmost importance.

In England, the Maria Calwell case highlighted the contradiction that whilst child abuse necessitates professional contribution of considerable complexity, it frequently demonstrates a proclivity to be subjected to isolated, dislocated services that enervate the energy and enthusiasm of involved professionals. The stakes are high and feelings of frustration and recrimination can be exaggerated when it is felt that an individual, agency or profession appear to be shirking their responsibilities (Hill and Ebeling 1975). What causes such professional paralysis?

Let us consider the Social Work profession first. It should surely be a matter of course that social work cannot aspire to anything higher than the protection of the weaker members of society (Timms 1964). Nevertheless, social workers tend to be as immobile as everyone else. For many of us the major frustration in practising social work is that we have to put so much effort into applying band-aids to situations without any chance of changing the underlying causative factors. It is disturbing therefore, that social workers do not regard developing services for young children as a high priority, as there is agreement amongst all schools of social work that early childhood, being the base of life's edifice, is not only the most vulnerable period in the lifespan but also the time when the foundations



of mental and physical health are established.

And yet social workers are just as uncomfortable and frightened as other disciplines when faced with child abuse. And their reaction tends to be the same: ignore it. Social workers do not like using legal authority or other constraints on their clients. They like to be nice guys and are inadequately prepared for their roles as agents of social control. The protection of children by changing family life, is a major responsibility and duty, and conflict between the parents' and child's rights not withstanding, and many social workers do not match up.

Doctors have also shown a marked reluctance to act when confronted with the child at risk or the abused child. The application of the correct medical treatment for physical trauma is insufficient (Bentovim 1974): the doctors' roles include diagnosis, consultation evaluation and prevention. Apart from lack of opportunities for professional advancement, the lack of financial incentives, the drain on emotional resources, there are other specific reasons why the medical profession is reluctant to get involved. Its training is frequently inadequate: doctors can leave medical school knowing very little about child abuse. They have minimal training in interpersonal skills, and some have a great deal of difficulty working with other disciplines as peers. Court proceedings can cause them a great deal of concern and when they overcome all these obstacles and enter the fray it can appear to the doctors that none of the other professionals comprehend their respective roles.

Physicians and surgeons like psychiatrists and social workers, are inadequately prepared for their roles as agents of change or social control: they like to be nice guys too. They also suffer from a tendency to over-identify with the parents, sometimes at considerable expense to the child.

Nurses, in common with other professionals, frequently fail to fulfill their roles in child abuse and are reluctant to look beyond presenting symptoms and consider parenting problems. Prevention is better than cure and visiting nurses in the community have a unique opportunity to detect and prevent potential abuse. In the maternity hospital delivery room and nursery, nurses are ideally placed to initiate early recognition and pre-abuse intervention (Bridges 1978). And yet, so often, they will not take the responsibility of passing on their doubts to other professions.

In casualty and out-patient areas in hospital, nurses should be alert to the child at risk and the parent under stress, and when the child is an in-patient they can observe parent-child interactions and relationships more readily than some other professionals. However, in many cases nursing staff feel reluctant to pass on their observations because they consider that it is not their place to do so or because they think that they lack the necessary competence or qualifications.

Child abuse involves other professionals in a variety of roles; it is not solely a medical problem or a social illness. The flexibility of health and social welfare departments, of lawyers and police, of psychologists and developmental specialists are also essential, and yet these groups are equally prone to paralysis.

Much of this must sound extremely negative. It is my contention that working in child abuse is often nasty, unpleasant, uncomfortable. Of course it can be a positive and fulfilling experience, but to deny the reality of the difficulties either to oneself or to others would be doing everyone a disservice.

Although acknowledging that each profession has its own goals, and its own language, these must not be allowed to obstruct the trust and understanding that we need to work together effectively. Each profession and every professional must demonstrate flexibility, an openness to differing approaches and opinions, and an ability to deal with complexities.

Our success in co-operating with each other directly dictates the degree of protection that the child receives from neglect and from abuse. No real progress in prevention will be possible until this co-operation and co-ordination takes place.

The partial or total paralysis of professions, is, I suspect, frequently caused by confusion about priorities, and whilst clarification should not be regarded as an immediate panacea, working out to

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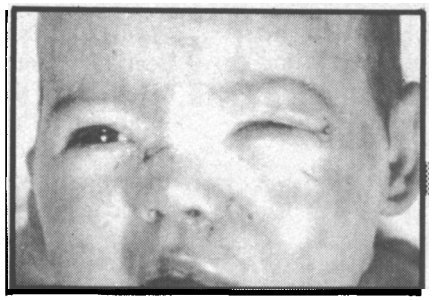

whom our responsibility lies should make child abuse less traumatic not only for ourselves but hopefully for the child and his family. The first priority should always be the safety of the child (Schmitt 1978). Helping the parents is the second priority; the third should be to reunite the family, although acknowledging that there will always be occasions when this will not be possible.

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THE RIGHTS OF THE CHILD 20 YEARS AFTER: DREAM OR REALITY

By Mehr Kamal, Editor, UNICEF Information Bulletin

Anniversaries provide a convenient time to stop and look back on the event they commemorate, a time to take stock of what has been achieved and assess what remains to be done. November 20, 1979, will mark the 20th anniversary of the United Nations Declaration of the Rights of the Child. This year — the International Year of the Child — is particularly suited to this type of instrospection. IYC has put the spotlight on the situation of children all over the world and provided an impetus for child-related research. Drawing upon some of the statistics available, let us measure the rights the United Nations affirmed for children 20 years ago against the reality of their lives today.

The Preamble of the Declaration states that children, because of their physical and mental immaturity, need special safeguards and care and that individuals and groups should strive to achieve children's rights by legislative and other means. Mankind, it says, owes to the child the best it has to give.

In 1975, more than one-third of the world's four billion people were children under the age of 15. If current projections hold, there will be nearly two billion children in the world in the year 2000.

The Declaration of the Rights of the Child affirms that **all** children are entitled to special protection and opportunities and facilities to grow in a healthy, normal manner in freedom and dignity. It states that children should have the right to a name and nationality, love, understanding and an atmosphere of affection and security. It entitles them to protection against all forms of neglect, cruelty, exploitation, racial, religious or other discrimination and to an upbringing in a spirit of peace and universal brotherhood.

Yet today, millions of children are discriminated against because of their race, religion, sex, or parents' political views. Millions of others are denied affection and security. These include abandoned children, "street" children who fend for themselves in the developing world's rapidly growing cities, and those children who have been forced to flee their homeland to live in refugee camps. The United Nations High Com-