

## The Battered Child Syndrome — Some Research Aspects

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Growing awareness of violence to infants dates from 1946, when Caffey<sup>1,2</sup> described the association between subdural hematomata and fractures of the long bones in young children. The recognition almost a decade later that such injuries could be inflicted by parents<sup>3</sup> and the coining of the emotive term, "battered child syndrome,"<sup>4</sup> stirred doctors in America to recognize the alarming frequency with which such children had mistakenly been regarded as accidentally injured. Interest was aroused in England after case reports<sup>5</sup> in 1963 and the British Paediatric Association's warning memorandum<sup>6</sup> in 1966, which helped define the problem and offered guidelines for treatment. Although mandatory reporting of battered babies has occurred in America since 1961, the exact numbers of children involved are still unknown. Doctors have estimated that there are 10,000 to 15,000 cases annually in the United States, with a mortality rate of 10 per cent. In the United Kingdom, statistics are still a matter of informed guesswork, for there is no legal necessity to report cases. Hall<sup>7</sup> has calculated that there are 4,400 children with injuries of an inadequately explained nature being treated annually in hospital casualty departments.

According to Kempe,<sup>8</sup> every parent is a potential "baby basher." Fleming<sup>9</sup> has pointed out that there can be very few parents who, at one time or other, have not been exasperated beyond endurance by the behavior of their children. Fortunately for most, the expression of their exasperation stops short of real violence. Gil<sup>10</sup> has argued that because a certain measure of physical abuse of children is condoned by American culture as a "normal" aspect of child rearing, parents placed under enough pressure, however kind they may appear under normal circumstances, will batter their children.

In contrast to these recent views, anthropological evidence<sup>11,12,13</sup> shows that whole civilizations or groups of people suffering from extreme stresses, deprivations and frustrations have not lashed out and would not lash out at their children. Van Stolk, writing from a Canadian perspective,<sup>14</sup> has also challenged the belief that child battering is a regrettable and inevitable aspect of human nature under stress. She has urged that if we are to understand such abnormal behavior, the inside mechanisms as well as the cultural mechanics which create and maintain a structure of child battering must be investigated.

### Parental Characteristics: Contrasting Viewpoints

Recent observations<sup>15</sup> have suggested that battering parents are not confined to any particular personality type, intelligence level, or social class, and that "child abuse is psychodynamically related and has nothing to do with race, colour, sex, creed, income, education or anything else."<sup>16</sup> Some authors, however, have noted that most battering parents are young<sup>17</sup> and from the lower social classes.<sup>18,19</sup> Mental illness and subnormality have been observed by several authors.<sup>3,20,21</sup> In addition, Gibbens and

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Walker<sup>22</sup> mention that criminality and alcoholism are often found. In contrast, others<sup>23</sup> believe that those who injure their children are not aggressive criminals but relatively normal persons exposed to unusual and excessive stress. The view has also been put forward<sup>15</sup> that psychopathy is not a significant finding. It has been suggested<sup>15, 24, 25</sup> that baby batterers were deprived of mothering in childhood, and prematurely expect and demand a great deal from their own children. They also suggest that baby batterers have common misunderstandings with regard to child-rearing and look to the child for satisfaction of their own parental needs. Baby batterers are not, however, unique in this respect, for the same is said to apply to murderers<sup>26</sup> and other criminals.<sup>27</sup> The importance of social adversities in precipitating baby battering has also remained controversial. Some see the problem as a response to stressful social circumstances and society's permissive attitude to violence.<sup>10</sup> Others<sup>15</sup> view it as primarily a manifestation of parental maladjustment.

A vast array of environmental stresses has also been regarded as contributory. Some have commented on the frequency of out-of-wedlock pregnancies.<sup>20,28</sup> High incidences of divorce, separation and unstable marriages have also been reported.<sup>4</sup> Social isolation, unemployment, and lack of immediate support from other relatives are regarded as important.<sup>18,29</sup> Other factors considered predisposing include promiscuity,<sup>18</sup> families of larger than average size,<sup>10</sup> poverty, insufficient education,<sup>25</sup> geographical mobility<sup>22,30</sup> and inadequate housing.<sup>20</sup>

Paulsen and Blake<sup>31</sup> have cautioned against viewing battering parents as a function of educational, occupational, and social disadvantage, and have pointed out that most people in deprived sections of the community do not batter their children. In fact, some regard social, educational, economic and demographic factors as irrelevant<sup>15</sup>; instead, emphasis is laid on maladjustment resulting from harsh childhood experiences.

### **The Birmingham Child Abuse Study**

A knowledge of parental characteristics seems to the author to be of prime importance in the management of the battered baby syndrome; for, despite clinical descriptions of battered children,<sup>32,35</sup> there has been no previous comprehensive and controlled study which has included medical, social, and psychological assessments. Furthermore, previous studies have not considered the issue that some factors may be typical of low social classes in general and not particularly characteristic of baby batterers. Nor has the relative importance of various social stresses, childhood backgrounds, and methods of child-rearing been adequately assessed. The study, therefore, has attempted to reconcile diverging opinions by examining a wide variety of such characteristics and the role of social class. It has also aimed to determine whether parents who confessed to battering differed in certain respects from those who did not confess.

A detailed description of the subjects, methods and findings from the study has been reported elsewhere.<sup>36-42</sup> Over a two-year period, 134 battered infants and children, aged under five years, and their parents were studied in detail. Most children had been admitted to hospitals. All the parents who had either confessed to inflicting trauma or had inadequately explained their child's injuries were referred by consultant pediatricians to the author. These parents then underwent standardized psychiatric, psychological, and social interviews. The results were compared with a matched group of children admitted to hospitals as emergency cases.

Because the correct diagnosis is often missed, and agencies involved are still unsuspecting, this paper describes the salient features of these 134 battered children and their parents.

### **Characteristics of Battered Children**

The average age of the children was 18.5 months, and equal numbers of both sexes were

involved. The findings supported the view 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."<sup>43</sup> The battered children had a multiplicity of injuries in various stages of healing. Vague accounts – "must have knocked his head against the cot," "fell off the bed," "bruises easily" – were offered as initial explanations by the parents. Bruising to the head or cheek, a black eye without gross bruising of the forehead, a "purple ear," or fading bruises of the ear and surrounding scalp were prominent features supporting those who rate the head as an important site of trauma.<sup>19,44</sup>

Though bruises, fractures, subdural hematoma, and malnutrition are being increasingly recognized as stigmata of baby battering, little emphasis has been placed on child abuse by burning. Our finding that nearly one-fifth had serious burns or scalds, and that such children were significantly older than the remainder of the sample, support suggestions that many incidents of child abuse by burning pass for accidents.<sup>45</sup> Cigarette burns were not common, but burning of the buttocks or perineum by placing the child on a hot metal surface was a particularly striking feature – a finding also observed by Vesterdal.<sup>46</sup> The importance of skeletal surveys (repeated two weeks later if negative) was shown by the fact that nearly half also had fractures.

Mortality rates for children subjected to willful violence vary among different series – less than 2,<sup>19</sup> 3,<sup>34</sup> 11,<sup>4</sup> 25-30,<sup>47</sup> and 55<sup>46</sup> per cent. Among our cases, after excluding cases where the parents had gone to prison, the rate was 8 per cent – similar to that of Kempe<sup>4</sup> and Cooper.<sup>48</sup> Other series in the U.K. have found higher rates.<sup>7,49</sup> The commonest causes of death in 0-4 year olds are birth injuries, infections and congenital abnormalities. Apart from "accidents," battering in Birmingham in 1971 ranked next above motor vehicle accidents as a cause of death.<sup>50</sup> Fifteen per cent of the children involved developed spasticity, paraplegia and other neurological impairments that required long-term rehabilitation. Only 22 battered children were without brain damage, head injury, low birth weight, or failure to thrive. Furthermore, regardless of head injury, language retardation was found in a significant proportion of the sample, and their overall intellectual ability was lower than that of the controls, suggesting that they will be subsequently handicapped in their scholastic ability. The possibility, therefore, that battering is responsible for a sizeable proportion of mentally handicapped children needs further exploration.

Fifteen per cent of the sample had low birth weights compared with 5-7 per cent in the general population.<sup>52</sup> Several authors<sup>19,28,34</sup> have asserted that low birth-weight babies are particularly at risk from battering, and others have interpreted this as failure of bonding due to separating the mother from her child during the neonatal period. Many low birth-weight babies in this and other series<sup>19,28,34</sup> may, however, be simply explained as reflecting those maternal characteristics that predispose to delivery of low birth-weight babies – low social class, youthful and single status, and rejecting attitudes during pregnancy.<sup>52</sup> All these characteristics were prevalent in our sample.<sup>39</sup> Newson<sup>53</sup> has pointed out that responsiveness to a baby is not a simple matter of biological necessity but a general characteristic shared by many people who are not mothers. Furthermore, unfavorable mother-child relationships are related to undesirable maternal attitudes long before the neo-natal period, and to personality abnormality.<sup>54</sup> Considering also that only a few babies weighed under 2,000 g. at birth, or required long-term separation from the mother, it is unrealistic to expect that increased or improved maternal child contact after confinement<sup>51</sup> will substantially reduce the risk of subsequent battering.

No support was found for suggestions that difficulties during pregnancy, labor or after birth<sup>15,19,30</sup> are responsible. Most mothers had normal confinements, and only a few babies were battered during the post-partum period. Indeed, many mothers had long-standing emotional and personality problems and<sup>37</sup> displayed rejecting attitudes towards their children irrespective of perperal factors.<sup>39</sup>

Milowe and Lourie<sup>55</sup> have suggested that some children are particularly at risk and unwittingly invite physical abuse from their parents. Our results<sup>38</sup> showed that battered children were in some respects lethargic, and that difficulty, especially crying or clinging behavior, was encountered by the mother and may have precipitated battering. However, after spending some time in the hospital, they were no more irritable than the controls, suggesting that such difficult behavior results from interaction with a neurotic mother.

### Characteristics of the Parents

The mothers were found to be young (average age 23.5 years). They were also nearly four years younger than the national average when they gave birth to their first infant, suggesting that battering is associated with youthful parenthood.

The infrequent occurrence of battering in older parents with large families observed in this and other series<sup>21,56</sup> also suggests that the risk of child abuse diminishes with parental age. The parents were predominantly from the lower social classes (three-quarters were from social class IV and V compared with about a third in the general population).

Lack of family cohesiveness was found to be an important factor underlying baby battering. In more than one-third of cases the biological father was absent from the home, and in half the mother was living with some other man. Half the mothers had married before the age of 20 years and three-quarters had conceived pre-maritally, such a combination being particularly likely to lead to marital breakdown.<sup>57,58</sup> Several other predictors of divorce<sup>57</sup> were also prevalent among the baby batterers — short acquaintance before marriage, disharmony in child-rearing, dissatisfaction with the partner's handling of the child, and neurotic and personality disorders — suggesting that a substantial number of battered children will eventually grow up in broken homes and be at risk of social maldevelopment. Considering that fatal battering occurs where young, unstable, deserted and unhappy women associate with young, psychopathic, and criminal men,<sup>59</sup> and that such parents were over-represented in our sample,<sup>37</sup> it may be concluded that battered children are at risk not only of social maldevelopment, but also of death.

Pre-marital conception and illegitimacy were important precursors of baby battering, the rates of occurrence being two and three times respectively higher than the general population rates.<sup>39</sup> Considering that high proportions of out-of-wedlock pregnancies are unwanted,<sup>54</sup> that illegitimacy occurs in 60 per cent of fatal battered baby cases,<sup>33</sup> and that the inconvenience of an unwanted and illegitimate child was the most common motive responsible for child murder,<sup>60</sup> it might be argued that the most effective way to prevent child battering is to prevent unwanted births. Indeed, several authors<sup>10,61</sup> have suggested that prenatal training for motherhood, ready availability of contraceptives, abortion on demand, and encouragement of sterilization after the birth of the third child can be important factors in the prevention of child abuse. However, though society may facilitate or impede the availability of abortion of unwanted conceptions, the evidence suggests<sup>62,63</sup> that abortion will produce a reduction in unwanted births only if the motivation for limiting family size already exists. The same argument holds for sterilization.<sup>54</sup> A significant proportion of battering parents expressed a negative attitude towards contraception, and only 12 per cent of mothers had considered an abortion during the relevant pregnancy. This information indicates that the preventive methods mentioned above,<sup>10,61</sup> admirable though some of them may be, will have very little impact in preventing baby battering. The author's pessimistic view that such parents are ineffective in and distrustful of birth control is shared by others,<sup>64</sup> and is also supported by our other findings<sup>39</sup> that the baby batterers, unlike the controls, were well on the way to perpetuating the large size of their family origin.

Several interesting psychiatric features emerged. Three-quarters of the mothers and

two-thirds of the fathers had abnormal personalities. The less severe types of personality disturbance were more commonly found among the mothers who, in general, had features of emotional immaturity and dependence. Nearly half were of sub-normal intelligence. Battering may at best be regarded as an ineffectual method of controlling a child's behavior, and perhaps techniques of teaching child-rearing skills based realistically on the mother's low intelligence should be explored further as a possible means of correcting such ineffectual parenting.

The fathers, however, were of normal intelligence. One-third of them, however, were psychopaths, a finding which contrasts strikingly with Kempe's statement<sup>16</sup> that psychopathy is a feature in only 2 or 3 per cent of battering parents. The high proportion of psychopaths, a hard core group difficult if not impossible to treat, has also been observed in other studies.<sup>59,65</sup>

Nearly one-third of the fathers (and a significant proportion of mothers) had criminal records, usually for larceny. Nine per cent of the fathers had committed crimes of violence and five per cent had been convicted for serious sexual offences. Recidivism was also a feature of these parents. Though 19 per cent of the children's siblings had also been battered, only one per cent of parents had been charged with cruelty or neglect, a finding that highlights the capriciousness of the legal system towards parents who batter babies. Criminality and recidivism, particularly if associated with a psychopathic personality, should caution against an optimistic outcome, and in the author's view invoking a care order is essential if further battering incidents are to be prevented.

Nearly half the mothers were neurotic, the usual symptomatology being an admixture of depression and anxiety. One-third reported having an unhappy childhood. In general, neurotic mothers (in contrast to psychopathic fathers) confessed to harming their children and expressed willingness to discuss their difficulties further. For this particular group of mothers, the combination of symptomatic relief with a program of social relearning conducted by skilled therapists seems to the author to be far more beneficial than relying on programs of 'mothering' and other methods<sup>66</sup> that tend to reinforce their dependent behavior.

Only a minority of battering parents were obviously mentally ill. The bizarre nature of the injuries inflicted by these suggests they form a separate sub-group among baby batterers whose management must differ accordingly.

### **Management Aspects**

Recent comments<sup>67</sup> have suggested that social workers have been 'too soft' and have often misjudged situations because of their enthusiasm for keeping the child and family together. Medical personnel are, however, also reluctant to notify authorities, particularly if they consider that such action might result in parents being prosecuted. This reluctance may, of course, partly be due to the fact that medical and social welfare considerations on the one hand, and legal rights and safeguards on the other, are often hard to reconcile. However, by reserving to themselves this discretion of whether to pass on relevant information, the doctors or social workers concerned may deprive the child of his legal rights to protection.

The results showed a failure to ensure the protection of the child.<sup>40</sup> It was disconcerting to observe that the majority of cases were not brought to the attention of the juvenile court, reliance instead being placed on voluntary supervision. In view of the high mortality and morbidity reported in this and other series,<sup>7,23</sup> and the high frequency of re-battering that occurs, it was alarming to observe that no arrangements for supervision took place in 21 instances. It is the author's contention that local authorities are failing in their statutory role of protecting the child by being reluctant to institute care proceedings.

The quality and quantity of supervision available vary in different areas, and may, of

course, influence a local authority's plan of management. Nevertheless, supervision, whether it be voluntary or by court order, does not overcome the inherent difficulty in managing these cases, namely that no supervisor can be with the child or his family for more than a fraction of the time.

Social workers, in their desire to help parents and keep families together, may embark upon a program of casework. Considerable emphasis has been placed upon intensive casework with families since the passing of the Children and Young Persons Act, 1963. The success of this work has never been systematically evaluated. Furthermore, management at present is hampered by the local authorities' practice of imposing a dual role on the social worker. By appearing as the person who has made an application to deprive the parents of their parental rights, the social worker finds his task of establishing and pursuing a therapeutic relationship made even more difficult. In the light of the findings from this study it is already apparent that casework will not succeed in many instances and that trusting the parents unduly may have damaging consequences to the child.

Management of the problem has in the past too often been plagued by a tendency to rely on the case conference on the assumption that discussion alone is in the child's best interests. It has been the author's experience, however, that this method is often extremely inefficient, and perhaps a hospital-based regional team, consisting of a pediatrician, psychiatrist, social worker, and psychologist, should be established to tackle the overall problem.<sup>33</sup> Such appointments would perhaps improve the poor liaison that presently exists among the various agencies which concurrently and sequentially are involved in managing a case. It would also circumvent the unilateral action that often occurs through these agencies and go some way toward overcoming the present practice of returning the children to homes where re-battering takes place.

### **Concluding Comments**

In terms of morbidity and mortality, the battered child is a problem of major concern to society. Studies have shown<sup>64</sup> that the tendency to perpetuate child abuse in successive generations is not diminished by supplying extensive medical and social help to battering parents. Furthermore, 60 per cent of children who are returned home are re-battered!<sup>9</sup>

While every effort must be made to rehabilitate battering parents, this effort should not be at the expense of the safety of the child. The findings from this study also suggest that strong consideration should be given to permanent removal from parental care in those cases where, after an overall psychiatric assessment, the likelihood of parents responding to treatment is thought to be remote.

The results showed that when a variety of social and economic factors are carefully examined,<sup>39</sup> baby batterers are observed to be far less handicapped than previous studies have indicated. Furthermore, when placed alongside the high incidence of personality disorders, anomalies of status and youthfulness of the parents, socioeconomic support to such families will be meaningful only if included in a program of adaptation to such handicaps.

These findings also suggest that it may be wrong, even dangerous so far as the children are concerned, to rely too heavily on seemingly facile explanations of why parents batter their children. There is an over-ready tendency to assume that battering parents have experienced inadequate mothering in their own childhood and are, therefore, recreating in their own child-rearing practices the same maltreatment that they themselves experienced as children.<sup>15</sup> This superficiality should be avoided. Retrospective assumptions of this kind are attractive in that they are difficult to disprove. They are also, however, equally difficult to prove. To assume that all such parents or even the great majority can be adequately treated by "a transfusion of mothering," as has been

suggested,<sup>66,68</sup> may not altogether be justified, and in the light of the findings may even be dangerous to the children concerned.

The similarities between baby battering and other forms of deviant behavior are striking. Like delinquency and crime in general, baby battering occurs alongside a constellation of other social inadequacies or failure of adaptation rather than occurring in isolation. Such considerations might save some disappointment and wasted effort.

Innumerable studies of deviant behavior have been remarkably unrewarding in establishing either causes or treatment. Battering parents must first be properly classified and the natural history of the condition closely observed before we can be confident about treatment measures other than emergency action. Indeed, no study has convincingly shown that any treatment of battering parents is effective.

Child abuse has elicited spasmodic public concern for nearly a century, and yet no child protection service has so far developed that adequately meets the scope of the problem. Responsibility rests with local authorities and voluntary organizations, whose roles in some respects are complementary but in others may not always be harmonious. Both agencies rely heavily upon inexperienced and possibly inadequately trained social workers who are as yet ill-equipped to deal with these difficult cases. The past year has again witnessed a depressing number of children who have been battered to death following decisions by social workers to return the child home. The findings from this study indicate that such authority should be curtailed. Indeed there seems to be a strong case for setting up specialized hospital teams to carry out full assessments, giving priority to the safety and health development of the child. Such a team would be guided by the ethical consideration that governs all doctors — the child is at risk, the child is the patient, and all other considerations are secondary.

The results of this and other studies broadly delineate those groups in the community which are most likely to encompass child abuse. Furthermore, the findings support Polansky's view<sup>69</sup> that this is "an area in which social, medical and legal action must be authoritative, intrusive and insistent." As with crime and delinquency, treatment is likely to be only a supporting exercise. Prevention may lie in the effective education of the next generation and in changes in child legislation. Without expert approaches to these problems, it is apparent that nearly all abused children are at risk of physical, educational, and social maldevelopment, or of death.

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