Battered Child Syndrome in a Malaysian Hospital

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THE HELPLESS, dependant child has been a scapegoat and target for displacement of anger for adults. Medical interest in this phenomenon has been of recent origin. Caffey (1946) described characteristic traumatic bone lesions in six infants who suffered from subdural hematoma without history of non-accidental injury. Clinical features of the battered child syndrome include superficial bruises, damage to the epiphyses of long bones presenting with swollen painful wrists, fractures of long bones with subperiosteal elevation and reaction, rib fractures and abdominal visceral injuries. (Kempe, et al, 1962; Fleming, 1967 and Touloukian, 1968, Bwibo, 1970). Head injuries are common; may be associated with chronic subdural haemorrhage, brain-injuries leading to mental retardation or neurological features simulating neurological disease. (Caffey, 1946; Gregg & Elma, 1969 and Baron, Bajar and Sheaff, 1970). Apart from beating, whiplash-shaking and jerking of abused infants were common causes of the skeletal as well as the cerebro-vascular lesions; the latter was the most serious complication and by far the most common cause of early death. (Weston, 1965 and Caffey 1972) The psycho-social aspects of the battered child, his family and the abuser(s) are important factors in the presentation and management of this syndrome (Steele, B. et al, 1968). No cases have so far been reported in Malaysia and Singapore.

Aim of this Study

To stimulate interest in the diagnosis and management of a syndrome which often indicates a much larger, but ill-defined problem of deprivation and disturbed maternal-child interaction.

Methods of Study

All the battered child syndrome known to the Pediatric and Medical Social Work Unit, University Hospital, Kuala Lumpur, since its establishment in 1967 till December, 1973 are included in this study. We reviewed both the social case notes and the medical records of the children. The data were collated – using the guide-lines in the California Pilot Project for the study of child abuse (Gil, 1968).

Findings

(a) *Incidence*

A total of seven cases were collected – the annual cases being: 1971 (2 cases), 1972 (2 cases), 1973 (3 cases).

The annual paediatric admissions at the University Hospital, Kuala Lumpur were 1968 (606 patients) 1964 (1336 patients), 1970 (1,653 pattents) 1971 (2,191 patients), 1972 (2,214 prtients) and 1973 (2,224). Outpatient attendances were 1968 (2,126 patients), 1969 (4,686 patients), 1970 (5,772 patients), 1971 (4,547), 1972 patients (4,608 patients) and 1973 (5,148 patients). All the inpatients were also included under outpatients when they were seen just prior to admission.

(b) *Presenting medical complaints and examination findings* (Table 1)

Initial source of information: The grandmother of case 1, complained that her daughter, an unwed mother, physically abused and poured hot water on the child. The father of case 3, during his weekly visit to a baby-sitter, found

that this son had bruises all over his body. The neighbours informed him that the baby-sitter and some of her children had beaten the toddler. A friend informed the biological parents of case 4 that the child was physically abused.

Team effort in diagnosis: Medical suspicion of abuses of cases 2, 5 and 6 were confirmed when family members were interviewed. A social worker first suspected and later confirmed that case 7, born prematurely (birth weight: 3 lbs.) during a flood, was physically abused by the mother. The child was referred initially for social management of malnutrition.

(c) Characteristics of the child's family and the abusers. (Table II).

(d) *Management* (Table III)
As management of the abused child is a complex socio-medical problem, all the patients were referred to the Medical Social Work Unit. But the Social workers never had a chance to meet the mother of case 1, the only outpatient in this series and case 2 who was referred to her when she was on leave. The mother of case 1 did not respond to a letter requesting her to come for an appointment. A letter to case 2 was returned because there was no such address.

Discussion

Legal situation and case detection

In our country, under the Young Persons and Children Ordinance, 1957, suspected cases of ill-treatment may be reported to a welfare officer or the police. Generally, the police refer the cases to the state Social Welfare Offices for investigation and management. None of our seven children had prior contact with the police or Social Welfare department.

In America, in spite of explicit legal protection for people who reported suspected cases of child abuse, some doctors have doubts about contracting the agencies concerned or referred the children to hospital Silver et al, (1969), through a retrospective review of 52 suspected instances of child abuse at Childrens' Hospital of the District of Columbia and with information obtained from consultative work with physicians confronted with such cases, attempted to explore the "gray areas" which made it difficult for the physician initially in evaluating a patient to establish or reject, the diagnosis of child abuse. He classified the types of cases or situations which confuse the physician as followed: (1) the subjective interference; some doctors admitted that they did not believe a parent could abuse his or her child. Others felt that it was not useful to report cases because the community agencies did not get involved or did anything useful. (2) The benefit of the doubt; some felt that the parents might be telling the truth in denying a history of injury. The history of trauma may be negative because the informant is unaware that the child had been injured, e.g. if the child was injured by someone else or out of the parents' presence. Concern about (3) the responsibility for the act and (4) parental privilege to punish and (5) allowance been given to the effect of alcohol may contribute to doctors not reporting the cases to the agency concerned. If doctors avoid having to decide about whether the parents are guilty or not, but concern with what best can be done for the child and family, the last three situations should not prevent him from reporting the cases.

Characteristics of the victims

Age: Four of the seven battered children were below 3 years old. Seventy-eight percent of the 132 children in the Children's Hospital, Winnipeg, Canada, 1957 to 1971 were below 3 years old. (McRae, et al, 1973).

Child's role which contributed to the attack: The mother of the child No. 5 was unable to cope with child's stealing, lying and truancy. Case 7 was a premature baby. Six of the 132 Canadian children had behaviour problems.

Medical Complaints and Findings

Six of the seven children had bruises. McRae et al (1973) noticed bruising in 54 of the 132 Canadian battered children. Although blood clotting studies were mostly negative, they recommended that these be done routinely to forestall any query in a medico-legal case. No blood clotting study was done in our patients.

Three of the seven children had skull fracture while a fourth child had a fractured humerus attributed to a fall.

Characteristics of the Abusers:

The abusers are frequently adults, but occasionally may be a child.

(a) *Adult:* Except forcase 5, all the families involved were from thelower social economic class. Smith, et al (1973) nia controlled investigation of 214 parents of battered babies showed that they were young and predominantly of lower social class. Among the mothers, 76% had an abnormal personality and 48% were neurotic. Nearly half were of borderline intelligence; 11% had a criminal record.

Table I
Medical Complaints & Injuries Sustained

Case No.	1	2	3	4	5	6	7
Sex	F	F	M	F	M	F	M
Age	6	4	2	1	5	11 months	1+
Ethnicity	M	C	I	C	C	I	I
Medical Complaints	Pain, R knee	Vomitting* Abdominal pain	Bruises	Bruises	Motor vehicle accident	Fell down 4 days ago	Sores all over body – 6 months
Injuries Sustained 1. Bruises	R thigh	face, chest & hip	chin, body & limbs	face & +	cane marks, body	Both cheeks	Nil
2. Haematoma	Nil	Nil	R parietal infected	frontal & left temporal	Nil	L parietal	Nil
3. Skull-fracture	Not X-rayed	Not X-rayed	R parietal	occipital	Not X-rayed	Both parietal	Not X-rayed
4. Abrasion	Nil	Nil	Yes	Nil	Nil	Nil	Nil

*Coffee Brown vomitus with blood clot
+ Left periorbital oedema

Table II
Some characteristics of abusers and family

Case No.	1	2	3	4	5	6	7
Relationship to child	Mother	Mother	Baby-sitter	Foster-brother	Father (separated)	Grand-mother*	Mother
Age of abuser (Yrs.)	19	30 +	30 +	7	30 +	40 +	23
No. of children in family (where child stayed)	Nil	5 sibilngs	7 (children of baby-sitter)	1 (the abuser)	3 siblings – beaten up by father too.	4 siblings	3 siblings
Occupation of biological father	Unknown	Unskilled worker	Tapper	Odd-job	Odd-job	Contract labourer	Odd-job

*The father was either out of town or not at home. Her mother was very submissive to the grandmother. Both the grandparents who stayed next door, were alcoholic.

Table III
Management of Six Abused Children

Case No.	1	2	3	4	5	6	7
Associated findings	Hb: 12.3 G	Hb: 10 G	Hb: 8.4 G	Hypothyroi-dism	Hb: 12.4 G	Hb: 12.1 G/ (Mal-nourished)	Hb: 8.6 G/ (Mal-nourished)
Skeletal survey	Not done	Normal	Normal	Not done	Not done	Normal	Not done
Specific Treatment	(Out-patient)	I.V. fluid aspiration	Syrup peni-cillin & Cloxacillin	Nil	Nil	Social stimulation syrup bacterium	Crystalline penicillin
Contact with parents by Social Worker	No	No	Yes	Yes	Yes	Yes	Yes
Follow-up/ Readmission	Not given	Defaulted	Defaulted again inspite of reminder	Defaulted	Defaulted	Follow-up 3 times*	Yes

*She had an earlier admission from 28.11.72 – 3.1.73 for failure to thrive and bronchopneumonia. Two readmissions after detection of physical abuse:
1. July 1973 URTI & gastro-enteretis
2. Sept. 1973 admitted again for 1 day, fit, haematoma of R parietal– occipital and behind left ear found "due to fall during fit".

Off the athers, 64% had an abnormal personality, more than half being psychopaths; 29% had a criminal record. Revidivism was an associated feature.

In a psychiatric study of 32 men and 7 women convicted of cruelty with violence, Gibbens and Walker (1956) concluded that it was rejection, indifference, and hostility rather than cruelty in their own childhood which made cruel parents. In two-thirds of these cases, the living conditions were reasonable and sometimes good. This and other studies suggest that there is some overlap in the social and psychological elements that produce neglect or cruelty.

Terr (1970) found that important factors leading to abuse were fantasies of the abuser about the child, exaggerated dominant-submissive patterns in the marriage, and contributions of the child to the battering.

(b) *Child:* Case 4, who had a skull fracture, was allegedly battered by a seven year old foster brother. Adelson (1972) reviewed five infants, all less than one year old, who were killed by children 8 years or younger. None of the victims showed any stigmata of adult "battering" in the form of multiple, non-lethal metasynchronous trauma. Adult involvement in the fatal terminal episode was excluded by thorough police investigation. A preschool child is capable of homicidal rage when he is provoked by what he considers to be a threat to his sense of social security in his family unit or immediate human environment.

Management and Follow-up

The medical management is fairly clear cut. The social management – including counselling to parent-figures and teaching of child-rearing proves difficult. In many cases they avoided any further contact with the hospital as shown by the high rate of defaulting of follow-up.

Case 6 had a re-admission when she fell down during a fit and sustained a fracture of the right parietal bone. Just prior to the re-admission of case 7, he fractured his humerus during a fall.

Placement of the child to prevent recurrence of another attack needs planning. The grandmother took child No. 3 to her home after the incident at the baby-sitter's home. The real parents took back child No. 4 from the foster-home after the incident. Case 6 was fostered after the child's parents repeatedly requested foster-care and the child's physical condition deteriorated.

Morse, et al (1970) followed up 25 children from twenty-three families for three years after hospitalization for injuries or illnesses judged to be sequellae of abuse or gross neglect. During this follow-up period, approximately one-third of the children had again been suspected of being the victims of physical abuse or neglect. An assessment of intellectual, emotional, social and motor development disclosed that 70% of the children were judged to be below normal range, though often mental retardation or motor hyperactivity was thought to have preceded the abuse.

An Appeal to Medical Practitioners and Others

Seven cases of battered child syndrome within a six year period, with all these cases clustering in the last three years, may indicate that we are missing some cases. These seven cases include six with bruises, three with skull fracture and one with abdominal injury show that we are diagnosing mainly the severe degree of non-accidental injury to children. Among the resolutions passed at a Conference of multi-disciplinary workers concerned with the non-accidental injury to children was an appeal to hospitalize a suspected child immediately (B.M.J., 1973). This will allow time for medical and social investigations and management and probably, avoid a repeat assault. Currently, a service cum research orientated project is being carried out in Hospital Besar and University Hospital, Kuala Lumpur. The Family Counselling Service in the Social Welfare Department had been launched. The authors hope that in Kuala Lumpur, suspected cases will be referred to Hospital Besar and University Hospital for admission while all over Malaysia, suspected cases may be referred to the District Hospitals and State Social Welfare Officer. The general practitioners' alertness to these problems will prevent the hidden morbidity and occasional death in this syndrome. We hope that families need not be proved guilty in order to receive help for their children.

Summary

Between 1968 and 1973, seven battered child syndromes were treated in the University Hospital, Kuala Lumpur. All the seven children were seen between 1971 and 1973. The clinical features include bruises, scalp haematoma, radiological evidence of fractures of skull and abdominal visceral injuries. The history of assault was available at admission in three cases while the suspicion was confirmed later in the other four. Three of them were under three years old. One of the abusers was a 7 year old boy. The families concerned frequently did not bring their children for medical and social follow-up. The importance of team work

between the doctors and social workers, and hospitalization of the suspected child at the initial stage, were stressed. An appeal to medical practitioners and others for co-operation in detection of cases was made.

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