A Battered Child

by

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Introduction

Physical punishment of children by parents and adults has been justified over the ages in the belief that it is necessary to incalculate discipline in children. But the dividing line between "acceptable" punishment and child abuse has been vague and has always depended on the culture and mores of the society involved. It is also an emotionally charged issue as a case of "Battered Child Syndrome" would normally arouse the anger, abhorence and censure from the observer. As defined "Battered Child Syndrome" is "non-accidental physical assault or injury, minimal or fatal, inflicted on children by others caring for them." (Gill, 1968). This paper hopes to illustrate the psychodynamics of a family with a battered child and the problems arising from its management.

Case History

Jill, a six year old twin girl was brought by her mother to a local doctor. The mother had complained that Jill was unable to cope with kindergarten and wanted to know if she could start normal school in a month's time. She also complained that Jill was disobedient and stubborn. She was referred to a University Hospital, for investigation of behaviour problem and suspected Battered Child Syndrome.

At the first interview, both parents described Jill as a very difficult child. She had been the source of great distress since birth, especially to the mother.

Her mother had planned for the second pregnancy. She was pleased to have a girl when the first twin was born but was surprised that a second child was on the way.

Jill, weighing 3 lbs. 10 ozs. could not suck and had to be tube-fed and nursed in an incubator. Her mother doubted if she could live. She was upset and ashamed that Jill was a difficult child who cried and screamed continously. Pat, birth weight 4 lbs. 8 Ozs., was discharged after one month in the maternity home. Two months later, when Jill was 5 lbs. the mother had to accept her home after a staff of the maternity home had paid her a home visit to insist again on Jill's discharge. A servant had left one month earlier.

A week after Jill's return, the father was suddenly called away in his line of duty. The mother had to care for the three children. Tom, the eldest, (one and a half old) was beginning to crawl and walk. The mother was under severe stress at this crucial time. She slapped and shook Jill whenever she cried or refused her feeds.

The father returned five months later. Her mother said that Jill destroyed her toys, tore curtains, was messy and untidy, soiled her pants, had to be coaxed to eat and was generally unresponsive to her demands. The mother viewed this as Jill's stubborness and defiance of her. She slapped, shook, punched and caned Jill until her anger was dissipated. This occurred several times a day or a week.

Jill for the past one year, had not been able to

cry and did not attempt to hide or run from the beatings.

When Jill was four years old, she sustained a fracture of the left femur. The parents said that they knew of the fracture three days later when they noticed her limping. They denied any knowledge of the cause. Jill's brother said she fell off a swing.

Six months ago, Jill sustained a two inch incised wound, muscle deep, on her right forearm. The mother told the father that she had cut herself accidentally. Jill herself on the second day of admission to the present hospital said her brother cut her. But after Jill had been warded for sometime, and on being reassured that what she said would not be conveyed to her mother, revealed that her mother had cut her on the forearm. The father admitted later that he had suspected his wife but had not wanted to confront her on this.

Jill also was able to show the ways she was beaten including mimicing the strangle hold her mother had requently used on her neck.

Developmental Milestones and Mental Status of Jill

Jill was a full term twin delivery. She weighed 3 lbs. 10 ozs. There was no history of respiratory distress after birth but she was unable to suck.

Her earlier milestones were not available but she talked at 18 months (one to two words) and walked at over two years. Her twin sister was ahead of her at all stages of development.

Jill had attended one year of kindergarten and could only count to three and recall her alphabets up to E. Her twin sister was able to count to ten and recall all alphabets.

Jill's verbal ability was adequate to answer most questions.

She was a friendly girl, mixing well with the other children in the ward, but did not form any attachment to the children or nurses.

She was not depressed even when the parents left the ward. There was no expression of any acute distress.

Her behaviour in the ward was contrary to the history of the mother. There was no temper tantrums, no destructive behaviour, she was contented and ate well. Significantly, the responses of the nurses were that the was a well behaved child.

Physical Examination

At three feet four inches and thirty pounds, Jill was below the third percentile in both height and weight. Her skull circumference was 21½ inches. She looked wizen.

There was multiple small scars on the abdomen and neck. Those on the neck looked like nail scratches. There was a scar of an incised wound on the right forearm and a callus formation on the left femur.

She walked without a limp. Other systems were nromal.

Investigations

Routine blood examination and urinanalysis were normal

V.D.R.L. was non-reactive

X-rays of the chest, skull, right forearm were normal.

Blood Group A, Rhesus positive

(Twin sister blood group AB, Rhesus positive).

Family dynamics

The father, 32 years old, was a passive, soft-spoken man. He appeared calm and collected and resigned to the fact that his wife used to beat Jill. He was well educated and held a responsible job. His duties took him away from home for months at a stretch. He was brought up in a large family and his father was a retired school teacher who did not believe in caning his children.

Jill's mother, 34 years old was an obsessional woman and expected her children to respond to her demands exactly. Her husband described his reaction to her obsessive nature of demanding him to put his shoes in order as "I still can't get used to it". She had been educated till her L.C.E. and had worked as a clerk before marriage.

Jill's mother complained that her husband had not really helped her to care for the children as he was away from home for long stretches and also that when he was home, he preferred to stay out after work.

Her childhood was described as a happy one. Her own father had been a quick-tempered man and used the cane on his children though it was not frequent.

Jill's father in a separate interview, revealed he preferred to stay out as he did not want to inter-

fere when Jill was beaten. Many years ago, he had attempted to, but had got into quarrels with his wife who would then unleash further abuse on Jill or accuse him of investing Jill with his bad characteristics. She claimed that the two other obedient children had inherited her qualities. This made him angry. Though passive, he could and did make his wife angry but being silent in quarrels and made insulting remarks to his wife after she had calmed down.

The older boy was very much a mother's boy. He was very obedient to her and helped her with housework. The other twin was also more responsive towards her.

Management

It was realized at the earliest that management of Jill involved counselling the parents, especially the mother.

Jill was given a psychological test (McCarthy's Scale) and found to be handicapped in all major areas of functioning with an overall Intelligence Quotient of 67. Based on this finding and Jill's present difficulty to cope with kindergarten, it was decided that she could not attend normal school but would need specialized schools or more individualized teaching. Her twin's score was higher by about ten points in all scales with an overall Intelligence Quotient of 85. This was discussed with the parents and they accepted this.

Jill was referred to the pediatrician but except for her small physique and under weight, she was normal physically. All investivations were negative too.

The role the parents played was discussed with both parents and throughout the discussion, no attempt at fault finding or censure was made. Both parents were assured that the doctor understood the difficult period they had with Jill. It was stressed that the management of Jill would need the involve- of both parents and especially the mother as she was with Jill most of the time. The father had said he was urgently required back in another state on exigency of service. The mother said that she could not stay without the father. Both parents left the Hospital. It was difficult to engage the mother in any form of therapy. Attempts to prolong both their stay were fruitless.

There was time for only one two-hour session with the mother on the second day of Jill's admission and another two-hour session with the father when they returned after ten days.

In the interview with the mother, it was pointed out to her that Jill was unlike a normal child in that she was not very bright and would not respond as expected. It was pointed out to her that perhaps her expectation of Jill was based on the responses of Pat who was smarter and that Jill might not be able to come up to her expectations. It was pointed out also that Jill had been a difficult child to care for, and could test the patience of most mothers. It was suggested to her that future handling of Jill would need to take into consideration that Jill was a "slow" child.

Her own feelings about her husband were discussed. She felt that he could be more helpful in helping to care for the children. She was resentful that he was not at home evenings.

In a separate interview with the father, he revealed he had suspected his wife of physically abusing Jill but had not wanted to bring this up with her for fear of her response. He admitted to leaving the home in the evenings in order not to hear her nag him about the children. It was suggested to him that if his wife was unable to obtain attention and assurance from him, she could turn to the children for attention and Jill being unable to respond as the other two children could, might well be the source for her to vent her anger. It was suggested that if he could improve their interaction, the family as a whole and Jill in particular would benefit. It was suggested that further sessions with him and his wife could be useful.

There was only one session with both the parents and at this session, the future of Jill was discussed. A specialized day school for the mentally retarded was advocated. The placement of Jill was discussed and three alternatives were available:

(a) to stay with parents
(b) to stay with foster parents
(c) to stay with grandparents in another state, X.

The last option was most favourable with the interests of Jill's education in mind as there was a mentally handicapped children's school in X, 200 miles away from home. Secondly, the grandparents who also stayed in X, had volunteered to care for Jill a few years ago.

The parents decided to think it over and left for home. About five days later the father returned

on his way home from a service trip and wanted to take the child back. They had decided to allow Jill to stay with her grandparents but he was too busy to arrange this as yet. It was pointed out to him the danger of Jill being further assaulted on returning home and he promised to keep a closer eye on the child. An appointment was fixed for both parents to come with Jill at the earliest convenient time for follow-up, though the father had reservations if his wife would come. When the child goes to stay with her grandmother, the local social worker shall be contacted regarding follow-up.

Discussion

A battered child does not exist alone. There must be a battering parent (or others) and a family environment to conceive and perpetuate the abuse. Each parent's intrapsychic functioning and the family interaction as a whole has to be under stood.

Jill was brought to a local doctor for her behaviour problems and for assessment if she could attend normal school as the parents had felt she was retarded. On routine physical examination, he noticed that the child had multiple scars on the body and was stunted in both height and weight. Suspecting child abuse and aware of the problems involved in confirming the diagnosis, counselling of the parents and fear of recurrent abuses. the doctor referred her here for hospitalization and further management. On going further into the history, it was revealed that the child had been physically abused by the other, and that one was dealing not only with a mentally retarded child but also an abusing mother.

The contribution of Jill to being abused could not be ignored. Her birth was unexpected. She was born with maturation handicaps of being unable to suck, and was so sickly, she had to be nursed in hospital for three months. She was also a difficult child then as her screaming had upset nurses and mother, who had felt this was Jill's rejection of her. It was interesting to note that Pat who was raised in the same environment but without Jill' handicap, was not abused.

The separation of mother and child for three months might have hampered the development of attachment of mother to the child too. At the end of three months, the mother was strenously trying not to take Jill home. Maternal deprivation could have contributed to Jill's poor intellectual ability. M. Rutter (1972) in his review of maternal deprivation stressed that poor child-parent interaction contributed to intellectual impairment.

When she was eventually pushed home, the mother was in a state of severe stress. She had no servant or relative to help care for the one year old boy who was beginning to crawl and walk. There was the other twin to care for and to addition, the husband had to leave on service immediately. She even had fears of her husband being killed on duty. Jill, a difficult child with feeding problem and who cried easily aggravated her mother's insecurity and anger.

The mother herself, an obsessive, demanding person, expected her children to conform to her needs and wishes. Steele and Pollock (1968) stated "an obssessive-complusive character structure" being "one of the potent accessories in instigating as" abuse . The abusing mother expects the child to gratify her wishes, at the same time ignoring the child's own needs. Jill's mother had expected that "eat is eat", "sit is sit". Her two other children especially the son had been able to respond but not Jill.

Jill's mental retardation had made her less responsive to her mother's demands. Mental retardation, as other factors, like health status, illegitimacy, sex, time of birth, facies, could be a contributing factor to being abused. Morse (1970) found 43% of abused children to be mentally retarded.

The mother had not been subjected to abuse as a child, though it had been observed that some battering parents had also been abused in childhood. But her own mother had also been obsessional. Identification and at the same time conflicts with her own mother might have occurred but the reluctance of being involved in therapy had aborted any attempt at exploration in this area.

The father had played a passive role and this passivity had an element of condoning his wife's actions. It is not unusual for the non-abusing parent to consciously or unconsciously instigate abuse. In this case, the father had realized that any interference on his part might unleash more assault on Jill or a quarrel with him and he undertook to stay away from home. It could be his guilt feelings in not interfering that led him to spending more time with friends. But he did realize he could make his wife angry and had on occasions done this with intent.

Child abuse, is not an entirely psychiatric condition but a psychosocial one as well and the social worker can contribute in managing the case. But in Jill's case, there were difficulties to involve the female social worker as both parents did not stay in Kuala Lumpur and they attended the hospital only on brief visits. There was no time at all. But it was realized that a female social worker could participate as a co-therapist, in dealing especially with the mother who might have been more comfortable in talking to a female in some areas. It was also realized that home visits could be better be done by the social worker and to be on the spot to give advise to the mother on handling the child and to provide a good mother figure for her to identify with.

The Battered Child Syndrome involves not only the medical profession, but also social and legal agencies (Woon, et al, 1974). But it is the responsibility of the medical profession to assume leader-ship in this field. The doctor is in a position whereby he is the first person most likely to come into contact with these cases. Understandably, this puts him in a difficult position in dealing with the abused child and his parents. He may have to assume the roles of marriage counsellor, social worker, psychiatrist and possibly a witness in court. This may even be more difficult if he is also the family physician and had been caring for the family for many years. But his responsibility is for the welfare of the child and if a physician is emotionally involved with the family, an immediate referral would be essential, bearing in mind that 10% of battered children die and one-third of the remainder may be abused again. (Kempe, 1974: Morse et al, 1970).

Summary

A six year-old girl was brought by her mother to see a local doctor for advice on placement in school and behaviour problem. There was an inconsistent history of fracture of left femur at four years old. Physical examination revealed numerous scars on the neck and body. There was a linear, two-inch scar of a deep incised wound on her right forearm. The doctor referred the child to a hospital for the management of her presenting problems and suspected battered child syndrome. Management included an evaluation of the physical, social and psychological aspects of the child, the personality and behavior of the mother and the child's environment, viz. her father, her siblings, their family interaction and the social environment.

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