THE CHARACTERISTICS OF THE FAMILIES OF PHYSICALLY ABUSED CHILDREN

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To Francoise

"The iniquity of the fathers shall be visited upon the children, and upon the children's children, unto the third and to the fourth generation".

Exodus 34,7.

CONTENTS

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ABSTRACT

The study sets out to test the hypothesis that the families of physically abused children will show significant differences regarding their psychological, psychiatric and psychosocial characteristics when compared to families who do not have an abused child.

The Index group was formed from 49 physically abused Coloured children and their families who were referred to the Red Cross War Memorial Children's Hospital in 1977. The ages of the children ranged from 5 months to 13 years, and 4 died as a result of their injuries. The Control group comprised 24 Coloured children (and their families) who were attending the hospital as outpatients over the same time period, and who were ill enough to be kept for overnight observation in the Emergency Ward. The two groups were matched for social class, age of the child and the marital status of the mother.

The Index child was examined by a Paediatrician, and medical investigations requested when indicated. The following schedules were completed during the course of structured interviews with both groups of parents: The Circumstances of Injury/Illness Schedule, The Childrearing Attitudes Schedule and the Psychiatric Interview Schedule (which included a mental state examination). The Psychosocial Interview Schedule and an abbreviated IQ test were administered to the mothers only.

The major significant finding of the study was the presence of abnormal personality functioning and psychiatric disorders of parents in nearly all the Index families. The type of psychiatric disorder was characteristically a neurosis in the mothers and personality disorders with alcohol and drug abuse, and criminality, in the fathers. The manifestations of the abnormal personalities of the Index parents included the use of regular physical punishment by the Index mothers, the repetitive physical abuse not only of the Index child but also of his siblings, and physical violence towards adults, especially of the Index fathers towards the Index mothers; the premarital conception of the Index child, the numbers of children of both Index parents by previous liaisons, and the lack of family cohesiveness of the Index parents; the loneliness of the Index mothers and their poor self-esteem; the financial debts of the Index families; and marital dysharmony.

The Index families appeared to be of substantially lower social class than the general Coloured population of Cape Town. The following characteristics appeared to be associated with their low social class: low income, poor housing, unemployment, illegitimacy, teenage pregnancies, poor educational achievement and low IQ. Because of the matching for social class these characteristics were found to occur as commonly in the Control group.

It was concluded that a combination of abnormal personalities

and psychiatric disorders in the parents, factors associated with low social class, and marital dysfunction was the main etiological mechanism in the physical abuse of the Index children. The present study confirmed the finding of others that what distinguishes abusive parents from non-abusive parents is not so much the presence of specific abnormal childrearing practices or disturbances in particular parent-child relationships as the presence of a general disturbance of personality functioning and mental health. In other words child abuse is only one of many deviant kinds of behaviour manifested by the parents of multi-problem families.

PART I

INTRODUCTION

CHAPTER 1

GENERAL OVERVIEW OF CHILD ABUSE

Child abuse has been defined as *"the physical or mental injury, sexual abuse, negligent treatment or maltreatment of a child by a person who is responsible for the child's welfare".* (Mindlin, 1974).

The spate of horrifying cases of child abuse discovered in the last two decades has given rise to the query whether this is a new disease arising from the evils of modern civilisation. The answer is quickly found if one consults the pages of history. In the preface of his book *"The History of Childhood"* de Mause (1976) explicitly states that *"the history of childhood is a nightmare from which we have only recently begun to waken. The further back in history one goes, the lower the level of child care, and the more likely children are to be killed, abandoned, beaten, terrorised and sexually abused".*

Why the current preoccupation with child abuse then? Modern advancement in the sociological, psychological and medical sciences has contributed to a greater understanding of the normal and abnormal functioning of families, and has led to an increased sensitivity to the needs of children. Thus it was as recently as 1871 that the Society for the Prevention of Cruelty to Children was founded in New York City, and in 1899 that The Children's Charter was passed by the Parliament of Great Britain.

The gradual growth of concern among the medical profession about child abuse can be seen in isolated reports like that of Ambroise Tardieu in 1868 who described the autopsy findings of 32 children battered or burnt to death. However it was not until the 20th Century, after the discovery of x-rays, that the more obscure forms of physical abuse were studied and reported. In 1946 an American radiologist, John Caffey, described the unexplained association of subdural haematoma and abnormal x-ray changes in long bones, and in 1955 Woolley and Evans suggested that these injuries had been inflicted on the child by persons within the household. Worldwide recognition of the role of the child's parents and other caretaking adults in the causation of the injuries received its final impetus at a presentation of child abuse and neglect at the 1961 Annual Meeting of the American Academy of Paediatrics at which Henry Kempe coined the emotive term '*The Battered Baby Syndrome*'.

In the last two decades many countries have undertaken various measures to combat child abuse, and an international society has been formed for the prevention of child abuse and neglect. The current extent of the problem is reflected in the large number of abused children reported annually. Extrapolating from a national survey in the United States of America, Gil (1970) stated that there were approximately 500,000 physically abused children at any one time in the country. In Great Britain it has been estimated that of every 500,000 infants born, 3,000 would be seriously injured or deprived (Parke, 1975).

Today, attention is being focussed not only on physical abuse, but also on nutritional, sexual and emotional abuse, and neglect.

CHAPTER 2

CHILD ABUSE IN THE REPUBLIC OF SOUTH AFRICA

Several articles have appeared in the South African Medical Journal giving case histories of physically abused children and reporting the results of hospital-based pilot studies (Krige, 1966; Currie, 1970; Irwin, 1975; Househam, 1976; Robertson, 1976). According to these articles the South African experience has mirrored that of other countries where an initial trickle of reports of child abuse has increased into a steady spate. Official South African statistics or reliable estimates of the incidence of child abuse are not yet available, but the trends reported resemble those described elsewhere in the world. Kempe (1972) has worked out an estimate of 300 new cases per million population per year, based on American reporting of child abuse.

The total population of South Africa was 21,7 million in 1970, at the time of the last census before the present study commenced in 1977. The population is divided into four official ethnic groups, namely Blacks (Africans), Coloureds, Indians (Asians) and Whites (Europeans). Child abuse cases, similar to those described in other continents, have been reported in all four population groups, despite their distinct political, social, cultural and ethnic differences. However, no comprehensive controlled study of child abuse has yet been undertaken in South Africa, so that knowledge is still anecdotal. The present study is a comprehensive, controlled study of physical abuse among children in the Coloured population.

CHAPTER 3

THE COLOURED POPULATION OF SOUTH AFRICA

"Over more than 300 years there has developed in South Africa a number of persons of mixed origin, who have in common a sufficient number of physical traits, within varying limits and to such a degree that they may be called a population group. This population group is identified by law and to a large extent by tradition as the Coloured people ..... the Coloured people have no special, peculiar, typical culture which is so different from that of White Afrikaans or English-speaking South Africans that it could be called a 'Coloured culture'. The Coloured people do not represent a separate culture, but a subculture, namely the subculture of poverty ..... the subculture of poverty (which is different from simple poverty) has a strong tendency to be self-perpetuating ..... there is also encouraging evidence of those who have broken out of the vicious circle and who have achieved well".

Quotation from a recently published book about the Coloured people by a Coloured academic (Van der Ross, 1979).

The history of the emergence of the Coloured people in South Africa begins in the 17th Century. To the Hottentots and Bushmen who already inhabited the Cape at the time of arrival of the first Dutch explorers in 1652 were soon added black slaves from Mozambique, East Africa and Madagascar, and Asians from Ceylon, Indonesia and India. From the liaisons of these black people with the Dutch and other Europeans who

came to South Africa was born the Coloured people. Liaisons between the Coloured people themselves and indigenous blacks in Africa also occurred and continue today, as do 'illicit' liaisons with the present White population group. The traditional cultures of the various groups who became known as the Coloureds seem to have vanished within a generation of enslavement (O'Toole, 1973).

The Coloureds are the third largest of the four official population groups in South Africa, comprising approximately 10% of the total (1970 census). The great majority of the inhabitants of South Africa are Blacks (70%), with Whites making up 17% and Indians 3%. 87% of all Coloureds in the Republic live in the Cape Province, and 29% live in greater Cape Town. The total population of Cape Town in 1970 was 1,1 million with Coloureds accounting for 54%, or just over half a million.

The Population Registration Act (Act 30 of 1950) defines a Coloured person as a person who is not a White person or a Bantu (Black). However Indians are considered to form a separate population group to the Coloureds. Although the differentiation of South Africa's peoples on the basis of race, colour and other group affiliation dates back to the 17th Century, this Act prepared the way for the more rigorous separation of the different groups ('apartheid'). Politically the Coloured people lost status with the coming into power of the National Party in 1948. After having been on the common voters' roll since 1853, the Coloured people

had communal representation from 1958 until 1970 when the Separate Representation of Voters Amendment Act abolished all representation of Coloureds in Parliament. Blacks lost all representation in 1960. Coloureds are therefore afforded a middle status between that of the Whites and that of the Blacks, both politically and socially (O'Toole, 1973). Coloureds generally do not have much social access to the White group and can be described as a marginal group. Feelings of inferiority, uncertainty and a lack of group loyalty are attributed to them (Lotter, 1979).

Culture

Coloureds, unlike Blacks, are Western-oriented and have accepted the dominant Whites' language, religion (with the exception of a subgroup who are Moslems) and mode of existence, and use the Whites as a reference group. In the Cape Province 90% of the Coloured people give their first language as Afrikaans. According to the 1970 census 64% of all Coloureds in South Africa are Protestants, 10% are Catholics and 6,5% are Moslems. A very small percentage profess Judaism or Hinduism, 2% are members of the Black African Independent Churches and 1% profess no religion at all.

A Government Commission of Inquiry into matters relating to the Coloured Population group was appointed in 1973 under the chairmanship of Professor Erika Theron. In their report the Theron Commission drew attention *"to the confusion in race classification, the inequalities in rights, the resentment*

engendered by much of the legislation (The Group Areas Act, The Reservation of Separate Amenities Act and The Liquor Act) and the inadequate opportunities for Coloured people to participate effectively in decision-making. The Commission concluded that high fertility and mortality rates, insufficient housing and community amenities, considerable illiteracy among adults, the extent of unemployment and under-employment all contributed to creating poverty ..... major social problems related to the breakdown of family life, widespread crime, alcoholism and excessive drinking, and factors associated with workshyness. Nevertheless it was impressive that so many Coloured parents succeed in creating a happy married and family life under difficult conditions and at great sacrifice, even though they are not always legally married." (Van der Horst, 1976).

The problems listed by the Commission need to be examined more closely in order to understand the background against which the present study was undertaken. The following table clearly shows the increased birth, mortality and infant mortality rates in 1972. (Van der Merwe, 1976).

	Coloured	White
Birth rate (per 1,000 population)	34	22
Mortality rate	12	8
Infant mortality rate (per 1,000 live births)	124	20

In Cape Town this shockingly high infant mortality rate had been reduced to 26 by 1977 (Molteno, 1980). Almost half of the Coloured population is under the age of 15 years (45%)

compared to 30% in Whites. The average size of a Coloured family in 1970 was 5,2 compared to 3,7 in Whites (Van der Horst, 1976).

Illegitimacy

The rate of illegitimacy is far higher among the Coloureds in South Africa than among the other population groups, as the following table illustrates:

1977 Countrywide Illegitimacy Rates

(per 1000 live births)

Blacks	Not known
Coloureds	503
Indians	129
Whites	45

De Kock (1979) states that the reasons for the high rate of illegitimacy among the Coloureds must be understood in an historical context. During the 17th and 18th Centuries slaves were not allowed to marry. Illegitimacy was thereby encouraged because men outnumbered women and established liaisons with slaves. When Hottentots, Bushmen and Coloureds were freed in 1828 and all slaves in 1834 this did not lead immediately to stability through marriage, but to drunkenness, unemployment, poverty and illegitimacy. Subsequent legislation to protect White labour reinforced these problems. In the face of such difficulties moral values and organisation of family life and roles have been slow to deve-

lop. The poor economic and housing situation has led to overcrowding and lack of privacy, and exposure to sexual experience at an early age. Lack of knowledge and use of contraception has aggravated the problem of illegitimacy.

The high rate of breakdown of family life is reflected in the following table which shows the number of single-parent families in 1970 as a percentage of the total number of families:

	No father	No mother
Coloured	17%	3%
Indian	11%	2,5%
White	6%	1%
Black	Not known	

Illiteracy and poor educational achievement among Coloureds is aggravated by the fact that, until recently, there was no compulsory education for Coloureds and they had to attend separate schools. A survey in 1972 revealed that only 0,9% of all Coloureds over 7 years had completed their schooling (12 years) or studied further (compared to 22% for Whites), 12% had completed Standard 6 (8 years), and 16% had no school education at all (Van der Merwe, 1976).

Only the few thousand teachers, ministers, professional people and skilled workers among the Coloureds constitute a middle class by White South African standards. This group comprises only about 3% of the Coloured population (O'Toole,

1973). Family structure is related to class structure. Middle-class, light-skinned, educated, English-speaking Coloureds will most likely have stable, patrifocal families, but the average Coloured family is poor and often matrifocal (O'Toole, 1973).

Employment

As a result of job reservation (initiated by The Civilised Labour Policy of 1924) many skilled jobs were until recently reserved for Whites. The type of job generally available to a Coloured man until then was piecework, with little or no security and low wages, whereas most White men in South Africa have professional, technical, administrative or clerical positions. In 1966 there were approximately 86,000 labourers among Coloured men, but only 13,000 among Whites (even though there are nearly twice as many Whites as Coloureds in South Africa). The only profession in which there is a sizeable representation of Coloured men is teaching (O'Toole, 1973).

The average per capita income for Whites is nearly nine times that of Coloureds. In July 1975 approximately 19% of all Coloured households earned less than the minimum subsistence level for their area. There is a high rate of unemployment among the Coloured population - 19% among males in 1973 (Van der Horst, 1976). 1,7 of the economically active Coloured population was unemployed in 1977 compared to 0,6 Whites. Because of the low standard of education of many

Coloured people there is a widespread inability to budget economically on a limited income, and many people get into crippling debts with the hire-purchase system. The average Coloured family saves only 5% of total disposable income, and the poorest 40% of the population is not able to undertake any savings at all (Van der Horst, 1976).

Employment is an important issue because it is the key to the power of Coloured women in some lower-class households. Minority groups in any country tend to become matriarchal because the work force of the women is valued more highly than that of the men who are hampered by job reservation (Opler, 1969). Because Coloured men cannot earn enough to support their families, a great many Coloured women must work and as a result the men often become dependent upon the women for a great part of their livelihood.

Housing

The Theron Commission reported that poor and inadequate housing was viewed by the Coloured people as one of the major points of friction - *"an acute source of dissatisfaction and embitterment as well as the breeding-ground of social ills and of poor health"*. These problems are aggravated by The Group Areas Act (according to which many Coloured communities have been and are still being uprooted and rehoused in areas separate from other population groups) and by the rapid growth rate of the Coloured population. Although the majority of Coloured people live in houses provided by the State in urban

areas and townships, 46% of the Coloured population live in overcrowded conditions, and 40% live in slums. On average there is more than one family per dwelling and almost certainly more than 2,5 persons per room (Van der Horst, 1976). It is not surprising that the Commission felt that Social Welfare services were inadequate.

The implementation of The Group Areas Act has been criticised for the following reasons:

1. Communities have been split up and rehoused in different townships. No choice of area was allowed so that all social classes are mixed together.
2. Community facilities are non-existent as the new townships are often situated in bare wasteland.
3. The new areas are usually further away from the places of work so that increased transport costs are incurred. They are also further away from the large chain stores with their competitive prices.

(Smedley, 1979)

Crime, alcohol abuse and psychiatric disorder

The crime rate among Coloureds in the Cape Peninsula is one of the highest in the world. On any one day of the year 1 out of 126 Coloureds is in gaol compared with 1 in 210 Blacks, 1 in 1163 Whites and 1 in 1250 Indians (Terreblanche, 1977). There is a close association between alcohol abuse and crime in Coloureds with more than half of all convictions being due to alcohol and drug abuse. The Theron Commission found

a high incidence of crime in both sexes, and that offences were mostly connected with liquor and drugs, violence and theft. They were concerned at the high incidence of juvenile delinquency. They felt that the following factors contributed to the high crime rate: poor housing, disruption of families and communities as a result of Group Area removals, lack of or inadequate recreational facilities and community amenities, and inadequate police protection in the Coloured areas.

Wine is by far the most popular drink among the Coloureds, and the main drug abused is dagga (Cannabis sativa) which can be grown locally. In a community survey among the Coloureds of Cape Town, Gillis (1973) found the rate of addictive and pre-addictive alcoholism to be 4% and 3.2% respectively. Ten times as many men as women abused alcohol - about 1 out of every 7 men. Gillis also reported a clear association between psychiatric illness and alcoholism, and between low social class and alcoholism.

In a survey of psychiatric disorder in Cape Town Gillis (1968) found 11,8% of Coloureds to be definitely psychiatrically disturbed. The rate was higher in males than females, because of the association between males and alcoholism. Neuroses accounted for 46%, psychophysiological disorders 49%, personality disorders 24%, psychoses 17%, and organic brain disorders 3%. All types of disorder were commoner in the lowest social class, particularly amongst people living in overcrowded conditions and amongst those with the least

education. Physical ill-health was much more prevalent in the lowest socio-economic group; and 46% of psychiatrically disturbed individuals had some major or minor physical illness compared to 15% of those with no psychiatric disturbance. There was also more psychiatric disorder, recognised and unrecognised, treated and untreated, amongst the relatives of mentally ill persons than among relatives of healthy persons. Only a fraction of the psychiatric disturbance in the community was being treated; only 1% of persons made use of existing services, although at least 11,8% were judged to be in immediate need of treatment and many more would have benefitted from it.

Conclusion

The preceding pages have provided some facts from which a tableau of the mode of life of a large proportion of the Coloured population can be depicted. It would appear that many Coloured children grow up in multi-problem families within the poverty subculture - illegitimacy, overcrowding, poor housing, unemployment, matriarchal families, poor health, poor education, family breakdown, violent crime, alcoholism and drug abuse, and psychiatric disorder characterise such families. The marginality of the Coloureds is being intensified by a political system which prohibits their merging with either of the ethnic groups to which they can claim allegiance.

CHAPTER 4

REVIEW OF THE LITERATURE

Introduction

The vast amount of literature on child abuse which has appeared in recent years reflects the intense interest which the subject has aroused, as well as its multiple facets. To undertake a comprehensive review of child abuse literature is a daunting if not impossible task in a short work. It is particularly challenging to present a clear composition of the various contributions by authors and research workers from so many different fields. For child abuse is a multi-disciplinary subject of which few authors have succeeded in formulating a clear synthesis. Most reviews either concentrate on a particular aspect of child abuse or else present a collection of facts and ideas which have been incompletely digested and integrated.

The approach decided on for this review aims to do justice to the multi-disciplinary nature of child abuse as well as have relevance for the clinical study reported on later, by examining in some depth the three theoretical models which have been put forward to explain child abuse while at the same time attempting to synthesise them in a clear and meaningful way. The three models are The Psychiatric Model, The Sociological Model and The Social Interactional Model (Gelles, 1973; Belsky, 1978; Burgess, 1979). An examination of these models will provide the necessary background for understanding the significance of the findings of the clinical study, which in-

vestigates the psychological, psychiatric and psychosocial characteristics of physically abused children. Most authors who discuss these models say very little about the role of biological factors in the etiology of child abuse. A special section of this review will be devoted to this neglected area, although biological factors are not directly investigated in the clinical study.

Many authors have criticised the validity and reliability of much of the clinical research reported in the child abuse literature (Spinetta, 1972; Starr, 1978). Examples of such criticism are that many studies are uncontrolled, or do not control for significant variables like social class, or do not state whether the abuse cases included in their samples are of physical or emotional abuse, or neglect. Bacon (1978) states that research in child abuse suffers from conceptual weakness and lack of methodological rigour, and he gives guidelines for the design of child abuse studies:

1. It is essential to have an established definition of child abuse which is not a description nor a set of examples but a general statement of what in essence constitutes abuse. Without such a definition replication and validation are impossible.
2. Knowledge of the incidence and distribution of child abuse in the population under investigation is required, otherwise it is difficult to set up adequate control groups.

3. It is necessary to have a detailed theoretical or conceptual foundation by reference to which empirical data can be interpreted and explained.

Most studies in the literature fail to meet Bacon's rigorous criteria, nevertheless consideration of their various findings gives an indication of factors which may be associated with child abuse, promotes discussion and leads to the formulation of further hypotheses. On this basis, and with an understanding of the limitations of research into any human behaviour the literature on child abuse will be reviewed.

THE ROLE OF BIOLOGICAL FACTORS

The biological approach to child abuse draws on the hypothesis that physical factors play an etiological role in the genesis of violent behaviour. The evidence for this hypothesis will be described.

Sex differences

Steele (1976) notes the fact that in general more men show aggressive behaviour and violence than women. More men murder their wives, than wives kill husbands, and violent crimes in general are committed by men more often than women. The experimental evidence that the aggressive behaviour of male animals can be reduced by castration or the administration of female sex hormones has led to the implication of the male sex hormone, Androgen, in the generation of physical aggression in humans (Conner, 1969).

Rutter (1976) also maintains that the sex difference in aggressiveness has its main roots in biological factors. He lists the evidence in favour of a biological explanation as follows:

1. Increased aggressiveness in males is found in all cultures.
2. The sex difference is found in a wide range of animal species - not just in man.
3. The differences are present from very early in life.
4. Levels of aggression are responsive to sex hormone.
5. An additional Y chromosome seems to be associated with a somewhat increased tendency to aggressive behaviour.

However with child abuse there is no consistent gender-linked difference and many studies report a higher incidence of female than male abusers (Steele, 1974; Baldwin, 1975). Moreover infanticide is usually perpetrated by females (the mother), so that androgens alone cannot be responsible for the phenomenon of child abuse. The fact that infanticide often occurs during the postpartum period before the return of hormonal homeostasis has also been quoted in support of the role of biological factors in violent behaviour. However psychological or environmental factors may also be operative during this period.

Temperament

A more individual approach has been to underline the importance of the temperament of the abuser. Thomas, Chess and Birch (1968) demonstrated that individual differences in temperament were present from the first few months of life suggesting that such differences have a genetic basis. Moreover in their longitudinal follow-up study they found an important association between children's styles of behaviour in early childhood and the risk of psychiatric disorder when older. Children who were at risk were those with negative mood, low regularity, low malleability and low fastidiousness (Graham, 1973). It is therefore postulated that individuals endowed with certain temperaments are more likely than others to manifest violent behaviour in later life.

Brain damage

Similarly, brain damage has been put forward as a cause of

violent behaviour. Lindsay (1979) reported that 36 out of the 100 children in her follow-up study of Temporal Lobe Epilepsy manifested the catastrophic rage syndrome, and that the incidence was higher in the sub-group with identifiable neurological insult. A significant proportion of the 36 children has psychiatric disorder as adults, which was felt to be on the basis of biological rather than environmental factors. However Shaffer (1976) queried the whole concept of the catastrophic rage syndrome, stating that there is no reason to believe that there exists any specific syndrome of aggression and poor impulse control which differs materially from similar behaviours seen in children without brain damage.

On the other hand, the relationship between epileptic seizures and violence is well documented (Ervin, 1975). In such cases the aggressive behaviour occurs in the ictal or post-ictal stage and has been attributed to foci of abnormal neuronal discharge, especially in the limbic system (Mark, 1970). Gibbens (1956) found that a high proportion of baby batterers have a history of blackouts or fits. West (1979) compared a group of known abusers with a group of psychiatrically ill but non-abusing parents, and with a group of healthy mothers, and found that all groups had some very abnormal electroencephalographic records, with the most abnormal records with epileptic-type features being seen in the abusing group. However the differences between the groups were not statistically significant. Smith (1975) found that serious accidental head injuries did not occur

significantly more often in the fathers of abused children than controls after adjustments had been made for social class.

Violent behaviour can be released in states of alcoholic intoxication, and is considered to be a hazard of drug-dependency states, especially of alcohol, but also of the barbiturates, amphetamines and LSD. Psychotic patients sometimes become violent but it is likely that their violent behaviour is due to a combination of organic and psychological factors.

Chromosome abnormalities

An association has been reported between chromosome abnormalities and violent behaviour. In 1967 Price and Whatmore published a paper in which they described a chromosome abnormality - 47 XYY - in a significant number of men with criminal records who were in a maximum security mental hospital. Further studies have confirmed that there is an increased frequency of the XYY genotype in males in penal institutions and in hospitals for mentally disturbed criminals, and that these men often show a combination of antisocial behaviour, increased height and psychiatric illness or mental deficiency (Gardner, 1972; Telfer, 1968). However the majority of the individuals with the 47 XYY genotype do not show violent behaviour, nor would this abnormality explain the phenomenon of child abuse in women.

Conclusions

Although there is evidence of a link between violence and biological factors such as hormones, chromosomes and abnormal neuronal discharge, the role of such factors in child abuse is still obscure. It is possible that by means of more specific investigations into the amounts and types of aggression in child abuse cases, and with more sophisticated and accurate, but simpler, laboratory techniques, the role of such factors may be elucidated. Similarly while the temperament of the abuser is an undeniable factor, its relative importance in the pathogenesis of child abuse is not yet clear.

THE PSYCHIATRIC MODEL

The most basic assumption of the psychiatric model is that factors within the individual abuser are responsible for child maltreatment. The main factors reported in the literature will be discussed.

Emotional immaturity

Emotional immaturity has been implicated as a cause of child abuse, as many reports have stressed the youthfulness of most child abusers (Renvoize, 1974; Smith, 1975; Ounsted, 1976; Fowler, 1979). In Ounsted's series 40% of the mothers were under the age of 20 when they had their first child, compared to the overall average for their area of less than 9%; while Fowler found the average age of the mothers in her study to be 19 years 6 months at the birth of their first child. These figures suggest that there is an undue representation of teenage mothers among the parents of battered children. Quoted in support of the argument for an etiological relationship between teenage parenthood and child abuse is the known association between teenage parenthood and problems which may predispose to child abuse such as illegitimacy and low birth-weight, and other obstetric, paediatric, social, educational and psychological problems (Phipps-Yonas, 1980).

However on closer examination the relationship between teenage parenthood and the various problems reported is a complex one. Teenage parenthood, illegitimacy, low birth-weight and many

related problems have all been found to be associated with low social class. In the British National Child Development Study Wedge (1975) found that children born to teenage mothers were much more likely (1 in 14) than ordinary children (1 in 25) to be socially disadvantaged, that is, to have poor housing, a low income and a large family or a one-parent family.

Therefore Phipps-Yonas (1980) concludes that the adverse consequences of teenage parenthood are not directly due to the youthfulness of the parents, but rather to their personal characteristics and social backgrounds, as they often come from multi-problem families in the lower social classes, and fail to secure adequate obstetric care for themselves. Kinard (1980) comes to a similar conclusion with regard to the link between teenage parenthood and child abuse. He finds that it is not age per se which predisposes to child abuse, but rather that the link is due to the association of both with low social class.

Nevertheless, it seems likely that even within the same low social class teenage mothers would have more difficulties than older mothers with the role of mother, wife and homemaker, because of their own conflicting developmental needs, and that such conflicts may predispose to child abuse.

Mental subnormality

Some early studies reported that the parents of abused children did not differ significantly from the general population in terms of their educational level and intelligence (Steele, 1974), however more recently the consensus of many surveys is that there is a high rate of educational and intellectual limitation among abusers (Renvoize, 1974; Kempe, 1976; Hession, 1976; Gabinet, 1978). Hession states that about 40% of discovered cases of serious injuries come from families with at least one parent with an Intelligence Quotient (IQ) lower than 75. Smith (1975) found that the mean IQ in his group of mothers of abused children was 80. The limitations of psychometric testing are well-known but the increasing body of literature reporting a low IQ in a large number of child abusers cannot be ignored, especially in view of the association between child abuse and low social class. The prevalence of mild mental retardation in adults and children is very much higher in the lower social classes (Kark, 1974).

Educational achievement is also related to economic disadvantage (Lewis, 1967). Berthoud (1976) describes how being brought up in a deprived home prevents the full development of a child's potential abilities, so that he is not in a position to take advantage of schooling. The finding of low IQ and educational achievement in child abusers can therefore be explained in part by the association of each with low social class, but it is also likely that low IQ itself in a parent increases the risk of child abuse due to defective cognitive resourcefulness and parenting skills, and the re-

duced ability to cope independently and to achieve material advantages through higher training and better jobs (Kempe, 1978).

The childhood experiences of the abuser

The literature about the deleterious effect of adverse childhood experiences on subsequent parenting prompts the question: *"Will the abused child of today become the abusing parent of tomorrow?"*. Steele (1974) maintains that the most common element in the lives of child abusers is the history of having been significantly deprived or neglected, with or without physical abuse, in their own earliest years. He states that when men and women become parents, two kinds of memories are activated, often largely unconscious: the memories of what it was like to be a child, and the recollections of how one's parents cared for one in the earliest years. From these two sources the main patterns of child-rearing will be derived.

Many other authors support the finding of adverse experiences in the childhood of abusers (Belsky, 1978; Straus, 1979; Smith, 1975). Most frequently mentioned is the experience of being abused or neglected themselves (Spinetta, 1972). Emotional deprivation (Melnick, 1969), unhappy childhoods (Lukianowicz, 1971) and rejection (Gibbens, 1956) have also been reported. Some investigations describe the loss of one or both parents, and removal into foster-care (Scott, 1973; Tutuer, 1966; Baldwin, 1975). The effect of such events

was studied by Frommer (1973) who found that women who had experienced traumatic separation from their own parents before 11 years were more likely to have problems with mothering functions. Experimental studies with monkeys have shown that animals isolated and deprived of social contact during infancy later go on to become neglectful, incompetent and sometimes cruel parents (Rutter, 1972).

Poor social circumstances which might have a harmful effect on the childhood development of abusers occur more commonly in the lower social classes. Thus lower class families are more likely to be poor, to have large families with overcrowding, and to display marital dysharmony, inappropriate childrearing methods and serious physical illness (West, 1977; Graham, 1979). Deviant behaviour, violent crime and psychiatric disorder generally are all commoner in the lower social classes (Schurink, 1979a; B.P. Dohrenwend, 1970). Other adverse experiences to which the children of the poor are exposed include: absence of childhood and early initiation into sex (Lewis, 1967), family breakdown and one-parent families (Ferri, 1976) and malnutrition with its possible long-term effects on cognitive development (Stoch, 1968). The prevalence of adverse childhood experiences in the lower social classes raises the question whether this is the explanation for their association with child abuse. Yet it seems likely that the individual who grows up amidst violence for instance, has a greater chance of becoming violent than one who has not experienced violence, no matter to which social class he belongs. As Korbin (1977) points

out, we need more information on individuals who were abused in their childhoods but who have not become abusive parents, as well as on individuals who were not abused as children but who have become abusive parents.

Psychiatric disorder

"It is our impression that with few exceptions our patients had emotional problems of sufficient severity to be accepted for treatment had they presented themselves at a clinic or psychiatrist's office". (Steele, 1974)

Steele felt that abusive parents had heterogeneous psychopathology and presented the wide spectrum of emotional disorders seen in any clinic population. Henry and Ruth Kempe (1976) confirm this view, adding that approximately 10 - 15% of abusive parents seen have psychiatric diagnoses that make their potential for treatment very poor, namely, psychoses (including 'postpartum depression'), severe neurotic depressions, sociopathic personality disorders and severe alcoholism and drug addiction. Rigid, fanatical, moralistic parents also have a poor treatment prognosis.

Ounsted (1975) found serious mental illness, psychopathy and inadequate personalities among his sample, and reported that parents who abuse their children often come from families where violence has ruled down the generations. Many of his abusive mothers had a dependent yet angry and hating relationship with their own mothers.

In his Birmingham study Smith (1975) found that an abnormality of personality was a significant finding among the parents of battered children even after adjustments were made for social class. The less severe types of personality disturbance were more commonly found among the mothers, who in general had features of emotional immaturity and dependence. Among the fathers studied 33,3% were psychopaths. Similar personality characteristics were found between the fathers in his study and a group of fathers who killed their children (Scott, 1973). Twenty-nine percent of the fathers had a criminal record. No association was found with alcoholism or drug addiction. Forty-eight percent of the mothers were diagnosed as neurotic at interview, the usual symptomatology being depression, anxiety or a mixture of the two. Only a minority of battering parents were psychotic. Two mothers were paranoid schizophrenics, and 2 mothers and 1 father were psychotically depressed.

Despite previous suggestions to the contrary most studies now confirm Steele's (1974) finding that only a minority of battering parents are psychotic. On the other hand, a high incidence of neurosis, especially depression, has been reported (Steele, 1974; Smith, 1975; West, 1979). An increasing number of studies describe the frequency of personality disorder among abusive parents, especially antisocial personality disorder (Scott, 1973; Smith, 1975). The sex difference of psychiatric disorder reported in abusive parents resembles that in the general population (Smith, 1975) with the rates of neurosis consistently higher among

women and the rates of personality disorder consistently higher among men (Clausen, 1979).

Lynch (1976) drew attention to the disinhibiting effect of the minor tranquillisers, in particular the benzodiazepines, and their role in precipitating battering episodes. She found that many abusing parents had been on tranquillisers or antidepressants, prescribed for complaints of anxiety and depression.

Alcohol and drug abuse

Although some studies have not found an association between child abuse and alcohol abuse, Ten Bensel (1978) considers that the majority of studies reported in the literature have shown that abuse of alcohol and other drugs are factors of significance in the patterns of behaviour associated with endangering children. The known association between violence and abuse of alcohol and drugs supports such a conclusion (Linn, 1975; Robins, 1980). Black (1980), in a study of families where one parent abused alcohol, found all the children neglected to some degree, and 1 in 5 children had been physically abused. Billing (1979) in a Swedish study showed that infants born to drug-addicted women were subjected to abuse and/or neglect if they stayed with their mothers.

Crime

A large number of abusive parents have criminal records (Smith, 1975; Scott, 1973; Baldwin, 1975). In Smith's

study 29% of the fathers and 11% of the mothers had criminal records. The majority of convictions were for theft, followed by crimes of violence, sexual offences, and drunk and disorderly behaviour. Pickett (1977) reported an incidence of criminal records of approximately 35% in the fathers of abused children in Manchester.

According to West (1977) a deviant life-style in late adolescence and early adulthood (including drinking, gambling, drug use, reckless driving, a poor employment history, sexual promiscuity, aggression and delinquency) derive from an adverse family background in childhood (including poverty, large family size, marital dysharmony, inappropriate child-rearing methods and parental criminality), and Robins (1980) demonstrated that those who were deviant in a variety of ways in childhood (in failing or being absent from school, in being arrested, in being sexually precocious, in leaving home early, and in using alcohol and illicit drugs) tend to be arrested for a variety of acts as adults (theft, violence, disturbing the peace, drug use and gambling). According to these findings the early backgrounds of criminals closely resemble those already described for child abusers, suggesting that child abuse may often be just another crime perpetrated by known criminals.

Cultural factors, deviation and child abuse

Cultural factors are operative in psychiatric disorder, alcohol and drug abuse, crime, child abuse or any other devia-

tion. For instance some communities are more accepting of certain deviations than other communities. From his study of alcoholism among Anglo-Protestants and Franco-Catholics in Canada, Negrete (1980) concludes that the latter group are more accepting of the problem of alcoholism and therefore regard it as less deviant than the former group. Several reports have appeared in the literature describing cultural groups which accept certain forms of child abuse as appropriate disciplinary measures (Korbin, 1977).

Opler (1969), in discussing the relationship between culture and psychiatric disorder, maintains that the chief culture-related conditions producing psychopathology are poverty and rapid acculturation which destroy stable human values and disrupt culturally-based forms of family organisation. The relationship between psychopathology and poverty is confirmed by B.P. Dohrenwend (1970) who states that one of the most consistent findings reported in studies of psychiatric epidemiology is an inverse relation between disorder and social class. Thus it seems that the association between psychiatric disorder (diagnosed or undiagnosed) and child abuse can be attributed in part to the association of each with low social class.

Poverty also seems to be the main culture-related factor linking child abuse and crime. Thus Schurink (1979) reports an exceptionally high negative correlation between the income of adult men and violent and sex crime rates, and states that in the lower class culture the structure of the

lower class way of life plays the dominant role in producing deviant behaviour and violent crime. He maintains that one of the most important structural patterns in the lower class community is the female-oriented household in which the stability of the family unit is determined by one or more women. Male persons who grow up in this type of household feel inferior because they have not learned to interpret their male role in the community. In support of his findings he quotes the victimology hypothesis which holds that deviant and criminal behaviour occurs pre-eminently among young males from the lower social classes.

The association with low social class of child abuse and various forms of deviant behaviour raises the question whether such deviant behaviour has etiological significance in itself or only because of its association with low social class. Controlled studies investigating such behaviour in abusive parents and in which social class is held constant are rare in the literature, and not consistent in their findings, nevertheless it seems likely that individuals with deviant behaviour are more likely to abuse their children than individuals from the same social class who are not deviant.

Religion

Steele (1974) reported that, among those child abusers who were actively involved in their religion, there was a greater than average adherence to a strong, rigid, authoritative "fundamentalist" type belief. Smith (1975) did not find any

support for this in his study, nor for the suggestion that child abuse is related to any particular religious affiliation. Most of his parents were of nominal religion only. Gil's (1970) national survey of child abuse showed that the religious distribution among abusing parents corresponded closely to the religious distribution of the United States population.

Hollingshead (1958) found an association between particular religious affiliations and social class in America, as did O'Toole (1973) in South Africa. The association depends on historical factors and is therefore specific to particular geographical areas. It is probable that in a community where most members of a particular religious denomination are from the lower social class, an association will be found between that denomination and child abuse; but that a particular denomination, or religiousness, or absence of religion, is consistently associated with child abuse, has not been demonstrated.

Typologies

There have been several attempts to delineate a basic child-abusing type of person (Delsordo, 1963; Merrill, 1962). The following is the typology of child abusers formulated by Ruth and Henry Kempe (1976):

1. Historically they were abused or deprived as children.
2. Their emotional relationships are inadequate. Isolation, distrust and minimal support systems are the rule.

3. They cope poorly with crises, especially when they are made to feel rejected or inadequate.
4. They demonstrate role reversal, and they see physical punishment as an appropriate reaction to the child's failure to meet their needs.
5. They have a defective self-image. They feel they are no good.

Galdston (1968), using a psychoanalytically-orientated approach to child abuse, named seven factors which collectively dispose parents to resort to beating a child in order to spare themselves the conscious experience of their own intrapsychic stress:

1. A major reliance on projection as a defence against intrapsychic stress.
2. A tendency to translate affective states into physical acts without the intervention of conscious thought, i.e. they are impulsive.
3. The presence of intolerable self-hatred.
4. Correspondence of the child by sex, age and position in the family to traumatic events in the parent's own earlier life.
5. Lack of alternative defences against conflicts arising from poverty, illness, housing and other stresses.

6. Compliance with the abuse by spouse due to dependence and a reciprocal willingness to support projective defences.

7. Absence of available authority figures - grandparents, religious or social authorities.

Typologies rest upon the assumption that there are common psychological defects shared by all child abusers. The evidence against such a rigid notion is accumulating, especially in view of the increasing importance ascribed to environmental stresses in the etiology of child abuse. The weakness of the attempt to construct infallible typologies of baby batterers is underlined by the failure of the predictive profiles which depend on them (Jacobson, 1979). The predictive profiles have produced a high proportion of false positives (Paulson, 1977; Schneider, 1976), which calls into question the usefulness of the typology approach to child abuse. Child abuse would appear to be too individual a phenomenon to be explained by generalisations.

Childrearing attitudes

It has been suggested that child abusers have specific defects in their childrearing attitudes. Unrealistic expectations of the child's behaviour or performance have been noted by many authors (Belsky, 1978; Oates, 1979; Smith, 1975). The term 'role reversal' describes a relationship in which the parent looks to the child to meet her needs, rather than the reverse. When the child fails to do so, the frus-

trated parent attacks, injures and at times destroys the child. Besides role reversal, the excessive use of physical punishment has been attributed to abusive parents (Wasserman, 1967). In one of the more detailed surveys of the childrearing attitudes of abusive parents, Smith (1975) found that differences in childrearing attitudes between his experimental and control groups did not seem very significant and could not be considered in isolation from the mothers' personality, marital adjustment and social class. His group of abusive parents did not practice early toilet-training, restrictiveness over property, rigid feeding schedules or strictness with regard to aggressive behaviour, as has sometimes been reported for such parents in the literature. However he found battering parents to use more physical punishment, to demand instant obedience, to be relatively careless about the whereabouts or wellbeing of their child, to be unresponsive or excessively responsive to crying, and to become emotionally more involved when their child refused food. Differences in severity of toilet training, intolerance of screaming, and punishment of aggression disappeared when adjustments were made for social class.

De Lissovoy (1973) noted intolerance in childrearing to be prevalent among very young parents, and Newson (1968) found punitiveness and non-permissiveness to be more common among working than middle class parents. Lystad (1975) reports that working-class whites and blacks in America say that they were spanked more frequently as children than do

middle class whites and blacks, and adds that childrearing attitudes are also a function of the parent's age, education and culture. Thus the finding of inappropriate childrearing attitudes in abusive parents may be explained in part by their youthfulness and low social class.

With regard to class differences Tulkin (1977) finds that identical behaviours (e.g. holding an infant) might have different meanings for middle class and working class mothers, that middle class mothers allow their infants more freedom to move around the house, and that there is a feeling among lower class mothers that they cannot influence their child's development. The latter finding is in line with Minuchin's (1967) observation that lower-income mothers seem to see themselves as powerless, helpless and overwhelmed by their children. However Tulkin's study showed that, although there were indeed class differences in some aspects of maternal behaviour, there were also marked differences within each class, due to differences in maternal attitudes and personality.

Moreover maternal behaviour is not always in keeping with maternal attitudes. There is some evidence that interview-derived information about childrearing attitudes provides a stronger relation to behaviour than do the questionnaires that are currently available. There is also some evidence that maternal childrearing attitudes are more predictive of both maternal and child behaviour of middle and upper middle class than of lower class samples (Moss, 1977). Thus apart

from taking into consideration factors such as age, education, culture and social class, there are considerable research difficulties involved in assessing an individual's childrearing attitudes. There are insufficient studies of acceptable methodology that investigate the childrearing attitudes of abusive parents in detail, nevertheless it is likely that even among young, uneducated and poor parents markedly different attitudes will be found.

The literature refers on many occasions to the *mother's* childrearing attitudes. Jacobson (1979) studied both spouses of an abusing and a control group and found that there was a greater similarity in childrearing attitudes between the spouses in the abusing group compared to the spouses in the non-abusing group. It is likely that this similarity is the result of assortative mating and might account for the collusion between the parents of battered children that has been reported in the literature (Gil, 1970). Gil reported that in 30% of cases, both parents were present during the actual abusive episode.

Conclusions

Although some of the studies quoted are small, non-random and uncontrolled, there seems to be a consensus which is supported by the few better studies that youthful parenthood, low educational attainment and low IQ, experience of abuse or deprivation in their own childhood, inappropriate childrearing attitudes, criminality, psychiatric disorder

(diagnosed or undiagnosed) and alcohol and drug abuse are all found more frequently in abusive parents than in the general population. The correlation of these variables with low social class does not necessarily exclude them from being in themselves significant factors in the etiology of child abuse. They surely impede the optimal functioning of parents and thereby constitute risk factors for child abuse.

On the other hand it is clearly erroneous to assume that the individual abuser, who is the focus of the psychiatric model, exists independently of the family and society, and is unaffected by them. The psychiatric model thus contributes a necessary but only partial understanding of child abuse.

THE SOCIOLOGICAL MODEL

According to the sociological model child abuse needs to be viewed in the social context in which it occurs. Thus Belsky (1978) asserts that forces within society, rather than within the individual, are primarily responsible for the occurrence of child abuse. *"When families are subjected to stress, violence is likely to result; child abuse is simply one form which this violence may take".* According to such a view every parent is a potential baby batterer. This is in marked contrast to the psychiatric model where child abusers are felt to have definite characteristics which distinguish them from the general population.

On this theme Carter (1977) writes: *"To explain the failings of child abusers simply as the function of innate defects is simplistic. Complex social and economic forces are closely associated in processes which we do not fully understand in the problem of child abuse. Abnormal personality, emotional immaturity, dependency, borderline intelligence, child abuse and neglect, gross personality defects, neuroticism and crime are not necessarily the sole results of individual or familial pathology and defects.... Such an approach enables the humanitarian to concentrate his charitable interest on the defects of the victim, condemn the vague social and environmental stresses that produced the defect (some time ago) and ignore the continuing effect of victimising social forces (right now). It is a brilliant ideology for*

justifying a perverse form of social action to change, not society, as one might expect, but society's victim... A valid alternative analysis would focus not on personal defects but on institutional rejection and indifference, which leads to the development of protective subcultures which wall people off from the threatened destruction of their personalities."

The social forces that have been implicated in the etiology of child abuse can be considered under the headings: violence in society, stressful life-events and poverty. These three factors are not only inter-related but must also be seen in a cultural perspective.

Violence in society

Gil (1969) maintains that child abuse is a response to stressful social circumstances and society's permissive attitude to violence. His opinion is the result of his national American survey in 1967/8 in which the majority of his respondents viewed baby battering as virtually a part of normal child care. He felt that this view stemmed from the cultural attitude in the United States of America that permits the use of physical force in childrearing. In a later survey of family patterns and child abuse in a nationally representative American sample Straus (1979) reported that 14 out of every 100 American parents kicked, bit, punched, hit with an object, beat up, or used a knife or gun on a child, and concluded that child abuse is brought about by the very nature of Society and its family system. Straus believes

that the psychopathological view of violent behaviour which derives from psychoanalytic theory is an insufficient explanation of the problem unless placed in a socio-cultural context. He feels that violence stems from frustration due to the inability of family members to fulfil culturally prescribed roles as well as from environmental stress factors, and that society sometimes promotes and condones certain kinds of violence.

Kempe (1976) feels that the mass media are partly responsible for forming Society's attitudes, and condemns the glorification of violence on television. Garskof (1979) states plainly that the normative childrearing practices of advanced industrial countries are abusive. However certain childrearing practices in developing countries would also be regarded by Westerners as abusive. Korbin (1977) gives examples of punishments in different cultures; for instance, the Enga of Papua, New Guinea, may sever a portion of a child's finger or part of an ear for intruding upon the mother's garden. In South Africa a young black child may be given a severe thrashing with branches resulting in weals and lacerations for neglecting to tend the sheep properly. Korbin (1980) describes how Maori children in New Zealand in 1972 accounted for 51% of the neglect cases, 41% of the detrimental environment complaints, 54% of reports of children not being under proper supervision, and 46% of all children committed to the care of the State, although they constitute only 12% of the population. She cites social disorganisation, breakdown of

traditional support systems, rapidly changing circumstances and confusion about conflicting models available for child-rearing as contributing to an increase in child abuse in non-Western cultures.

It is questionable whether there is more violence in society today than in the past, or whether Western communities are more violent than non-Western ones. Certain cultural groups may be extremely indulgent to their children but very violent to their enemies, and furthermore within their community there might be one or more parents who are occasionally abusive to their children. It is possible to have one set of norms for violence between adults, and another for violence between adults and children. One cannot therefore make generalisations about the relationship between violence in society and child abuse, nevertheless some individuals will model themselves on the patterns of violence in their family, cultural group or society.

Stressful life-events

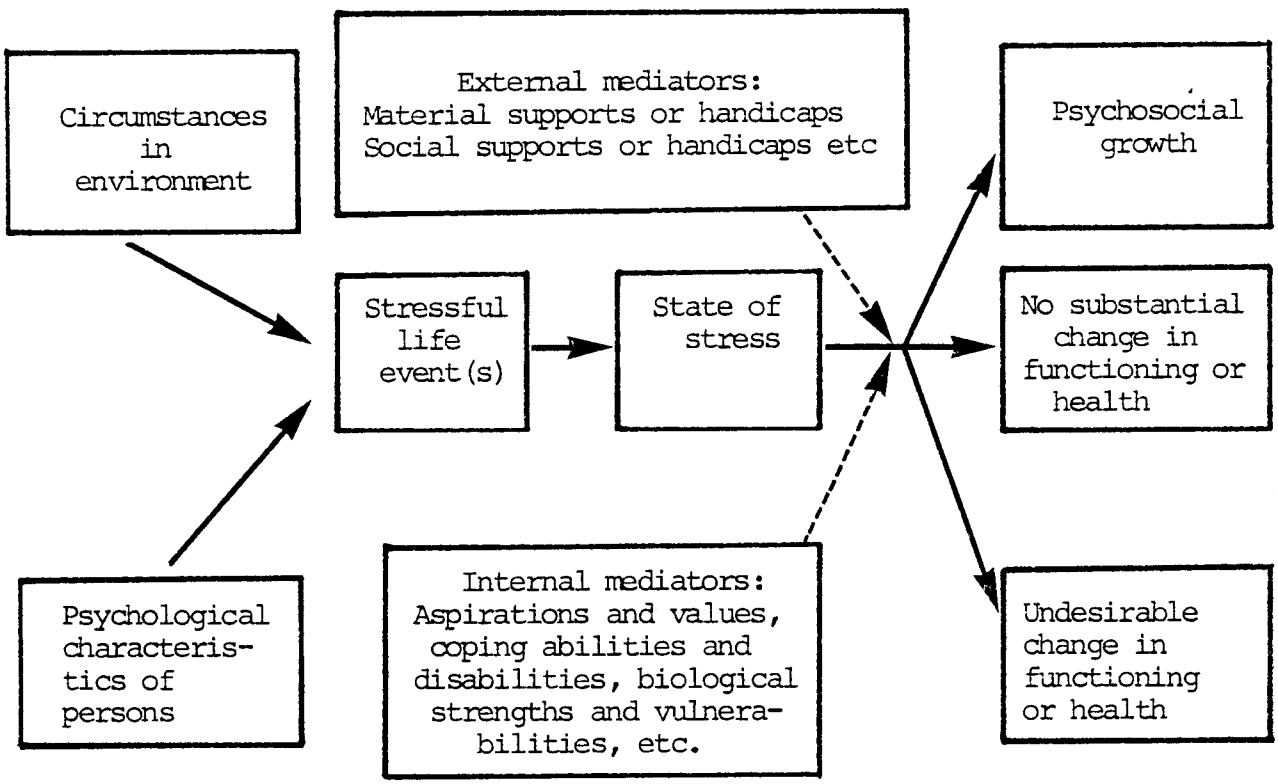
Stress, whether arising from adverse social circumstances, material losses, intra-familial conflicts or other stressful life-events is probably the factor most frequently quoted by proponents of the sociological model to explain why child abuse occurs. In view of its importance for child abuse, the concept will be discussed in some detail.

Stress is a complex concept because it can be viewed subjec-

tively or objectively. Barbara S. Dohrenwend (1970) states that when a person considers an event stressful it might say more about his condition at the time (e.g. pre-existing emotional disorder) than about the nature of the event - therefore stress must be defined in terms of the subjective andobjective nature of the event. Kaplan (1979) writes that subcultural and cross-cultural differences have been noted in perceptions of the amount of stress associated with particular life-events, as well as in the adaptive-coping-defensive patterns to stress, and Bruce P. Dohrenwend (1970) describes subcultural differences in modes of expressing distress. Straus (1980), attempting a definition, states that stress exists when the subjectively experienced demands are inconsistent (too much or too little) with response capabilities.

Another approach to the difficulty of defining and assessing stress has been the development of the concept of life-events. Kaplan (1979) defines a life-event as an individual's loss, addition, or redefinition of social position. Life-events can therefore be favourable or unfavourable or contain elements of both. Examples of unfavourable or potentially unfavourable life-events range from extreme situations such as natural and man-made disasters to more common events such as the birth of a first child, the loss of a job, divorce, ill-health, enforced rehousing, the loss of an important relationship or reaching middle age.

Hans Selye's formulation of stress (1956) has been translated by the Dohrenwends (1980) into social and psychological terms in the following paradigm:



The *internal mediating factors* referred to in the diagram include both resources and deficits such as intellectual abilities, physical health and inherited or acquired psychological vulnerabilities, while *external mediating factors* also include both resources and deficits such as material wealth, social support in the form of family, friends and community agencies, or the absence of such assets. *Circumstances in the environment* include fateful loss events, physical illness and injury, and events that disrupt social supports. The *psychological characteristics* category refers to stressful life-events brought about by the person's own actions.

This model of the effects of stress on individuals is clearly applicable to the phenomenon of child abuse, as represented by the category *undesirable change in functioning*, and it unites all three models described in this review. How much stress is required to produce undesirable changes in functioning or health has also been studied by the Dohrenwends. It seems that even normal persons may become psychiatrically disturbed if exposed to sufficiently stressful situations such as severe combat during wartime or to a triad which includes fateful loss-events, severe physical illness or injury, and events which disrupt their usual social supports.

It has also been postulated that the higher rate of psychiatric disorder in the lowest social classes might be because of the high rate of stressful events in those classes. Barbara S. Dohrenwend (1970) found that the frequency of

objective change-producing events probably does not vary with social class but that the proportion of events involving loss of status (that is, the proportion of unfavourable to favourable events) is greater in the lower than in other social classes. The larger proportion of unfavourable events, for example illness and death in the family, reported by the lower classes in her study could not be attributed to their own responsibility, that is, they were independent events. On the other hand it was not clear how far individuals in the lower classes could influence events in their lives so that they might obtain a greater proportion of favourable events.

The Dohrenwends (1980) also postulated that however much psychopathology may be a consequence of stressful circumstances, it also carries with it a *proneness* to such circumstances as well. They found that loss-events for whose occurrence the subject may be responsible are more characteristic of psychiatric patients and convicts than they are of community sample respondents and community leaders. They also reported that the more severe the disorder the more the likelihood that the events reported were consequences of the subjects' psychiatric condition. Therefore they concluded that the stressful events accompanying psychopathology are to some extent a function of this proneness of the individual involved.

There is now considerable evidence that some individuals are more vulnerable to stressful life-events than others. It would seem that the life-event must combine with an internal

or external mediating factor to be stressful. The particular factor involved would then constitute the *vulnerability*. Vulnerability would not have to be present if the life-events in themselves were extremely stressful and therefore approximated severe wartime combat stress (e.g. the triad mentioned previously). Psychiatric patients are both more prone and more vulnerable than the general population, as well as being victims of environmentally-induced stressors to some extent.

The Dohrenwends feel that life-events are more likely to be causes rather than consequences of psychopathology when their occurrence is outside the control of the subject, when they clearly antedate the first occurrence of the psychopathology, and when they are embedded in the hypothesised pathogenic triad of fateful loss-events, severe physical injury or illness, and other events that disrupt the subject's usual social supports.

The Dohrenwends have shown that stressful life-events may be both the cause and the consequence of psychiatric disorder, and that both are found more commonly in the lower social classes. They postulate that stressful life-events lead to undesirable changes in functioning or health, of which presumably violent behaviour towards children may be one type. In a recent study Straus (1980) investigated the association between stressful life-events and physical child abuse and found that the child abuse rate increased with

the number of stressors experienced during the previous year provided that the abuser had grown up in a family where he observed violence, his own marriage was not fulfilling and was one in which the male tended to be dominant, and the family was socially isolated and was of low social class. In other words stressful life-events resulted in child abuse when they were experienced by someone with particular vulnerabilities which include both ongoing stress and a past model of family violence. This finding shows that stress alone is insufficient to account for child abuse, but that a combination of factors from all three models is required before stress results in child abuse.

Child abuse and the poverty subculture

In his opening address to the Second International Congress of Child Abuse and Neglect Gil (1979) stated that only in a society where there is more equal distribution of wealth and opportunities would child abuse be eradicated. In similar vein Oliver (1977) states that families with pseudo-respectable tense parents of higher social standing do sometimes produce severely battered babies, but the bulk of child maltreatment cases in a locality are drawn from multi-problem families.

Pelton (1978) examined many of the statements and reports in the literature which imply that child abuse occurs without regard to social class, and came to the following conclusion: *"Both evidence and reason lead to the unmistakable conclusion that, contrary to the myth of classlessness, child abuse and neglect are strongly related to poverty, in terms of preva-*

lence and of severity of consequences. This is not to say that abuse and neglect do not occur among other socio-economic classes, or that, when they do occur, they never have severe consequences. However, widespread reports suggesting that abuse and neglect are classless phenomena are unfounded and misleading".

The terms social class, poverty and poverty subculture need to be clarified. Classification of families according to social class is usually based on the educational and occupational level of the head of the household, and the family income (B.P. Dohrenwend, 1970). Five social classes are recognised with the lower or working-classes (manual workers) accounting for classes 5, 4 and part of class 3, and the middle classes (white collar workers) accounting for classes 1, 2 and part of 3. Skilled manual workers usually fall into class 3, semiskilled in class 4, and unskilled in class 5.

Although many authors use the terms poverty and poverty subculture interchangeably, Oscar Lewis (1967) distinguishes between poverty and the culture of poverty. In his view the term poverty subculture implies a way of life as opposed to a condition of life. Poor people who are class conscious, active members of trade unions, or who adopt a world outlook may be desperately poor, but are no longer part of the culture of poverty. Features of the poverty subculture are chronic un- and under-employment with low

wages leading to a low income, absence of savings and a low level of education; poor housing with large families and overcrowding; free marital unions and a high incidence of abandonment of wives and children; a trend towards female-centred families; the absence of childhood and an early initiation into sex; lack of impulse control and strong feelings of marginality, of helplessness, dependence, and inferiority.

Other researchers have noted the presence of a definite sub-group within poor communities. In his Sheffield study Tonge (1975) described this sub-group as made up of multi-problem families, and found that such families were distinguished from other poor families by several factors, including a high rate of psychiatric disorder and unsatisfactory child-care practices. Berthoud (1976) described multiply-deprived families who suffer many different problems at once, and who are concentrated mainly in class 5. He states that the most obvious explanation for multiple deprivation lies in a cycle of mutual causation.

As an example of mutual causation he describes how children in a poor family can often make the difference between hardship and poverty. The cost of feeding children may stretch low earnings too far; the need to care for them may prevent women from working to increase the household income, or in the case of unsupported single mothers may prevent any earnings coming into the home at all; they can stay in the way of the

search for adequate housing; or sometimes they may reduce the flexibility of their fathers in seeking work. The result is a cycle of deprivation with today's deprived children becoming tomorrow's deprived parents.

Berthoud explains the origins of the unsatisfactory child-care noted in multi-problem families in the following way:

1. Only poor housing is available and it is usually in an unsatisfactory area.
2. Poor housing often means overcrowded housing.
3. There is often nowhere to play.
4. The parents often have to spend long hours at work or on housework; and there is no money to spend on educational recreational activities.
5. The life-style of working-class parents (in turn derived from their own parents) is, by comparison with middle-class parents, not suited to the child's development. Working-class parents are held to be less child-centred, they spend less time on the children and they exert discipline for their own sake, not for the child's long-term sake. Their child's language is slow to develop, and this in turn hinders his cognitive development, so that by the time he reaches school he is already at a serious disadvantage. The average child of an unskilled father is about a year and a half scholastically behind the average child of a professional father.

Socially disadvantaged children can be defined as those who come from large or single-parent families who are poorly housed and have a low income (Wedge, 1973). In the National Child Development Study in Great Britain 6% of all children were found to be socially disadvantaged. Such children were more likely to be born to teenage mothers compared with ordinary children, and already at the time of birth were facing substantially diminished prospects of normal development because of their mothers' poor antenatal attendance and heavy smoking. One in 8 mothers of disadvantaged children had a chronic or serious health condition compared to 1 in 20 of ordinary children, and 1 in 10 disadvantaged families used social agencies compared to 1 in 300 of ordinary families.

Certain problems reported by many authors to be associated with child abuse, namely financial problems, unemployment, frequent job changes, poor housing and a high incidence of domestic worries (Gabinet, 1979; Maroulis, 1979; Straus, 1979; Renvoize, 1974) were found by Smith (1975) to be linked to low social class. Other characteristics associated with both child abuse and low social class are a high rate of geographic mobility (Gibbens, 1956; Schloesser, 1964; Martin, 1974) and social isolation (Garbarino, 1977; Maroulis, 1979; Oates, 1979).

There appears to be an association between the poverty subculture and minority groups. Berthoud (1976) writes that

members of the racial minorities are at risk for social misfortunes: their earnings are often lower than those of white men of comparable age and occupational level; their children's reading scores are lower even than those of the unskilled workers' children; and their housing conditions are considerably worse than those of unskilled workers. Characteristically minority groups occupy a less priviledged position within society and become part of the poverty subculture.

Child abuse has been reported as occurring more frequently in minority groups. Gil (1970) suggests that the higher rate of child abuse among non-whites in the United States of America is due to discrimination by agencies and the higher incidence in them of socio-economic deprivation, fatherless homes and large families, all of which have been found to be strongly associated with child abuse. Smith (1975) reported that the percentage of battered non-white children in his sample was slightly greater than that of the local population, but he did not find discriminating attitudes and practices on the part of the referring agencies, nor did he find that his non-white families had more children or lived in poorer housing conditions than did the families of white battered children. However he did find among them a greater incidence of broken homes with absence of the biological father, excessive use of physical punishment and lack of support from extended family.

Although it is now clear that many, but by no means all, poor parents abuse their children, few researchers have attempted to isolate the factors which enable some poor

parents to avoid abusing their children. Studies comparing abusive families to non-abusive families within the same poverty group are difficult to find in the literature. Burgess (1979) compared families with authenticated physical abuse of children and families with neglected children to control families matched for age, number of children, income and educational levels of the parents. He found that the abusive and neglectful families displayed lower rates of interaction than the control families. This was especially the case for positive interactions (e.g. affectionate and supportive behaviour from mothers toward their children), and similarly the mothers in the abuse families exhibited rates of negative behaviour (e.g. threats and complaints) toward their children over 60% higher than the control mothers. Burgess concluded that, while it is certainly true that abuse and neglect occur within a broader, historical and cultural context tolerant of aggressive behaviour, these dysfunctional patterns are more immediately traceable to contingency histories within the family itself. However while these findings illustrate the differences in the interactions in abusive and non-abusive families, they do not throw light on the origin of such differences.

Smith (1975) compared 134 battered children under 5 years of age and their parents to 53 children under 5 years of age (and their parents) who were emergency admissions to Birmingham Children's Hospital and where there was no question of battering. Accident and trauma cases were excluded. He

found it difficult to obtain a control group of equally low social class to match the index cases and adopted a method of weighting the index sample results, equating them for social class of the controls, a procedure which is questionable. Smith found the following major variables to remain significant after adjusting for social class: personality disorder in parents, neurosis in mother, mother under 20 years old at the birth of first child, mother has subnormal intelligence, parents have criminal record, mother unmarried, battered child illegitimate, mother had adverse experiences in childhood, battered child had low birth weight and has developmental delays. (Hanson, 1977). Smith concluded that socio-economic factors should not be emphasised at the expense of personality factors as experience has shown that socio-economic aid alone does not prevent child abuse. In fact he maintains that no study has convincingly shown that *any* treatment of battering parents is effective.

Conclusions

Although there may be notable exceptions, the consensus of the literature is that child abuse normally occurs in the lowest social classes where the concentration of violence, psychiatric disorder and unfavourable life-events is greatest. Child abuse is most commonly part of a deviant way of life, otherwise known as the poverty subculture. This deviant way of life contains within it the seeds of its own destruction and is therefore self-perpetuating for many of its members. The intergenerational cycle of child abuse has been graphi-

cally described by Oliver (1973).

The question that remains unanswered is how do some individuals break out of this intergenerational cycle? It could be postulated that in the same way as constitutional deficits in biological and psychological make-up, and adverse social forces may promote the development of the abusive adult, so the combination of biological and psychological assets, and favourable social opportunities might permit the development of relatively healthy adults even from multi-problem families. Life on earth would be short-lived if there were not in existence a fair distribution of resources and potential for healthy growth.

THE SOCIAL INTERACTIONAL MODEL

The social interactional model supplements the psychiatric and sociological models by stressing the vital role in the etiology of child abuse of a breakdown in relationships within the family. The effect of inadequate or disturbed parenting, and of marital dysfunction, and the effect of the child on the parent are the main interactions put forward by proponents of this model (Burgess, 1979).

Marital dysfunction

Chapman (1977) states that except in certain cases of clearly diagnosed mental illness or sexual perversion, ill-treatment of children almost always originates in the breakdown of relationships between their parents. Henry and Ruth Kempe (1978) also feel that the relationship between the parents is of great importance for child abuse, and that family discord and stress before the episode of abuse are likely; and they find that the spouse of the abusive parent is often unsupportive.

A number of studies have corroborated the above statements by finding serious marital dysfunction and a high rate of family breakdown in the families of abused children (Creighton, 1979; Fowler, 1979). Wife-battering and husband-battering have been described (Pickett, 1977; Straus, 1979) and Ounsted (1975) reported a high rate of sexual problems among mothers referred because of a risk of child abuse. The mothers also

complained that their spouses lacked understanding of their difficulties and were impatient and unhelpful.

Smith's (1975) abusive parents did not directly admit marriage problems but a significant proportion reported dysharmony in childrearing and dissatisfaction with the partner's handling of the child. He felt that these characteristics might be taken as indices of disagreement between husband and wife over their respective roles, and that such indices are predictors of divorce.

Various reasons have been put forward to explain the association between marital dysfunction and child abuse. One explanation is that the kind of people who are likely to abuse children are attracted to one another because of their many similarities, but are also the kind of people who are unable to sustain a healthy relationship with one another. The finding of similarities existing between marriage partners, particularly with reference to social qualities or characteristics, is known as homogamy (Eshleman, 1974). Assortative mating between homogamous individuals has been reported in parents of abused children (Ounsted, 1976) and in other deviations (Reich, 1980). Scott (1973) has shown that fatal battering has been found to occur where young, unstable, deserted and unhappy women associate with young, psychopathic and criminal men.

Smith (1975) felt that marital breakdown and child abuse might be joint effects of factors such as: premarital conception, early marriage, short acquaintance, dysharmony over child-rearing, neurosis and personality disorder, and lack of support from relatives.

Marital dysfunction may also lead directly to child abuse through the displacement of marital conflicts onto the child. A mother may take out on the child aggressive feelings she is unable to express towards her husband, and a father may hurt a child in order to get back at his wife. Parents may blame a child for the breakdown of their relationship. More indirectly, marital dysfunction may lead to emotional lability in the parents with decreasing impulse-control. However, it must be borne in mind that although children are very frequently made to suffer because of marital conflicts, not all divorcing parents physically batter their children.

The frequent association between marital dysfunction and child abuse might also reflect the reported association of each with low social class. In support of the link between marital dysfunction and low social class Tuckett (1976) quotes various studies to show that the early years of the marital relationship of manual workers and their wives are unlikely to be of the kind where the partners feel that they can confide in each other, with the result that their marriages are characterised by poor communication.

Dysfunction of parenting

Ruth and Henry Kempe (1978) estimate that about 20 - 30% of parents have some difficulty in caring for their children adequately. They consider adequate parenting to be the ability to recognize the needs of a child for physical care and protection, nurturance, love and the opportunity to relate to others, bodily growth and the exercise of physical and mental functions, and help in relating to the environment by way of organizing and mastering experience. In addition to recognising these needs, a parent must be able to meet them or at least facilitate their being met.

Many factors, operating from within the parent and without, may contribute to the poor parenting skills described in the parents of abused children. Poor self-esteem (Burgess, 1979) and dissatisfaction with their current life-roles of parent, spouse, homemaker or breadwinner (Smith, 1975) have been reported. Jacobson (1979) found that lack of impulse-control and lack of empathy were the prime ego-deficits that characterised her group of abusive parents. She found that the abusive group had significantly poorer awareness and acceptance of their own affectional needs than did a matched control group. Because of this they were unable to empathise with others or to reach out for emotionally rewarding relationships, and their relationships with their children were characterised by role reversal. Aggressiveness and lack of impulse-control in abusive parents have been reported by other authors (Spinetta, 1972) but studies investigating the origin, ex-

pression or control of aggressive impulses have proved inconclusive.

Any parent who is physically ill is more likely to have difficulties in relating to her child. Lynch (1976) found that frequently mothers of abused children had minor health problems. Excessive tiredness, iron deficiency anaemia, severe dental caries and headaches were all commonly found. Many had gynaecological problems and some had serious illnesses such as chronic renal disease, thyrotoxicosis, tuberculosis and multiple sclerosis. Ounsted (1975) reported a high incidence of physical ill-health in a group of mothers who had been referred because it was thought that their children were at risk for battering. Two-thirds of the mothers reported migrainous attacks of sufficient severity to require withdrawal to bed. Of all the parents more than one-third had suffered from Besnier's syndrome (asthma and eczema).

The poor social skills described in many abusive parents indicate serious difficulties in relating to others. Smith (1975) found that a significant number of abusive mothers rated themselves as lonely, but not bored, compared to controls. They also reported less social activities although this variable became insignificant after social class control. Abusive parents tend to be isolated, and without friends, and they have trouble turning to others for help. They often cope poorly with crises (Kempe,1978).

Certain characteristics of the families of abused children may be the result of poor parenting skills or contribute to them. Large families of closely spaced children have been reported by many workers to be associated with child abuse (Gil, 1970; Smith, 1975; Creighton, 1979) although this finding was not replicated in Fowler's study (1979). Household disorganisation has been described by some authors (Elmer, 1967; Young, 1964) but in Smith's study (1975) this finding was no longer significant after adjustments had been made for social class. Smith reported a large percentage of unmarried mothers cohabiting with a man who was not the biological father of the child, and Gabinet (1978) found a high incidence of single parents among the families of abused children. Maroulis (1979) noted an association between working mothers and child abuse but did not clarify the nature of the association.

Many of the factors relating to poor parenting skills that have been mentioned so far have been found to occur more commonly in the lower social classes (Lewis, 1967; Hollingshead, 1958), suggesting that individuals with poor parenting skills are found more often in the poverty subculture. However it is unlikely that the finding of poor parenting skills in child abuse is due solely to the association of both with low social class, as ill-health and ego-deficits such as poor impulse-control occur in all social classes, and may lead to child abuse.

The role of the child in abuse

Martin (1977) underlines the tremendous capacity of the child to influence and modify the behaviour of his parent. He suggests that given a parent with a higher than usual potential to abuse a child, and given certain life-stresses which might increase that potential, some characteristic or attribute of the child may be just enough to tip the scale. On the other hand Boardman (1962) feels that an adult who inflicts injuries is not reacting to the specific behaviour of the child but to his own feelings (for instance, feeling miserable) and cautions against an attitude which focusses on the child's role in the abuse, thereby minimising the responsibility of the parent.

In a follow-up study Elmer (1977) found that abused children had low self-esteem, and behaviour which made peers, parents and teachers reject them. Whether inhibited, compulsive, angry or socially pseudo-adult they seemed unable to relax and enjoy themselves. Smith's (1975) sample of abused children were not observed in hospital to be more difficult than the controls and he felt that the reported difficulties in handling them were probably related to the mother's neurotic tendencies. He found that more mothers of battered children considered the child difficult than controls, but on specific direct questioning he did not get the impression that these children were in fact more difficult than the controls.

According to Ounsted (1975) many children who are battered have unrecognised physical and/or behavioural abnormalities or are thought to have them by their mothers. Abused children have been described as irritable and very active (Belsky, 1978; Milowe, 1964) thereby contributing to their own abuse, but Smith (1975) found them to be less wakeful, excitable or tired during the day than controls.

Martin (1977) believes that the following factors in the child increase the chances of physical abuse:

1. Any factors intruding into bonding and attachment e.g. prematurity, early separations.
2. Any factors making the child less gratifying e.g. feeding difficulties, mild neurological immaturity or dysfunction.
3. The child does not meet parental expectations - the wrong sex, or the parents have unrealistic expectations, or there are congenital anomalies or physical illness; or delayed development or poor school progress; or the child is illegitimate; or his physical or emotional attributes are not pleasing.
4. The child invites abuse by provocation.

The factors listed by Martin have been corroborated by many authors. Bonding failure has been reported as occurring in a significantly high percentage of abused children (Kennell, 1976; Ounsted, 1975; Chadwick, 1978), whether it is due to the role of maternal or child factors. Smith (1975) feels

that the association between low birth weight, bonding failure and social class is a very complex one. Low birth weight may be due to low social class, youthful and single status, and rejecting attitudes during pregnancy, and therefore it may be the pre-existing conditions and emotional status of the mother that relate to subsequent battering, and not the difficulties caused by the low birth weight or bonding failure (e.g. handling problems, or admission to the intensive care unit).

Obstetric complications, prematurity and low birth weight have been reported in many studies of abused children (Lynch, 1977; Friedrich, 1976; Oates, 1979; Creighton, 1979). Any stress during pregnancy or delivery is likely to affect the bonding process between mother and child. Abusive mothers are also poor attenders at antenatal clinic, a fact which is undoubtedly associated with a higher incidence of obstetric complications. Poor antenatal attendance is correlated also with age, low social class and personality disorder (Phipps-Yonas, 1980). Teenage mothers from multi-problem families are likely to be the poorest attenders and may evoke little sympathy and insufficient concern among the busy, rotating staff of the antenatal clinic.

Physical and mental handicap, physical illness, behaviour problems, difficult temperaments such as in excessively irritable or colicky children that cry incessantly, have all been described more frequently in abused than non-abused

children (Ounsted, 1975; Gil, 1970; Glaser, 1979; Lynch, 1977). Feeding difficulties have been implicated. Neligan (1976) reports that feeding difficulties are associated with low birth weight infants. Non-organic failure to thrive, leading to psychosocial dwarfism, has also been described (Ayoub, 1979).

A high percentage of abused children are conceived out of wedlock and are illegitimate (Simons, 1966; Renvoize, 1974). In his sample Smith (1975) found that the rates of occurrence of premarital pregnancy and illegitimacy were two or three times higher than the general population rates in all age groups. This finding did not alter when adjustments were made for social class, although an association between illegitimacy and low social class has been reported elsewhere (Lewis, 1967; de Kock, 1979).

Apart from sexually-motivated abuse or specific cultural practices, child abuse has not shown any consistent sex ratio (Smith, 1975). Children of all ages including adolescents may be battered. The reported higher incidence of abuse of small children may be due to several factors unrelated to the age of the child, such as for instance the young age of most parents of young children, and a relative lack of reporting of abuse in older children. Reporting of abuse depends to some extent on the age-group with which the reporting agency customarily works. It does not seem likely that any one age is universally more difficult to handle than

another, but rather that individual parents find certain developmental stages more difficult to cope with than others.

Most studies report that the oldest child is more likely to be abused (Renvoize, 1974; Gabinet, 1978; Moore, 1979) but Smith (1975) found that there is a tendency for the currently youngest child to be abused, whether the first child or not.

The argument that the child plays a role in provoking abuse was supported by early reports that usually only one child in a family was battered. However subsequent research has repudiated this finding. Smith (1975) found that 50% of the children in his sample had been battered more than once, and one-third of his abused children had a sibling who had also been maltreated. Renvoize (1974) states that most children in the family have been abused, not just one, and Castle (1975) found that where the first child had been battered, there was a 13 to 1 chance that a subsequent child would be injured. These findings indicate that the individual characteristics of a particular child are not generally the main factor leading to his abuse.

How many of the characteristics of abused children are inborn and how many are the result of the pathological environment to which so many of them are exposed? Martin (1977) drew attention to the fact that many of the characteristics of abused children are quite similar to the pathological traits of their parents, e.g.:

1. One-third have intellectual deficits.
2. The incidence of learning difficulties are increased - 50% have speech and language, or perceptual motor development or other cognitive problems.
3. 50% have poor self-concept.
4. They have a sombre and joyless demeanour, and don't know how to play.
5. They have little sense of self, with frozen watchfulness, instant obedience and role reversal.
6. They have deviant object relationships, with no trust or object constancy, and social and peer isolation.

When one takes into consideration the disordered personalities of the parents of abused children and their social disadvantages, it is not surprising that the children have so many handicaps. Martin (1974) states that the abusive environment, apart from the actual physical trauma, impairs the development of the child neurologically, cognitively and emotionally. In this way the cycle of abuse is perpetuated from generation to generation.

Conclusions

It is apparent from this review of the literature that a satisfactory explanation of child abuse must include factors from all three theoretical models. It has been shown how families are affected by sociological forces, and how within the family failure of the parents and children to meet each

other's needs is related to their individual biological and psychological make-up. The parents may react in a number of deviant ways when they feel they are no longer able to cope, one of which is to physically abuse one or more of their children. Physical abuse of children is characteristically only one of many deviations in multiply-deprived families. However not only are there notable exceptions to this general rule, but there are also a number of individuals who are able to break out of the intergenerational cycle of multiple deprivation. Very little has been written in the child abuse literature about the factors involved in their breaking out of the cycle of deviation, probably because the subject would involve far broader theoretical concepts than most clinicians are familiar with. To thoroughly understand all the aspects of child abuse would be to thoroughly understand human nature, and the meaning of human existence.

PART 2

THE CLINICAL STUDY: BACKGROUND

CHAPTER 5

THE AIM OF THE STUDY

The aim of the study is to obtain an informed understanding of the nature of child abuse in the Cape Town community. Child abuse cases have been identified at the local Children's Hospital and reported in the literature since 1970 (Currie). At first the number of referred cases was small, and could be managed on an individual basis. As the case-load grew it became necessary to train a child abuse team, and to formulate guidelines for the diagnosis and management of child abuse cases which could be used generally in the hospital. Local experience of child abuse at the time was still too limited to serve as the only basis for such guidelines.

It did not seem valid to extrapolate from the experience of other countries without first attempting to replicate their findings locally, especially as South Africa has such a diverse population and so unique a socio-political structure. Even from within the Republic of South Africa have come varying reports about the characteristics of child abuse cases identified at the major centres, for instance regarding their social class distribution (Irwin, 1975; Robertson, 1976). As in many other countries there are important differences from one part of South Africa to another, related to geographical, historical, political and ethnic factors. For instance, some areas have a preponderance of one racial group, while others have very significant variations in their population composition.

It was therefore decided to set up a controlled study of child abuse in Cape Town. Although it would have been ideal to have all racial groups represented in such a study, numbers of child abuse cases in certain groups were too small to permit valid conclusions to be drawn from their analysis. Consequently the study was confined to the Coloured population. The Coloureds constitute the major population group in Cape Town, and most of the child abuse cases seen at the Children's Hospital come from this group.

CHAPTER 6

THE HYPOTHESIS

Because child abuse is a multi-disciplinary subject, its etiology cannot be understood without investigating variables from at least the main disciplines involved, namely the Psychiatric and Sociological disciplines. Such variables would be drawn from the factors described in the Psychiatric, Sociological and Social Interactional Models of child abuse. An investigation of these variables in a clinical study of local child abuse cases would provide the knowledge required to understand the nature of child abuse as it occurs locally, and also to compare local findings to those of other studies in different populations. In the present study these variables are referred to as the psychological, psychiatric and psychosocial characteristics of child abuse.

The Social Interactional Model has stressed the importance of the family relationship in child abuse, so that a study of the etiology of child abuse should investigate not only the abuser and the abused, but their families also, and in order to circumvent some of the problems of defining what is meant by child abuse, it was decided to study only physically abused children. Such children form the bulk of the child abuse cases referred to the Children's Hospital in Cape Town, not counting nutritional abuse. The subject of the present study is therefore the psychological, psychiatric and psychosocial characteristics of the families of physically abused children.

The hypothesis which the study must test is that the families of physically abused children will show significant differences regarding their psychological, psychiatric and psychosocial characteristics compared to families who have not been referred because of physical abuse of their children. In statistical terms the null hypothesis is that there are no differences between these two groups of families. In this respect the study differs from most studies of child abuse which have been uncontrolled and of an exploratory nature, letting the observations suggest hypotheses that might be tested, and looking for correlations between child abuse and other factors. In the present study, for each variable the null hypothesis is that there is no difference between the index and control group.

CHAPTER 7

THE RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

The study was conducted at the Psychiatry Department of the Red Cross War Memorial Children's Hospital, Cape Town. The Children's Hospital was established in 1956 as a closed teaching hospital by joint agreement between the Provincial Authority and the University of Cape Town, and is the only Children's Hospital serving the area, although it is not the only hospital which treats children. It serves largely as a community hospital for children who come from families in the lower socio-economic group, and as a referral centre for selected patients, regardless of socio-economic status, who require specialised care.

The hospital caters for children of all races up to the age of 13 years, and at the time of the study had 249 beds. A survey conducted in the Outpatients Department in 1972 showed that there were approximately 224,000 attendances that year, of which 78% were Coloured (includes Indians), 15% Black and 7% White (Willoughby, 1979). 75% of the children were under 6 years, and 25% over 6 years.

CHAPTER 8

THE INDEX FAMILIES

Nearly a thousand letters (see Appendix) were sent out in February 1977 requesting referral to the research team of all parents who were strongly suspected of currently physically abusing their children. Letters were addressed to all the provincial and private hospitals in Cape Town that treated children; all private general practitioners, Paediatricians, General Surgeons and Orthopaedic Surgeons in Cape Town; all District Surgeons and State Pathologists; all Commissioners of Child Welfare (Magistrates), Public Prosecutors and Regional Commissioners of Police; all Child Health Clinics; and all Social Welfare Agencies dealing with children. Notices were published in the South African Medical Journal and the Social Work Bulletin.

All Coloured child abuse cases identified by the research team prior to the closing date of the study in November 1977, were included in the Index Group. Sixty-six Coloured children were referred, of whom only 49 met the selection criteria and formed the Index Group. All the families of the 49 children agreed to take part in the research study. (During the period of the study 4 White and 4 Black children were also referred to the research team, of whom all the White and 1 of the Black were regarded as child abuse cases. No Indian children were seen).

The selection criteria were: detectable recent physical injuries, and a diagnosis of child abuse. Injuries were regarded as being due to child abuse when the child abuse was observed by a reliable witness, when the abuser confessed to his deed, when no other possible explanation for the injuries could account for them, or when there was a very strong suspicion that they were due to child abuse. Suspicion of child abuse was divided into two categories: highly suspicious and mildly suspicious. Only highly suspicious cases were included in the Index Group. Injuries were regarded as highly suspicious when child abuse was the most likely explanation for them.

Seventeen of the Coloured children referred were excluded from the Index Group, either because there were no detectable injuries, or the injuries were judged to be accidental in origin, or they were cases of emotional abuse or neglect and not physical abuse, or they were only mildly suspicious of child abuse.

The 49 children in the Index Group came from 48 different families - 2 children came from the same family, and they were step-siblings. All the children were under the age of 14 years. Children who had passed their 14th birthday were not even seen by the research team, as the hospital does not offer facilities to this age group who are expected to attend adult clinics. A record was not kept of how many children over the age of 14 years were referred to the research team

but the number was very small.

The source of referral of the 48 families in the Index Group is shown in the following table:

1.	Children's Hospital Outpatients Dept.	35
2.	Child Health Clinic	7
3.	Social Welfare Agency	2
4.	Self-referred	2
5.	Private General Practitioner	1
6.	Follow-up of newspaper report	1

CHAPTER 9

THE CONTROL GROUP

As most child abuse cases identified at the Children's Hospital in the past have been referred from the Hospital Outpatients Department, it was decided to form a control group from another type of patient referred from there. These are children presenting at the Outpatients Department with physical illnesses requiring overnight observation or treatment at the Hospital. Such children are referred to the Emergency Ward, which is a 30-bedded ward situated in the Outpatients Department. Mothers are required to spend the night with their children.

All the control children were Coloured, and were matched with the Index children for age, marital status of the mother, and the social class of the family. If the Index child was pre-school, the control child had to be less than 6 months younger or older; if the Index child was of school-age, the control child could be up to 1 year younger or older. The purpose of matching for age was to find control parents who were coping with similar developmental demands to the Index parents, and the purpose of matching for marital status of the mother was to control for illegitimacy. As there is a high incidence of illegitimacy in the Coloured population, and as it is an important variable in child abuse, it was felt to be advisable to guard against marked differences between the two groups in this respect.

Children who were in the Emergency Ward because of accidents were not included in the control group. Many mothers refused to act as controls. Some of these were very anxious about their sick children, and others were exhausted after spending one or possibly two nights in the Ward without a proper sleep. Twenty-four children and their families consented to form the control group.

The decision to control for social class was taken because so many of the factors implicated in the etiology of child abuse are associated with low social class and because most of the Coloured population are from the lower social classes. It seemed important to hold this variable constant in order to see if the other factors remained significant. It proved difficult to find control families who were from as low a social class as the Index families, which supports the reported association of child abuse with low social class. Fleiss (1973) states that matching increases efficacy when the characteristic being matched is strongly associated with the factors under study.

The social class system used in the present study is an adaptation of that developed by Hollingshead (1958), which is based on

1. The residential address of the family
2. The occupational position of the head of the household
3. The number of years of school which the head of the household has completed.

Examples of the 5 social classes are given below as they are used in the study. Local educational terms have been used in place of American ones. Schooling in Cape Town starts with Substandard A (average age 6 years), followed by Substandard B, then Standards 1 to 10. School spans 12 academic years, so that the average age of school-leavers is 18 years.

Class 1

Executives, community leaders and graduates with professional training.

Class 2

Teachers, social workers, managers and persons with some formal education after completing school.

Class 3

Bank tellers, secretaries, technicians and persons who have completed Standard 10. Husbands and wives are usually fairly equally qualified in this class.

Class 4

Semiskilled workers, like welders and factory assistants, who have mostly completed Standard 8 at school. The wives are often more qualified than the husbands.

Class 5

Mostly unskilled workers without a regular occupation, e.g. messengers, labourers and domestics, who have only reached Standard 2 or 3. They are often paid on a weekly basis.

CHAPTER 10

METHODOLOGY

The research design

The research design is primarily between group and cross-sectional, i.e. the study compares families who have been referred to the Hospital because they have a physically abused child to families who have been referred because they have a physically ill child, during the same current period.

The aim of the research is to investigate the differences between families who have an abused child and families who do not, with a view to ascertaining the etiological factors in child abuse, as it occurs in Cape Town. Before drawing general conclusions from a particular study of this nature, certain sources of possible error must be taken into consideration. Firstly, the Index Group may not be representative of physically abused Coloured children and their families in Cape Town. Although attempts were made through widespread notification and publicity to ensure that all child abuse cases identified in Cape Town during the period of the study were referred to the research team, it is likely that some, especially milder cases and cases from higher class families were not. Furthermore not all abused children are taken to a health or welfare facility, nor are all cases correctly identified there. It must also be borne in mind that the findings of the study refer primarily to physical abuse, and not to the whole spectrum of child abuse and neglect.

Secondly, the diagnosis of child abuse was not absolutely certain in all the Index cases, so that it is possible that some were misdiagnosed. The justification for keeping highly suspicious cases in the sample was that they were more likely than not to make a positive contribution to the findings of the study about child abuse. Most studies have reported that a considerable proportion of child abuse cases are never conclusively proved, so that the exclusion of such cases from the Index Group would seem to bias the group more than their inclusion.

Thirdly, the batterer of the child was sometimes not a member of the family, so that the Index Group is made up of families in which a parent is the batterer as well as a small number of families in which neither parent is the batterer. Conclusions reached in the study about the characteristics of the Index parents do not therefore discriminate between abusive and non-abusive parents. Unfortunately the sample was too small for comparisons between abusive and non-abusive parents to be made in a within-group study.

Fourthly, the pool from which the Control Group was drawn is not representative of the Coloured population generally. However the effect on the control family of having an ill child neutralizes to some extent unwanted effects in the Index families of having an injured child, and the fact that both Index and Control children and their families were being investigated in a hospital setting would minimise the bias

which would possibly occur if only one group were coming to the hospital as patients.

The research instruments

The choice of research instruments for the present study was determined partly by the nature of the variables to be measured, partly by factors relating to the co-operation of the subjects, and partly by economical factors. It was not possible to use instruments that were expensive in terms of time or numbers of staff involved, or that would demand more participation from the research subjects than they were willing or capable of giving. Direct observation or home-visiting were felt to be beyond the scope of the research project envisaged, as was the use of the Present State Examination because of its lengthiness and its concentration on recent psychopathology.

A search through the catalogues of psychological tests was unproductive. There were no assessments of family dynamics or parenting that would yield the information required in the present study, which investigates the broad spectrum of family life as well as more specific issues relevant to child abuse. The personality inventories in common use do not measure family functioning, are very time-consuming, are not available in both official languages of the country, and would be beyond the intellectual capacity of most of the families in the Index Group.

Clinical assessments like Fould's Symptom-Sign Inventory devote too much space to the diagnosis of psychoses, which were not expected to form a large proportion of the diagnoses of the Index families, and do not assess personality disorders, which were expected to form a significant percentage of the diagnoses in the Index Group. Fould's Hostility and Direction of Hostility Questionnaire seemed to be a measure that would be particularly relevant for a study of child abusers, but its use in this study was decided against in view of Smith's finding (1975) that there were no significant differences on this test between abusing parents and controls. Consequently it was decided that structured interviews would provide the best means of satisfying the aim of the study, and would be complemented by a mental status examination of the parents, an intelligence test for the parents, and a physical examination of the child. Copies of the interview schedules used in Smith's Birmingham study (1975) were obtained, as it was felt that the two studies were similar in aim and design, and that it would be an advantage to use interview schedules that had already been tested in the field. The present study would then also provide an opportunity to replicate his findings, or at least compare the findings of two similar studies in very dissimilar surroundings.

Four schedules were adapted for interviewing, and a fifth served to record additional data (see Appendix). The aim of the adaptations of Smith's schedules was to ensure that the language in which questions were phrased was familiar and

intelligible to local interviewees, that the content of the schedules was such as to be the equivalent of a complete psychiatric history and examination as set out in the standard textbooks, and that questions were phrased and answers recorded in such a way as could easily be computerised.

1. Circumstances of injury/illness schedule

This schedule records the circumstances of the abusive episode (omitted for the Control Group), and the present status (current functioning) of the children. The schedule contains 35 questions.

2. Childrearing attitudes schedule

This schedule comprises 12 questions.

3. Psychiatric interview schedule, and Mental State Examination

In this schedule information is obtained about the child's developmental history, about the parents' childhood experiences and family background, and about the parents' current functioning and relationships, within and without the family. There is in addition space for the recording of a mental state examination. The schedule contains 64 items, including a psychiatric diagnosis. All diagnoses were based on the classification proposed in the American Psychiatric Association's Diagnostic and Statistical Manual, No. 2, 1968.

4. Psychosocial interview schedule

This schedule recorded all the psychosocial information about the family and contained 49 questions.

5. Additional data schedule

In this schedule were recorded the nature of the injuries and other medical information derived from the physical examination of the child, diagnostic identifying data about the abusers, and the plans for the management of the case. There were 52 items.

The Physical Examination form (see Appendix) records a brief developmental and medical history of the child, in addition to the physical and neurological examination.

The psychological test used for assessing the IQ of the parents was the one employed in Smith's (1975) study, namely an abbreviated form of the Wechsler Adult Intelligence Scale, using four subtests: vocabulary, block design, comprehension and picture arrangement (see Appendix). The full test was considered too long, and other researchers have likewise used abbreviated tests (Hyman, 1977). A high correlation ($r = 0,90$) has been demonstrated between this shortened form and the full test (Maxwell, 1957). There was no standardised IQ test for the Coloured population available at the time, nevertheless it was felt that the use of a test like the Wechsler would provide a standard against which the Index and Control groups could be compared provided that the individual IQ levels were not taken as absolute.

The Wechsler Adult Intelligence Scale is available in both official languages of the country (English and Afrikaans) and

all the other interview schedules were translated into Afrikaans by a professional translator (only English versions have been included in the Appendix, for the sake of brevity). Before the commencement of the research interviews the parents were asked which was their mother-tongue, and thereafter the appropriate version was used throughout. All the interviewers were bilingual. Thirty-nine (80%) of the Index mothers and 20 (83%) of the Control mothers were Afrikaans-speaking, 10 (20%) and 4 (17%) respectively were English-speaking.

Statistical treatment of the data

Variables from the Index and Control groups were compared using the X^2 test for homogeneity of proportions (Fleiss, 1973). Yates' correction for continuity was applied to questions where there were only two responses, and the expected number of responses was less than five. The Index and Control groups were said to differ significantly if p was less than 0,05, i.e. a 5% significance level was used.

Pair-wise comparisons of the reliability of the three raters (psychiatrist, psychologist and psychiatric social worker) were carried out according to the method advocated by Fleiss (1973). The method compares the number of times the two raters agreed on their assessment, with the number of agreements that would be expected by chance in the event of there being no true agreement between them. The association

between the two raters was measured by a co-efficient

$$\text{Kappa} = \frac{P_O - P_C}{1 - P_C}$$

where P_O = proportion of agreements observed, and

P_C = proportion that would occur by chance.

The calculations were performed on the UNIVAC 1100/81 computer using the CROSTAB 2 programme of STATJOB - a computer package developed at the Academic Computing Centre of the University of Madison, Wisconsin, U.S.A.

Procedure

When Index subjects were referred, the research assistant (a psychiatric social worker) made some preliminary enquiries to ascertain whether the case seemed to be an appropriate one for inclusion in the Index Group. Any queries were discussed with the senior member of the research team (the author). If the case was appropriate the research assistant was usually able to arrange an immediate physical examination. All physical examinations were carried out by the same person, a Senior Paediatrician with training in developmental assessment, and usually in the same examining room. Haematological investigations and X-rays were arranged when deemed necessary. It was not possible to have skeletal surveys in all cases routinely.

Usually following the physical examination, but sometimes before, the research assistant interviewed the Index parents, administering the Circumstances of injury/illness and the Childrearing Attitudes Schedules. The research assistant then arranged the psychological testing, which was always done by the Senior Clinical Psychologist, and afterwards the administration of the psychiatric interview schedule by the Senior Psychiatrist (the author). The battery of assessments was completed with the administration of the psychosocial interview schedule by the research assistant. It was not always possible to follow this order in every case, and sometimes parents had to be brought back another day for completion of the assessments, but each interviewer always used the same room for their respective interviews.

The control children were not physically examined by the research team. Their medical records were consulted, and if there were any queries the doctor in charge of the Emergency Ward was approached. Sometimes the control mothers were reluctant to leave their child so that the interview had to be conducted by the bedside, which was not a satisfactory arrangement. However psychological testing was always conducted in the psychologist's room.

Pilot study

Pretesting the research instruments is essential for achieving maximum validity (Sainsbury, 1975). Consequently it was decided to use the first 10 Index cases as a pilot study. In

the pilot study it was found that a number of the questions in the interview schedules were couched in language too sophisticated for our subjects, and some of the questions were ambiguously worded or the possible answers too vague to be reliable. One or two questions had been omitted due to oversight. As a result the schedules were appropriately modified.

It also became clear that a considerable proportion of Index fathers would not co-operate with the research study, even when arrangements were made for them to get off work, and they were offered transport to the hospital. Even offers of an honorarium were unproductive. Consequently the schedules were altered in such a way that some information about the fathers could be gained through the mothers' schedules. It was decided that the psychosocial interview schedules would be administered to the mothers only, and that only mothers would have psychological testing. Fathers would be encouraged to complete the Circumstances of injury/illness schedule and the Childrearing attitudes schedule, and to attend for the psychiatric interview. However it was apparent that the main body of parental/family information would be about the mothers, or derived from the mothers.

There were objective as well as subjective reasons for the unavailability of the fathers. They lost pay if they attended at the hospital during work hours, and some employers would not even allow them time off from work, despite explanatory

telephone-calls to the employers by the research assistant. The fact that many of the fathers were the batterers was a potent deterrent to their attendance, probably reinforced by threats from their spouses to report them to the doctors.

Factors affecting the validity and reliability of the study

1. Conceptual difficulties with regard to the phenomenon of child abuse

A universally acceptable definition of child abuse would be hard to find, even for physical abuse. The presence of detectable physical injuries would not be accepted in some cultures as absolute proof of abuse, if they were sustained during the course of an acceptable disciplinary action. It is also possible that some severe disciplinary measures would not leave physical marks on some children, although the action might be considered in itself to be abusive. Some children reportedly bruise more easily than others.

If one is considering child abuse and neglect as a whole, it is artificial to look only at cases of physical abuse. Although one expects that children who have been physically abused, have also been abused previously in other ways, this is not invariably the case. Not all physically abused children show signs of neglect, nor have they all been sexually abused;

and occasionally, a fatal battering is the child's first experience of physical abuse, especially if the batterer is someone who does not normally live with the family, or is not the mother. There are also some severely emotionally abused children in whom physical abuse has not been a significant feature.

This study does not include any "potential abusers", a term describing individuals, usually self-referred, who feel that they are about to abuse a child physically. The study therefore does not set out to investigate the whole spectrum of child abuse and neglect, but it is thought likely that some of the characteristics of the families of physically abused children will be common to the families of children abused or neglected in other ways, so that the study should promote understanding of phenomena beyond its particular focus.

2. Difficulties concerning the identity of the batterer

It is not usually possible to determine the identity of the batterer in every case of child abuse, so that one has to consider the characteristics of battering parents collectively, rather than being able to define the characteristics of abusive and non-abusive spouses separately. Similarly, even when neither parent is the batterer, they are customarily studied in the same Index Group as the known battering parents. The numbers involved in this study are too small to permit of within-group comparisons, but the Control Group was compared both to the full Index Group and to a modified Index Group

from which the families were removed in which neither parent was the batterer. However, it has been reported in the literature that abusive and non-abusive spouses bear a close resemblance to each other, as do the families of abused children irrespective of whether the batterer is a parent or a caretaker outside the family (Baldwin, 1975; Ounsted, 1976).

3. The validity and reliability of the structured interview

Much of what has been written about the standardisation of structured interviews applies to the present study (Sainsbury, 1975). Factors affecting standardisation are the ability of the interviewer to gain the respondent's confidence, the ability to get the respondent to talk freely but to keep him to the topic in hand, and the ability to avoid influencing the respondent's answers or be influenced by him when recording the answers.

In order to be valid an interview must measure what it sets out to measure, and not include extraneous factors. Validity will be impeded if the respondent does not understand the question, if the topic is one about which he may not wish to give a true answer, or if the respondent gives answers which he thinks will please the interviewer. The present study attempted to achieve a high level of validity by conducting a pilot study, by using language intelligible to the respondents, by ensuring that the respondent understood the purpose of the study, by stressing confidentiality, and by putting questions about sensitive topics near the end of the interview

whenever possible.

An interview schedule is reliable if its findings are reproducible, i.e. it must be able to produce the same answers from the respondent irrespective of where or when or by whom it is administered. The present study aimed at improving reliability by unambiguous wording of questions, by asking quantitative rather than qualitative questions, by being careful not to alter the meaning of the question by too much interpretation, and by allowing the respondent to ventilate feelings about the abuse and referral to the hospital before administering the schedules. Reliability was impeded by the fact that the respondents were often anxious, or depressed or hostile, the answers to some of the questions involved memory of distant events, and the interviewers came from a different social class and ethnic group to the respondents.

In order to provide some assessment of factors that might be influencing the validity and reliability of the present study, interviewers were asked to record at the end of their interview whether the respondent had appeared co-operative or not; whether the interview had seemed mainly reliable or mainly unreliable - if unreliable, whether this was due to difficulty understanding the questions or because of the interference of the emotional state of the respondent; and to rate the respondent for depressive, anxious and hostile mood, and poor self-esteem. The latter ratings from the different interviewers (psychiatrist, psychologist and psychiatric social

worker) would be compared, and would provide some index as to the presence of any interviewer bias. The interviewers were each supplied with guidelines about how to assess and rate the four areas, in order to minimise the effect of different conceptual approaches (see Appendix).

4. The reliability of psychiatric diagnoses

Several studies have shown that if two psychiatrists interview and diagnose patients independently of one another under ordinary working conditions, they are likely to make the same diagnosis only 30 - 40% of the time, and even when both are experienced and share the same orientation agreement is rarely better than 60% (Sainsbury, 1975). As there are recognised difficulties about making a reliable psychiatric assessment of a parent at the time of his referral for child abuse, both because of feelings about the referral and because of the lack of collateral information about the parent from the family doctor or relatives, the author first consulted the other schedules of each parent and his spouse before making the psychiatric diagnosis. This was felt to be especially important in the diagnosis of personality disorders, and alcohol and drug abuse, as the men in particular under-reported their own antisocial behaviour and alcohol and drug abuse. Despite considerable previous psychiatric experience with Coloured patients, it is possible that the accuracy of the author's psychiatric assessments may have also been affected by such factors as subcultural differences in modes of expressing symptoms, and by the bias which may occur when the respondents are

of lower social class than the interviewer. B.P. Dohrenwend (1970) reported that psychiatrists, when basing their assessments on face-to-face interviews as opposed to written reports, rated more lower class than higher class patients as ill.

PART 3

THE CLINICAL STUDY : RESULTS AND DISCUSSION

CHAPTER 11

METHOD OF REPORTING THE RESULTS

The problem of how to report the results of approximately 300 variables and not allow the more numerous findings of no statistical significance to eclipse the few findings of major significance has been dealt with fairly stringently by reporting and discussing only the significant findings in the main body of the text, and simply recording the other results without comment in the Appendix. All the important positive and negative findings of the study appear in the main text. In the Appendix only the results of the mothers' interviews are given, as the Index 'fathers' group was incomplete and uncontrolled. The term 'fathers' refers not only to the biological fathers but to whichever adult male (stepfather or boyfriend) was living with the Index mother and acting as father to the Index child.

The variables reported in the main text have been grouped according to subject, rather than according to the Schedule from which the information was derived. To avoid the confusing impact of numerous tables of figures, the results have been simply presented as positive or negative statements followed by the percentage of the Index and Control group to which the statement applies. All percentages have been reduced to the nearest whole unit. When the statement does not refer to the whole group, the size of the sample is indicated in the discussion section. Where differences between the

Index and Control groups have achieved significance at the 5% level ($p < 0,05$), the p value has been shown next to the results. These values are not set out again in the Appendix.

In order to balance and complement the analytical presentation of the results of the study, three case-reports are provided. These cases have been chosen to illustrate some of the different child abuse situations encountered in the study, and they also demonstrate the very *individual* nature of child abuse. The *common* factors in child abuse can be seen in the full list of cases given in Chapter 17. When bracketed numbers appear in the main text next to extracts from case-histories, they refer to the case numbers listed in Chapter 17.

CHAPTER 12

CASE-REPORTS

Case No. 1

Alvin, a 28 month old illegitimate child, was taken by his mother to a doctor at another hospital, at the suggestion of his caretaker who was concerned about his cough and speech delay. On examination Alvin was found to have a bruise on the left cheek, linear bruising on the right cheek and old bruises on the back. His mother could give no explanation for them, and when the doctor stated that they appeared to be inflicted injuries, the mother immediately blamed the caretaker. However she could not "remember" the address of the caretaker. Neither Alvin nor his older brother (of a different father) had had previous suspicious injuries according to the mother, and a skeletal survey was negative. Although Alvin had been admitted to the referring hospital 6 months previously for pneumonia, he was currently well. His weight was on the 5th percentile, and height on the 3rd. The mother said that Alvin cried a lot and could make you cross quickly. She slept in one room with her two children and said that because of Alvin's crying they did not get enough sleep.

In the Childrearing Attitudes Schedule the mother stated that she doesn't hug or play with Alvin, and that she expects instant obedience from him. She said that Alvin has a bad temper and makes her angry: *"I get very angry at times and can kill him"*. She did not answer the question about physical

punishment despite being asked several times.

The mother, Margaret, was 23 years old, single and of no fixed abode. She had had an unhappy childhood because her father used to drink and become physically violent towards her mother and all the children. They all had to sleep outside on such occasions. Margaret was fond of her own mother, but did not see so much of her, as they spent a lot of their childhood with their maternal grandmother who lived about 50 kilometres from Cape Town. Margaret had had repeated hospitalisations during her childhood for a "stomach complaint". She had truanted from school, and finally left at the age of 12 years. She had started working immediately and had had 7 jobs altogether, having been dismissed from the last one 2 weeks previously because she had missed a day's work. Her jobs were mostly in factories, or working as a waitress, and she was considered to belong to Social Class 5.

Margaret was the 2nd of 9 children. One brother had died at birth, and another is deaf and dumb. Margaret's mother had had two admissions to a psychiatric hospital, and her father left home four years ago. She doesn't get on with her stepfather or her sister who lives in Cape Town. Margaret described her own personality as follows: *"I used to be very rough, like a man - I used to hit a man back. Now I just cry".* Margaret said she had often been in fights with other adults - usually over complaints about her children - and she had appeared in court many times because of this. She admitted that

she often gets anxious and depressed and has been given tranquillisers at another hospital, not the same hospital she attended with her child.

Margaret found out after she became pregnant with Alvin that his father was already married. Three months ago he divorced and married someone else. Margaret related this with much feeling. She was on tranquillisers during the pregnancy and had had 'morning sickness' throughout. She had wanted to *"give Alvin away"*, but had changed her mind when he was born. She said with feeling that she doesn't want more children, and she has not let Alvin's father see him, because of the way he treated her.

Margaret had no income at the time she was referred to the research team and was dependent on handouts. She had moved frequently, often sleeping with her children in the open. She denied previous contact with social agencies. She said she was often lonely and bored, and had no social or domestic leisure activities.

Her IQ was 68, and at mental status examination she was assessed as having a depressive neurosis and an explosive personality. She refused admission to hospital for psychiatric treatment, and was referred to the local Child Welfare agency. She asked them to take her children, and when they were placed in foster-care she disappeared. When the foster-mother found that she couldn't cope with the children, they were transferred

to a Place of Safety. Later, Margaret went to the Child Welfare agency and demanded her children. When the social worker refused to release them immediately, Margaret physically assaulted her and the police had to be called. Subsequently the children were released to Margaret after it had been arranged that she stay with her sister, and the agency arranged a monthly grant for her. The Child Welfare agency continued to supervise the children's care, and Margaret agreed to attend the Child and Family Unit for supportive therapy. A course of antidepressants which had been prescribed, was discontinued by Margaret, and she resisted further attempts to admit her as an in-patient.

Case No. 10

Shahieda, a 3 year old only child, was fatally battered *after* she had been referred to the research team. Shahieda was first brought to the hospital by a man in whose house Shahieda and her mother had been lodgers, and whose wife used to still care for Shahieda from time to time. On this occasion Shahieda had abrasions on the left side of her face, and bruises on the left thigh and both buttocks. The mother's boyfriend had allegedly beaten up both Shahieda and her mother, Salama. The man who accompanied Shahieda said he would take her home with him, and would tell the mother to come to the hospital. He agreed to advise the mother to lay a charge against her boyfriend but apparently she refused to do so. When the mother did not keep her appointment at the hospital, a community social worker

visited the home and said that Shahieda was still with the man who had brought her to hospital. When the research assistant telephoned the mother at work to give her another appointment, Salama said that she had taken Shahieda home with her again. When the mother did not keep the second appointment, it was discovered that Shahieda had been battered to death the day before.

The mother said that the day before he killed Shahieda, Philip, her boyfriend, was trying to teach Shahieda, a Moslem, to say Christian prayers. He said he wanted to train her to his ways as she was too attached to her mother. He was cruel towards Shahieda and beat her severely because she couldn't say her prayers properly. The following day, Monday, the mother stayed at home as she was thinking of coming to the hospital, although the appointment was not till the Tuesday. The mother thinks Philip was anxious about what would transpire at the hospital. He called Shahieda to come to the kitchen, and when she wouldn't, he beat and kicked her to death.

The mother described Shahieda as a quiet child, who was not difficult in any way and who had not had any serious illnesses. In the Childrearing Attitudes Schedule the mother expressed only caring attitudes about Shahieda and children in general.

Salama was 21 years old, a divorcee according to Moslem law, and cohabiting with Philip, a single 20 year old Christian, in his brother's house. Salama said she had always been a

nervous child. Her father left home when she was 6, and was never seen again. Salama was the middle of 8 children and got on well with her mother. She left school in Standard 6 and worked in factories for 2 years before getting married by Moslem law at the age of 17. Her husband deserted her when Shahieda was 14 months, and she went back to work while Shahieda was cared for by the caretaker whose husband had first brought Shahieda to hospital. This arrangement lasted for 2 years until Salama went to live with her boyfriend, about 3 months before Shahieda's death.

Salama said she was nervous during the pregnancy, but there were no complications and Shahieda weighed more than 2,5 kgs. Salama said she still has a good relationship with her mother and other relatives, and has good friends. She has always got on with the people at work, and describes herself as a friendly person. Her health is good, but she is a very nervous person and frequently cries. She has never consulted a psychiatrist but a maternal uncle and aunt have both had admissions to a psychiatric hospital.

Philip said he had had treatment as a child for a serious "blood" problem. He had been a nervous and unhappy child because a brother used to hit him a lot and because his father died from Tuberculosis when he was 4 years old. Philip was the youngest of a family of 15, of which 8 had died and 1 was currently in gaol. His relationship with his mother was good at first but had later deteriorated. However he said he still got on well

with his relatives and a few friends. He left school in Standard 6 and worked as a driver for three years, but left *"because the employer was difficult"*. He had subsequently worked in a factory, but was unemployed at the time of the abuse.

Philip described himself as getting on well with others, but Salama described him as difficult and impatient. He said Salama was a good person. He stated that his health was good, but he admitted to smoking dagga and abusing alcohol. He had never had psychiatric treatment, but a cousin had been admitted to a psychiatric hospital. He denied physically assaulting Salama, but admitted to battering Shahieda, and also his brother's children on occasion. He had a criminal record - at the age of 14 he had received cuts for theft, and at the age of 18 had been imprisoned for assaulting someone with a knife. His brothers also abused alcohol and had criminal records. Philip had no children.

Salama and Philip and Shahieda lived in a bedroom in his brother's house, on her income of R18 per week, which she felt was adequate. They were considered to belong to Social Class 5. Salama had regular social and domestic leisure activities and was not lonely or bored, but she was worried about finance and accommodation. They had not had contact with any social agency. Philip said they had a good relationship, but Salama maintained that it was very ambivalent. They used to argue about Shahieda because Philip said Salama

was too possessive, and he was jealous. Salama admitted that she spoilt Shahieda. They also argued about his dagga smoking. Salama said that he used to physically assault her.

Salama's IQ was 76, and she was assessed as having an anxiety neurosis. Philip was given the diagnosis of Antisocial personality. He was sentenced to 4 years imprisonment for culpable homicide.

Case No. 23

Fernandez, a 9 year old boy, was brought to the hospital by his mother because she wanted help. She had recently attacked and choked him because she found his new reading book torn to pieces, and Fernandez lied about it, saying that it had happened while he was turning the pages. She felt she would have strangled him if someone had not pulled her away. She had beaten him previously with a strap, leaving marks, and found that she was beginning to hit him harder and harder over the last 6 months. She had also poured petrol in his mouth.

Fernandez, the 3rd of 4 boys, was born with congenital arthrogryphosis, but his birth weight is not known. His mother said she rejected him at birth. She hated him because he was crippled, and felt that his disability might in some way have been the result of his father's unfaithfulness at the time. At the age of 2 months he was admitted to hospital for a year, and then transferred to an Orthopaedic Hospital where he had

corrective surgery to his feet, enabling him to walk. He still wears orthopaedic boots and sleeps with his legs in splints. He remained in hospital till the age of 8 years when the hospital discovered that his mother had adequate accommodation for him at home. She had visited very rarely, and had given the hospital the impression that she was a living-in domestic. In fact, she had not worked for the last 4 years and was cohabiting with the deputy-headmaster of a school in his large house. The mother said that for the first few months at home Fernandez was good, but then he just stopped doing what he was told. She said he cries if you just look at him, and he eats too much, stuffing the food into his mouth. He soils occasionally and wets the bed and wakes her nearly every night. He is jealous of his younger brother, and he steals and lies. She said his body gives off an unpleasant smell no matter how much she washes him, and his teeth are badly discoloured. She said he reminds her of his father, and she feels nothing for him - she just wants him out of her sight. According to his teacher, he is attention-seeking at school, and fights with smaller children. He is making satisfactory progress, but has problems with arithmetic. There were no problems with the other boys - the two older ones were living in the country with their maternal grandmother who had reared them.

In the Childrearing Attitudes Schedule the mother said she can't hug Fernandez. She reacts negatively to toilet accidents, messiness and Fernandez' aggression. She expects

instant obedience and regularly gives physical punishment. She rarely praises him.

The mother, Frances, was 38, a divorcee who was cohabiting. Fernandez' father had died shortly after their divorce. She was one of 15 siblings, and could not recall any adverse childhood experiences. She had had a good relationship with her family, and still has. She left school before Standard 6, and worked until 4 years ago. She had known her husband for much more than 6 months before marrying him, as they only married while she was pregnant with Fernandez. She was happy to be pregnant even though they were not yet married, but the pregnancy was stressful because her husband started going out with other women.

Frances described herself as strict. Her health was good, however she had been depressed and upset since Fernandez came home, and she had started hating him again. She had never had psychiatric treatment and there was no family history of psychiatric illness. She denied physical aggression or alcohol or drug abuse. Her brothers abused alcohol but there was no history of criminality in the family. She had no children by previous liaisons.

The family was considered to belong to Social Class 3. They lived in a 4 bedroomed house and had no debts. Frances was not lonely or bored and had a variety of social and domestic leisure activities. However, she worried about her emotional

state. She had a good relationship with her cohabitee, and was satisfied with herself and her boyfriend. He did not abuse alcohol, and did not physically assault her.

Frances had an IQ of 70, and was assessed as having a diagnosis of depressive neurosis. Fernandez was also tested on the Old South African Individual Scale and given an IQ of 81. Frances agreed to have counselling, and to bring Fernandez for individual therapy at the Child and Family Unit. However after four sessions each, Frances was resistant to further therapy as she felt that her relationship with Fernandez was continuing to deteriorate. It was decided that it would be in the best interests of both Fernandez and his mother to place him in a Children's Home. He was admitted at the beginning of 1978, and 6 months later was reported to have made a good adjustment there.

CHAPTER 13

THE CHILDREN

The injuries of the Index children	Percentage of Index group
Bruising	59
Burns	14
Fractures of the long bones	14
Central Nervous System	12
Fractures of the skull	8
Internal	6
Perineal (sexual)	4

The mean age

The Index children	52 months
The Control children	39 months

Sex	Percentage of Index group	Percentage of Control group
Females	57	58
Males	43	42

Other characteristics	% of Index group	% of Control group	p
Premarital conception	50	14	0,05
Illegitimacy	52	42	
Mothers' ill-health during pregnancy	24	8	
Mothers' stress during pregnancy	50	38	
Birth weight less than 2500 gms	31	Not known	
Present ill-health	13	100	
Previous serious illnesses	16	25	
Previous suspicious injuries	33	0	0,005
Behaviour problems	39	13	0,05
Poor eater	27	21	
Poor sleeper	45	50	
Excessive crying	31	13	
Siblings' previous suspicious injuries	28	0	0,05

Discussion

The injuries

Although the majority of the injuries were not life-threatening, serious injuries formed a considerable proportion of the spectrum seen, and 4 children died as a result of the abuse. Seven children had multiple injuries. The proportion of fatal and multiple injuries is approximately half that reported by Smith (1975) in his study, but the difference can be explained at least in part by the fact that his Index children were much younger, that is, all under the age of five years. Smith found that the incidence of all injuries in his Index children decreased with increasing age, with the exception of burns.

The children's bruises were both localised and widespread, and did not follow any particular pattern. The burns comprised cigarette burns (1), heater burns (1), scalding (1), open fire (1), stove plate (2), and 1 of uncertain origin. The classical finding of multiple fractures in various stages of healing was not a feature of this study, as most of the fractures were single.

The Central Nervous System injuries consisted of subdural haematomas (4) and cerebral damage following asphyxiation (2). One of the internal injuries was a contused bowel, and the other 2 internal injuries were sustained during the course of fatal battering. The postmortem findings of the 4 fatally

injured children were:

1. A 2 year old girl abused by a 16 year old babysitter

Old cigarette burns on the sacral and buttock areas.
Bruising of different ages all over the body.
Bruising over the Right frontal scalp, and over the Right cerebral hemisphere.
Subdural haematoma of the Right hemisphere.
Mesenteric haemorrhages. (Case No. 3)

2. A 3 year old girl abused by a 16 year old male neighbour

Perineal injuries from sexual assault.
Bronchial pneumonia.
Cerebral damage from anoxia. (Case No. 5)

3. A 3 year old girl abused by mother's boyfriend

Extensive bruising, including a subaponeurotic scalp contusion.
Laceration and contusion of the upper lip.
Gaping linear wound on the Left calf.
Contusion of the Thymus, the anterior mediastinum and the Left lung.
Retroperitoneal contusion and intraperitoneal haemorrhage.
Bilateral subdural and subarachnoid haemorrhage. (Case No. 10)

4. A 6 year old girl abused by mother's brother

Perineal injuries from sexual assault.
Laceration around the neck from strangulation with wire.
Cerebral damage from anoxia. (Case No. 49)

The four children who were fatally injured were all young girls and their attackers were all males, but a sexual motive for the attack was evident in only two of the cases. None of the 4 children died at the hands of a biological parent. The old cigarette burns noted in the first case were thought to have been inflicted by the child's mother on a previous occasion, but the truth was never ascertained. The second child was ill in bed with pneumonia at the time of the attack, and was allegedly smothered by her attacker after the sexual abuse.

Previous suspicious injuries

The term *previous suspicious injuries* includes past injuries due to acknowledged abuse as well as injuries strongly suspected of being due to abuse. The repetitive nature of child abuse is confirmed by the significant percentage of Index children who had been battered previously, a percentage which is almost certainly less than the true incidence. Over half of the Index children in Smith's (1975) study had been battered previously. Although all the Control mothers initially denied previous suspicious injuries, one Control mother subsequently acknowledged abusing her child previously. Examples of the previous suspicious injuries reported are:

1. An Index mother who had battered her 5 year old daughter: *"I'm always hitting her. She gets bad bruises. I don't know why I single her out - I can't stand her".* (Case No. 16)

2. The Control mother of a 6 year old girl: *"A few years ago I hit her and her sister with a strap on their buttocks and their face because they wouldn't go to school. They had bruises and cuts".* (Case No. 14)

The findings of previous suspicious injuries in a significant proportion of the siblings of the Index children confirms the conclusion reported in the literature that child abuse is not confined to one child in the family. The number of cases of previous suspicious injuries in siblings is expressed as a percentage of the number of Index (38) and Control (19) children with siblings. Although all the Control mothers again denied previous suspicious injuries of siblings initially, two Control mothers subsequently acknowledged previous abuse of siblings. Examples of the previous suspicious injuries reported for siblings are:

1. An Index mother whose 2 year old boy had been battered by his father: *"He also hit our older daughter when she was small, and she still has a mark on the side of her head. On another occasion he hit her in the face so that both her eyes closed up".* (Case No. 36)

2. The Control mother of a 9 month old boy: *"My husband hit*

our oldest child some years ago and gave him a bleeding nose and swollen lips". (Case No. 6)

Sex and age

In keeping with the findings of most child abuse studies, the sex difference among the battered children was not a statistically significant one.

Despite matching for age, the mean age of the Control children was 12 months younger than that of the Index children. However it was not a statistically significant difference. The ages of the Index children ranged from 5 months to 13 years 2 months. The age distribution of the Index children resembled that of children attending the general outpatients department of the hospital, with 31% of the Index and 25% of the outpatients children aged 6 years or more (Willoughby, 1979).

It was not possible to assign the Index children to a meaningful ordinal position on account of the large number of their half and stepsiblings, some of whom lived at home and others elsewhere, a situation also described by Fowler in her Norfolk study (1979). The Index child was more often a second or subsequent child of the mother's than a first or only child, as in Smith's study (1975). However as a considerable proportion of the Index children and their siblings had been battered previously, the study was not able to identify the ordinal position of the child first battered by the parents.

Behaviour problems

Mothers were asked to report any personality or behaviour problems such as nervousness, naughtiness or stealing. Although the assessment of behaviour problems by a mother is subjective, the validity of the ratings was improved by the fact that the Index mothers had to supply details of the behaviour and the interviewer had to satisfy herself that the problem behaviour really existed. The finding of a considerable proportion of behaviour problems in the Control group lessens the likelihood that the assessment was invalid.

The presence of behaviour problems in abused children has been quoted in favour of the concept of the abuse-provoking child, but they may equally be the result of the abusive or an otherwise detrimental environment. In the British National Child Development Study Davie (1972) found that behaviour problems occurred more commonly in lower class children. The considerable proportion of behaviour problems in the Control children may be secondary to their physical ill-health, or be a reflection of their low social class.

The following is an example of the behaviour problems reported: An Index mother who battered her 9 year old son said: *"He's nervous when I give him a scolding. In the beginning he used to take my money - I gave him beatings. He doesn't listen and I don't like it".* (Case No. 23)

Bonding factors

Illegitimacy rates in the two groups were similar because of the matching of the mothers for marital status. Unlike most child abuse studies, the illegitimacy rate of the Index group was not significantly greater than the national illegitimacy rate for the Coloured population in 1977 (50%). The reason for this is not clear because the Index mothers seemed both younger and of lower social class than the general population. However the incidence of premarital conception was significantly high in the Index group (19 Index and 10 Control mothers had never married).

Physical ill-health and stress during pregnancy were reported more commonly by the Index than Control mothers, but the difference did not reach statistical significance. The most frequent complication of pregnancy reported was high blood pressure. The stress seemed to be often due to the extra-marital nature of the conception, which led to conflicts with in-laws and physical assault by the father of the child, and an increase in symptoms of anxiety and depression.

Information about the births of the Index children was scanty owing to missing and incomplete maternity records. The high percentage of known low birth weights (the birth weights were known for only 32 Index children) is not significantly greater than the 24% reported by Molteno (1980) in a survey of Coloured births in Cape Town, and can be related to the youthfulness of Coloured mothers and their low social class. Some

of the low birth weight babies were separated from the Index mothers and transferred to intensive care units, but details are lacking. Concern was recorded by the nursing staff in the maternity notes about two of the Index mothers:

1. *"The mother was reluctant to move and asked the staff to help her with the baby".* (Case No. 2)
2. *"The mother did not visit her baby after discharge from hospital".* (Case No. 9)

Two Index children were born with congenital abnormalities. The mother of the boy with congenital arthrogryphosis expressed feelings of revulsion towards him, and had rejected him over the years. The other child was born with legs of unequal length.

Three of the Index children compared to none of the Control children had experienced separation from their mothers within the first few years of life: the mother of one was hospitalized, one mother died and the third child was placed in foster-care because of neglect.

Health and development

Although no developmental tests were administered, none of the Index children were found to have severe developmental delays or mental retardation, or neuro-epileptic conditions. Similarly, marked physical neglect was not a feature of the Index group compared to the Controls.

The present physical illnesses of the Index children included Tuberculosis, Kwashiorkor, Pneumonia and Gastro-enteritis; and their previous illnesses were mostly Pneumonia or Gastro-enteritis severe enough to warrant admission to hospital. All the Control children were ill, with a variety of moderately serious conditions, so that the substantial history of previous illnesses is not surprising.

Disturbances of eating and sleeping, and excessive crying

A considerable number of both Index and Control children were regarded by their mothers as poor eaters, a finding which may reflect their low birth-weight, their current ill-health or difficulties in the mother-child relationship. In only two cases was a feeding problem cited as the precipitating factor for the abuse.

A large percentage of both Index and Control children woke frequently at night, which may be related to ill-health, anxiety, or overcrowding and domestic conflicts.

Although not reaching statistical significance excessive crying was reported more frequently among the Index children compared to Controls, and may reflect disturbed family relationships in the Index group, as crying was cited as a precipitating factor in the battering of 9 (18%) of the Index children. The incidence in Smith's (1975) study was 21%.

CHAPTER 14

THE FAMILIES

Family constitution

	Index Group	Control Group
Single parents	13 (27%)	7 (29%)
Married parents	22 (45%)	13 (54%)
Cohabiting 'parents'	14 (28%)	4 (17%)

Relationship of mother to child

	Index Group	Control Group
Biological mother	45	24
Adoptive mother	1	0
Stepmother	1	0
Foster-mother	1	0
No mother	1	0

Relationship of 'father' to child

	Index Group	Control Group
Biological father	26	17
Adoptive father	1	0
Stepfather/mother's boyfriend	9	0
Foster-father	1	0
No father	12	7

Social class of family

	Percentage of Index Group	Percentage of Control Group
Class 1	0	0
Class 2	0	0
Class 3	2	4
Class 4	23	25
Class 5	75	71

Monthly income of family

	Percentage of Index Group	Percentage of Control Group
0 - 49 Rand	37	21
50 - 99 Rand	28	38
100 - 199 Rand	26	33
R200 -	9	8

Domestic worries reported by mothers

	Percentage of Index Group	Percentage of Control Group
Finance	82	46
Domestic friction	49	13
Mother's health	45	17
Employment	41	29
Housing	37	38

Other significant characteristics

	% of Index group	% of Control group	p
Family in financial debt	60	17	0,005
Mother regards housekeeping allowance as inadequate	78	50	0,05
Three or more domestic worries reported	59	21	0,005
Poor marital relationship	63	18	0,01
Mother dissatisfied with spouse	61	24	0,05
Mother regards spouse's relationship with child as poor	50	6	0,01
No mutual decision-making between spouses	43	6	0,05
No agreement about child's discipline	42	0	0,005

Discussion

Family constitution

The two groups were matched for marital status of the mother. Of the 13 single parents in the Index group, all were mothers except one. In the 1970 national census single parent families in the Coloured population formed 20% of all families, whereas an analysis of consecutive Coloured births in Cape Town in 1976 revealed that 32% were born to single parents, 57% to married couples and 11% to cohabiting couples (Molteno, 1980). The Index group did not therefore contain a significantly high percentage of single parents, but did have an unusually large percentage of cohabiting couples which raises the possibility that cohabiting couples may be more at risk for child abuse than single parents.

Twenty-three (47%) Index children compared to 7 (29%) Control children were no longer living with both their biological parents, and, furthermore, whereas all these 7 Control children were living with their biological mothers only, nearly half of the corresponding Index children were living in reconstituted families. This finding not only suggests that the Index parents are less stable than the Control parents, but raises the interesting possibility that children in reconstituted families may be at greater risk of child abuse than children who live with either one or both of their biological parents only. The child with a step-mother had lost his own mother by death, and the foster-child had been removed from her biological mother because of neglect.

Large families were not a feature of either the Index or Control groups, although the parents came from families which were considerably larger. The great majority of Index and Control families had 4 children or less, if one did not count the step and half-siblings.

Socio-economic factors

The two groups were matched for social class. The concentration of child abuse cases in Class 5 is striking even though the Coloured population is known to have a large lower class. There are no official figures for the social class distribution of the South African population, but in Molteno's (1980) study of Coloured births in Cape Town the distribution was: Classes 1 - 3, 36%; Class 4, 27%; Class 5, 36% (social class was based on the occupation of the breadwinner). The association between child abuse and low social class is widely accepted now (Pelton, 1978). Smith (1975) who did not control for social class, also found his Index group to be of significantly lower social class than the controls, even though both were drawn from a hospital pool.

In keeping with their low social class both groups had equally low incomes. Approximately 60% of both groups had an income of less than R100 (£62) per month. According to the Department of Statistics the average income of a Coloured person in 1977 was R174 per month.

Only 4% of both groups saved money. Despite their similar incomes a significantly greater percentage of Index families compared to Control families were in debt. The reasons for this difference were related partly to lower income and partly to greater expenditure in the Index group. More Index than Control families had a smaller income, or no income at all as a result of unemployment. The details of the expenses were difficult to ascertain, but debts appeared to be mainly for clothing, furniture or medical treatment. The reasons for the greater expenditure by the Index group can only be surmised: They had more children to support as a consequence of their previous liaisons, and they must have spent more money on alcohol and dagga than the Control group, who abused these substances much less. Finally, it seems likely that the Index parents had more difficulty coping with household organisational duties such as budgeting, as they seemed to have less stable personalities, and more domestic problems than the Control parents. The suggestion that the Control parents had better coping skills than the Index parents is borne out by the fact that, although as many as half the Control mothers felt that their housekeeping allowance was inadequate, only 17% were in debt compared to 60% of the Index group.

An exceptionally high rate of unemployment was not a feature of the Index group. Twenty percent of the Index 'fathers' and 14% of the Control fathers were unemployed, compared to the 1973 rate of unemployment among Coloured males in South Africa of 19% (van der Horst, 1976). Forty-five percent of

the Index mothers were working (approximately half full-time) compared to 38% of the Control mothers (all full-time).

Accommodation was equally poor in both groups, and over-crowding was evident. In 13 Index and 6 Control families there were more than 8 persons in accommodation ranging from one room to two-bedroom houses. It was not possible for home-visits to be done.

Geographical mobility was not a feature of either group, an unsurprising finding in view of the critical housing shortage for the Coloured population in South Africa. There was also no difference between the groups regarding contact with social agencies (39% of the Index group and 30% of the Control group).

Domestic worries

A significantly high percentage of Index mothers reported multiple domestic worries, and the main ones are listed in a separate table. Their concern about finance, domestic friction, employment and their own health was realistic, as these were all areas of acknowledged stress for the Index families, and less so for the Controls.

Marital dysharmony

The single parent families were excluded when assessing the marital characteristics of the two groups, although some of the single Index mothers had ongoing relationships with the biological fathers of the Index children, and some of these

fathers were the batterers. The presence of an unsatisfactory relationship between the marital couples and cohabitees as reported by the mothers, distinguished clearly between the Index and Control families, a finding also reported by Smith (1975). Nineteen Index mothers and 2 Control mothers said they had been physically assaulted by their spouses ("wife-battering"), and 7 Index mothers admitted having physically assaulted their spouses ("husband-battering"). The marital relationship in the Index group was therefore characterised by physical violence.

The marital relationships were also characterised by the inability of the Index couples to come to mutual decisions about important family matters, including the Index child's discipline. These characteristics may have been causes and effects of the poor marital relationship. The relationship was further plagued by the finding that so many of the spouses had a poor relationship with the Index children, according to the mothers, which may have been related to the fact that a considerable proportion of the Index 'fathers' were not biologically related to the Index children.

The study was not designed to tease out definitively the factors leading to the marital dysharmony. The personalities and previous life-experiences of the spouses were undoubtedly contributory factors, as well as the circumstances of their marriages or living together. Although they did not all reach statistical significance the following circumstances of

the marriages were found more frequently in the Index group: premarital conception, acquaintance before marriage of less than 6 months, mothers reported other motives for marriage than 'love', and a negative reaction on the part of the mother on learning that she was pregnant. Factors relating to the child which were found more frequently in the Index group may also have contributed to the marital breakdown, namely more emotional stress and physical ill-health during the pregnancy, the spouses' jealousy of the mothers' attention to the Index child, and the Index children's behaviour problems. Although children's behaviour problems may cause stress in the marriage, they may also be caused by marital conflicts.

CHAPTER 15

THE MOTHERS

The mean age in years

	Index Group	Control Group
At interview	27	26
At marriage	22	21
At the birth of the first child	19	20

Education

	Percentage of Index Group	Percentage of Control Group
Standard 6 or less	94	92
Completed schooling (Std. 10)	0	0

Mean IQ

Index Group	Control Group
77	75

Religion

	Percentage of Index Group	Percentage of Control Group
Protestant	59	84
Catholic	23	8
Moslem	18	8

Mothers' childhood experiences

	% of Index group	% of Control group	p
Separation from own mother before 4 years	23	17	
Family break-up before 16 years	56	50	
Anxious as a child	57	35	
Unhappy as a child	45	25	
Conduct disorder as a child	16	21	
Serious ill-health as a child	27	33	

Mothers' childrearing attitudes

	% of Index group	% of Control group	p
Hugs or plays with child frequently	81	100	
Believes all children should be toilet-trained by 1 year	20	9	
Over-reacts to child's toilet accidents	24	9	
Over-reacts to normal messiness of children	27	25	
Expects instant obedience	41	46	
Regularly uses physical punishment on child	26	4	0,01

Other characteristics of mothers

	% of Index group	% of Control group	p
Mother has children by previous liaisons	43	4	0,001
No domestic leisure activities	27	0	0,05
Lonely	59	21	0,005
Ill-health	37	17	
Dissatisfaction with self	49	13	0,01

Psychiatric disorder

	% of Index group	% of Control group	p
Neurotic symptoms	82	38	0,0005
Neurosis	67	33	0,05
Personality disorder	8	0	
Psychosis	2	0	
Alcohol abuse	8	0	

Discussion

Age, education and IQ

At the time of the interview the Index mothers' ages ranged from 17 years to 46 years, compared to Smith's (1975) study where the range was 16 to 40, with a mean of 24 years. There was no statistical difference between the Index and Control mothers' ages, suggesting that the Index mothers may be no younger than mothers in the general population of similar social class. However, there are no official South African statistics with which to compare their ages. The youthfulness of the Index and Control mothers at the birth of their first child is probably related to their low social class. In his analysis of Coloured births in Cape Town Molteno (1980) found 20% to be the product of teenage pregnancies, compared to 33% in both the Index and Control groups in the present study, a difference which is very likely associated with the lower social class of the latter.

The finding of low educational achievement and low IQ in both the Index and Control mothers is probably a reflection of their low social class, for which they were matched. Only 35 Index and 19 Controls had IQ tests. Smith (1975) found a significant difference between the IQ's of his Index mothers (80) and Control mothers (95) even after adjusting for social class. Although the IQ's in the present study cannot be taken as absolute because the test used was not standardised on the Coloured people, the mean IQ of the Index mothers (77) is remarkably similar to that of the abusive mothers in Smith's study (80). The IQ range of the Index mothers was 54 to 117.

Religion

There was no significant difference between the Index group, the Control group or the Coloured population generally regarding their religious affiliations. All the mothers professed affiliation to a religious group, and over 75% stated that religion played a meaningful role in their lives. Smith (1975) also did not find any significant factors relating to religious affiliation, but less of both groups reported a personal faith.

Mothers' childhood experiences

Unlike many child abuse studies, the Index mothers did not report a significantly greater number of adverse childhood experiences. The reasons for this may lie in the fact that the mothers of both groups were both from the lower social classes, and they were not asked specifically about physical abuse and neglect in their own childhoods. Large percentages of both groups reported negative childhood experiences, suggesting that a common factor such as low social class may be operating.

Separation refers to separation for more than one month, and family break-up refers to the absence of either parent for at least two years consecutively. Most of the latter absences were caused by the desertion of the father. The high incidence of family break-up in both groups is a finding also reported by other studies of lower class families.

Conduct disorders in childhood were recorded if the mother reported truancy, stealing or fighting to a marked degree, or other similar behaviours. Both groups reported a considerable incidence of both conduct disorders and serious ill-health as children, both of which have been described as occurring more frequently in the lower social classes.

Although not statistically significant, the difference between the two groups regarding their memories of being anxious or unhappy as children was more marked than for the other childhood experiences. These memories were reported by a considerable number of the Control mothers, but by notably more of the Index mothers. The mothers said that their anxiety and unhappiness in childhood was mostly associated with rejection by parents, or domestic friction involving alcohol abuse and physical violence. It is not difficult to see a likely connection between these childhood experiences and child abuse, alcohol abuse and violence in their own subsequent families. Moreover it was found that three-quarters of those mothers who reported anxiety or unhappiness in childhood had a diagnosed neurosis at the time of the present study. Smith (1975) also found that a significant proportion of Index mothers recalled neurotic symptoms in childhood, and impaired relationships with their siblings and parents, and rated their parents as harsh and rejecting.

Mothers' childrearing attitudes

The only significant finding regarding the childrearing attitudes of the two groups was the regular use of physical punishment by the Index mothers, confirming the opinion of many authors that child abuse is related to the acceptance of physical violence as a means of disciplining children.

The Childrearing Attitudes Schedule was not a very reliable measure of the mothers' attitudes. The questions were not specific enough and were over-inclusive. Some investigated general attitudes, while others asked about the mothers' attitude to a particular child (the Index or Control child), which then introduced different factors. The general similarity between the two groups regarding their childrearing attitudes, if it reflects a true similarity, may be due to their similar age, and cultural and social class background. After adjusting for the effects of social class and youthfulness Smith (1975) still found the following differences between his abusive and non-abusive groups to be significant: the abusive mothers used more physical punishment, and were more under- or over-involved with their children.

Other characteristics

A very significant number of Index mothers had children by previous liaisons, suggesting a greater promiscuity as well as lack of contraceptive use. This finding could not be explained on the basis of low IQ or lack of education, or be due to differences in age or social class, but indicates

differences in personality and moral values.

A significant percentage of Index mothers said that they were lonely, dissatisfied with what they had made of their lives, and had no domestic leisure activites. These variables are probably inter-related. Their loneliness seemed to be a subjective phenomenon as they reported as many social activities as the Control mothers, such as visiting friends or attending Church meetings. Their feeling of loneliness may reflect their poor self-esteem, their poor marital relationship and their poor social skills generally. Domestic leisure activities included reading, sewing, knitting, crocheting, watching television and any other hobby or special interest. The absence of these activities may have been due to personal inadequacy, ill-health, preoccupation with domestic worries, or household disorganisation.

The ill-health reported by the Index mothers included asthma, rheumatoid arthritis, epilepsy, hypertension and gynaecological problems.

Psychiatric disorder

The Index mothers were characterised by neurotic disturbances. Almost all the Index mothers complained of neurotic symptoms such as excessive worrying, fearfulness and crying spells, and 2 out of every 3 Index mothers were diagnosed as having a definite neurotic disorder. The majority of neuroses were anxiety and depressive neuroses, with 1 mixed neurosis in the

Index group and 1 hysterical neurosis, dissociative type, in the Control group. The rate of 33% in the Control group is high, but Gillis (1968) reported a similar figure (29%) in his survey of psychiatric disorder in the Coloured population (males and females) in Cape Town. Smith (1975) also found a significant rate of neurosis in the mothers in his abusive group (48%), but the rate in the Control group was very low (10%).

Personality disorders were not a feature of the mothers in either group. None of the Control mothers were given this diagnosis, and only 4 of the Index mothers. Two were explosive personalities, 1 an inadequate personality with habitual excessive drinking, and 1 a passive-aggressive personality with habitual excessive drinking. Smith (1975) reported a similar incidence of personality disorders in the mothers of his two groups.

Only 1 mother was diagnosed psychotic - a borderline psychosis - and she was the batterer of the Index child. Smith's (1975) finding was 3%.

Alcohol and drug abuse were not a characteristic of the mothers, a finding also reported by Gillis (1973). None of the mothers admitted drug abuse, and only 4 Index mothers were given a diagnosis of alcohol abuse. Three were habitual excessive drinkers and 1 was an episodic excessive drinker. Three of these mothers were living with men who abused alcohol. Smith (1975) also found a low incidence of alcoholism

and drug dependence in both groups of mothers.

Only a small percentage of Index mothers (6%) and Control mothers (4%) had criminal records, compared to 11% and 0% respectively in Smith's (1975) study.

Despite the high rates of neurotic disorders in both groups only 10% of the Index mothers and 8% of the Controls had received psychiatric treatment. The small number of psychiatrically disturbed individuals who make use of psychiatric facilities has been a frequent finding of epidemiological studies. Gillis (1968) found that only 1% of psychiatrically disturbed Coloured persons in Cape Town used existing services.

The Index mothers reported considerably more alcohol and drug abuse and criminality in their parents and relatives than the Control mothers, although the difference did not reach statistical significance. Thirty-five percent of Index and 26% of Control mothers reported psychiatric illness in a parent or relative. In most cases the illness was treated by admission to a psychiatric hospital, indicating again that outpatient psychiatric services are under-utilised. Gillis (1968) found that 10% of the relatives of psychiatrically disturbed Coloured respondents in Cape Town had suffered from a psychiatric disorder or been treated in a psychiatric hospital, compared with 4% of the relatives of respondents with no psychiatric disorder.

CHAPTER 16

THE FATHERS

The Index 'Fathers' mean age at interview — 29 years

Education

	Percentage of Index group	Percentage of Control group
Standard 6 or less	83	Not
Completed schooling (Standard 10)	0	Known

Religion

	Percentage of Index group	Percentage of Control group
Protestant	70	74
Catholic	12	13
Moslem	18	13

Other characteristics reported by mothers

	% of Index group	% of Control group	p
Father has children by previous liaisons	36	12	
Alcohol abuse	43	6	0,05
Drug abuse	38	7	
Criminal record	49	6	0,01

Psychiatric disorder

	Percentage of Index group	Percentage of Control group
Neurotic symptoms	42	
Neurosis	25	Not Known
Personality disorder	42	
Psychosis	4	

Discussion

Too few Control fathers attended for a fathers' Control group to be constituted. Any information about the Control fathers that is reported, has been derived from the Control mothers. In such instances the total sample of Control fathers numbers 17, as there were 7 Control families without a father.

Similarly, where information about the Index 'fathers' was obtained from their spouses, the number in the sample was 37, as there were 12 Index families without a father. Only 24 Index 'fathers' completed the Circumstances of Injury/Illness and Childrearing Attitudes Schedule and the Psychiatric Inter-View Schedule, nevertheless some of the more important findings from these interviews are given.

The age of the Index 'fathers' at interview ranged from 19 to 60, and the mean was 2 years older than the Index mothers. In Smith's (1975) study the mean age of the Index fathers was 27, but then all his abused children were under 5 years of age.

The poor educational achievement of the majority of the Index 'fathers' resembles that reported for the Index mothers, so that it can be postulated that their IQ's would also follow a similar pattern to those of the mothers. Smith (1975) found the mean IQ of his Index fathers to be 92, compared with 102 in the Controls.

The distribution of the religious affiliations of the Index 'fathers' resembles that of the Coloured population generally, as does that of all the other parents.

The Index 'fathers' reported lower rates than the Index mothers for all their childhood experiences with the exception of conduct disorder (32%). As the Index 'fathers' tended to under-report compared to the Index mothers, this finding is particularly noteworthy, especially as it tallies with the known higher incidence of conduct disorder in boys compared with girls. As regards their other childhood experiences, there is no reason to believe that they were any better than those of the Index mothers.

There were no significant findings from the Childrearing Attitudes Schedule, but then it seemed to be even less reliable when administered to the Index 'fathers' than to the mothers.

Other characteristics reported by the mothers

The percentage of Index 'fathers' with children by previous liaisons is probably even higher than the figure given, as the Index mothers might not have been aware of all the children their spouses had fathered. Twenty-one percent of the Index 'fathers' had been married more than once compared to none of the Control fathers (12 Index and 4 Control fathers had never married). These findings show a lack of family cohesiveness in the Index 'fathers' and suggest that they were less stable compared with the Control fathers.

A significant incidence of alcohol abuse and criminal records distinguished the Index from the Control fathers. This information was derived from the mothers, as the fathers' reporting of these aberrations was unreliable. The pattern of their alcohol abuse was primarily the week-end drinking of excessive quantities of wine, as also described by Gillis (1973) in his report describing the high incidence of alcohol abuse in Coloured males. Five Index 'fathers' were considered to be episodic excessive drinkers, 7 habitual excessive drinkers and 3 addicted to alcohol.

The only drug reported to be abused was dagga (Cannabis sativa). The *occasional* smoking of dagga was not recorded as drug abuse. The question about drug abuse was included in the mothers' Schedule only well after the commencement of the study, so that the drug habits of the 'fathers' were recorded in only

29 of the Index cases and 15 of the Controls. It seems very likely that, if the information about drug abuse had been complete, the difference between the two groups would have been statistically significant. Smith (1975) did not find alcoholism or drug abuse to be a feature of either his Index or Control fathers, which is a surprising finding out of keeping with that of most child abuse studies.

The majority of convictions among the Index 'fathers' were for crimes of violence, the remainder being for drunkenness or theft. In Smith's (1975) study the main offence was theft, followed by crimes of violence, and the overall incidence was 29% in his Index group. The high incidence of crime among young Coloured males in South Africa is well documented and a matter of grave concern (Schurink, 1979).

The finding that the Index mothers, who come from families with high rates of alcohol and drug abuse and crime, have formed new families with men who have similarly high rates of these aberrations, shows how multi-problem families are perpetuated from generation to generation.

Psychiatric disorder

The pattern of psychiatric disorder in the Index 'fathers' is quite different to that in the Index mothers, with personality disorders commoner in the males and neuroses commoner in the females, as has been described in the psychiatric

literature. Although the Control fathers were not psychiatrically assessed, it is likely that the same significant difference regarding psychiatric disorder in the Index and Control groups would hold for the fathers as it did with the mothers.

The neuroses diagnosed were anxiety and depressive neuroses only. In one or two cases, as with the Index mothers, an individual received the diagnosis of both neurosis and personality disorder.

The one case of psychosis diagnosed was paranoid schizophrenia. This father was also an inadequate personality and used dagga, and he was the batterer of the Index child. He had discontinued outpatient psychiatric treatment four months before the abusive episode. The incidence of neuroses and psychoses in the Index fathers in Smith's (1975) study was 10% and 1% respectively. Neither were significant when compared to his Control group.

Nearly half of the Index 'fathers' were diagnosed as having a personality disorder: 4 antisocial personalities, 3 inadequate personalities, 2 paranoid personalities and 1 passive-aggressive personality. Gillis (1968) points out that the diagnosis of personality disorders is difficult because such individuals do not complain of specific symptoms and one has to rely on reports of behaviour and what one can observe during the interview. Therefore it would have been particularly valuable to have a Control group with which to compare

this high incidence of personality disorders in abusive 'fathers'. Smith (1975) also found a high percentage of his Index fathers to have severe personality ("psychopathic") disorders - 37%.

As with the mothers, only a small percentage (9%) of the Index 'fathers' had received psychiatric treatment. Forty-two percent of the Index 'fathers' reported psychiatric illness in a parent or relative, but the corresponding figure for the Control fathers is not known.

CHAPTER 17

THE ABUSIVE EPISODE AND THE ABUSERS

The diagnosis of child abuse

Acknowledged or witnessed	65%
No other possible explanation for the injuries	19%
Highly suspicious	16%

The time of injury

Morning	30%
Afternoon	42%
Evening	23%
Night	5%

The sex of the abusers

Male	26	(62%)
Female	16	(38%)
Not known	7	

The abusers' relationship to the Index child

Biological parent	27	(63%)
Step parent/mother's boyfriend	8	(19%)
Adoptive parent	1	(2%)
Foster-parent	1	(2%)
Other relative	2	(5%)
Unrelated caretaker	4	(9%)
Not known	6	

THE CHARACTERISTICS OF THE ABUSIVE EPISODE AND OF THE ABUSERS

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
1	2	Not known	Single	Injuries noted when mother brought child to doctor for unrelated complaint	Mother: Depressive Neurosis and explosive personality
2	1	Biological mother	Cohabiting with biological father	Mother was arguing with sister-in-law; child sat and cried; so hit her	Mother: Anxiety Neurosis
3	2	Male caretaker	Widow (single)	She wouldn't eat her food and she cried because she couldn't go out, so he hit her (fatal)	Mother: Anxiety Neurosis
4	6	Biological father	Married	Hit the child because he irritates him; he doesn't believe it's his own child	Father: Anxiety Neurosis and paranoid personality. Habitual drinker

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
5	3	Male caretaker	Cohabiting with biological father	Child was alone, sick in bed. When parents returned they found her dying, and she had been sexually assaulted	
6	1	Not known	Separated/ divorced (single)	Injuries noted when mother brought child to doctor for unrelated complaint	Mother: Depressive neurosis
7	8	Male relative	Married	Was teasing children with a knife, so hit him and fractured his nose	Mother: Anxiety neurosis. Father: Habitual drinker
8	1	Biological father	Married	Father was smoking dagga and hit her because she was crying for her broken dummy and didn't want the new one.	Father: Inadequate personality and paranoid schizophrenia. Uses dagga
9	1	Not known	Single	Not known	

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
10	3	Mother's boyfriend	Cohabiting	Child beaten and kicked to death by boyfriend because she wouldn't come to him when he called	Mother: Anxiety neurosis. Boyfriend: Antisocial personality. Uses dagga
11	9	Adoptive mother	Married	Mother beat him while father held him down, because he had worn his new shoes without permission, had ruined them, and then lied about it	Father: Depressive neurosis
12	12	Biological father	Married	She wouldn't answer when father asked her to do something, then she cried, so he hit her	Mother: Anxiety neurosis. Father: Habitual drinker and uses dagga
13	3	Biological mother	Married	Mother hit him because he wouldn't go to the creche	Mother: Depressive neurosis
14	6 months	Not known	Cohabiting with biological father	Not known - fractured skull	Mother: Anxiety neurosis. Father: Antisocial personality, and alcohol addict

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
15	13	Biological father	Divorced (single)	Child living with father. Circumstances of abuse unknown	Mother: Depressive neurosis. Father: Depressive neurosis and episodic drinker
16	5	Biological mother	Married	Mother hit her and pushed her to the ground because she was disobedient	Mother: Borderline psychosis
17	7 months	Biological father	Single	Father drunk - held child over open fire	Mother: Anxiety neurosis and inadequate personality and habitual drinker. Father: Habitual drinker and uses dagga
18	1	Biological mother	Married	Mother hit child because she was crying and asking for food	Mother: Mixed neurosis. Father: Inadequate personality
19	5	Biological mother	Cohabiting with biological father	Circumstances not known	Mother: Depressive neurosis

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
20	3	Stepfather	Married	Stepfather hit her because she wouldn't urinate in the 'pottie'	Mother: Depressive neurosis. Father: Anxiety neurosis
21	2	Biological father	Cohabiting with biological father	Father was drunk and took the child away and beat her up	Father: Anti-social personality; episodic drinker and uses dagga
22	1	Biological father	Single	Father was drunk and came to quarrel with mother; he took the child into the garden and beat her	Mother: Anxiety neurosis. Father: Depressive neurosis and explosive personality and episodic drinker
23	9	Biological mother	Cohabiting with boyfriend	Mother choked him and beat him because he tore the pages of his new reading book and lied about it	Mother: Depressive neurosis
24	10 months	Female caretaker	Married	Fractured skull - circumstances not known	Mother: Anxiety neurosis
25	3 months	Biological father	Married	Father hit him because he was crying and caused a subdural haematoma	Mother: Anxiety neurosis. Father: Anxiety neurosis

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
26	3	Mother's boyfriend	Cohabiting	Boyfriend was drunk - said the child did not like him, so started hitting him and caused a contused bowel	Mother: Depressive neurosis. Father: Anti-social personality and uses dagga
27	3	Biological father	Separated/ divorced (single)	Father didn't want to pay maintenance, and took the child away and poured boiling water over her	Mother: Anxiety neurosis. Father: Anxiety neurosis and antisocial personality and uses dagga
28	5 months	Biological mother	Married	Ingested 2 needles and parathion. Circumstances not known	Mother: Depressive neurosis. Father: Uses dagga
29	7	Biological mother	Married	Mother put his hands on the stove plate because she found him lying with step-sister	Mother: Depressive neurosis
30	7	Stepmother	Married	Mother put her hands on the stove plate because found her lying with step-brother	Mother: Depressive neurosis
31	1	Biological father	Single	Father hit her because she was crying because afraid of him	Father: Episodic drinker and uses dagga

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
32	1	Not known	Single	Fractured skull - circumstances not known	Father: Uses dagga
33	4	Biological father	Cohabiting with biological father	Father hit her because she couldn't remember things he had told her weeks ago	Mother: Explosive personality. Father: Passive-aggressive personality, habitual drinker and uses dagga
34	2	Foster-mother	Married	Neglected burn requiring admission - circumstances not known	Mother: Depressive neurosis
35	9 months	Not known	Cohabiting with biological father	Fractured ribs and clavicle - circumstances not known	Mother: Depressive neurosis. Father: Episodic drinker
36	2	Biological father	Cohabiting with biological father	Father hit her because she wouldn't eat, and he fractured her femur	Father: Episodic drinker and uses dagga
37	3	Biological mother	Married	Circumstances not known	Mother: Anxiety neurosis
38	1	Not known	Married	Circumstances not known	
39	6	Biological mother	Separated/ divorced (single)	Mother upset because neighbour shouted at child, and so hit him	Mother: Depressive neurosis

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
40	4	Biological father	Married	Father hit child when he came home because mother said child had been naughty	Mother: Passive-aggressive personality and habitual drinker Father: Alcohol addict
41	10	Mother's boyfriend	Cohabiting	Boyfriend drunk - hit child because he would not fetch water and was crying	Mother: Anxiety neurosis. Father: Alcohol addict and uses dagga
42	5	Biological father	Married	Father hit her because a boy pulled her pants down	Father: Habitual drinker
43	7	Biological father	Married	Circumstances not known	Father: Habitual drinker
44	7	Biological mother	Single	Circumstances not known	Mother: Depressive neurosis and habitual drinker
45	7	Stepfather	Married	Stepfather was drunk and hit him because he threw a stone at a girl. Stepfather fractured his humerus	Mother: Anxiety neurosis. Father: Inadequate personality, habitual drinker and uses dagga

Case No.	Age of Child (years)	Identity of abuser	Marital status of mother	Circumstances of the abuse	Psychiatric disorder
46	5 months	Female caretaker	Single	Subdural haematoma - circumstances unknown	Mother: Anxiety neurosis
47	1	Mother's boyfriend	Cohabiting	Mother quarrelling with boyfriend and holding child who was crying - he hit them both, causing a fractured skull	Mother: Anxiety neurosis and episodic drinker. Father: Episodic drinker and uses dagga
48	12	Stepfather	Married	Father was fighting with mother and hit the child too	Father: Anxiety neurosis and paranoid personality
49	6	Male relative	Cohabiting with biological father	Uncle angry with mother for demanding rent, so abducted his niece and sexually assaulted her and strangled her	Mother: Depressive neurosis

Discussion

Some 'fathers' were interviewed who were not living with the Index children. Information from these interviews has been excluded from all previous tables, but has been included for interest's sake in the final table: "Characteristics of the abusive episode and of the abusers", as these 'fathers' were often the abusers of the Index children. Apart from these cases, the term 'father' in the psychiatric disorder column always refers to the acting father of the Index child. In this table only the more serious injuries are specified.

In the majority of the cases the abuse was admitted by the abuser or witnessed by the other parent, whose allegations were accepted if they were borne out by the nature of the injuries. In 9 cases the diagnosis of abuse was regarded as certain because there could be no other possible explanation for the injuries. The remaining 8 cases were considered to be highly suspicious of child abuse because no other cause for the injuries could be detected, and the circumstances of the case made abuse the most likely diagnosis. No Control children showed recent injuries, but 2 had been abused in the past.

The circumstances of the abuse

No time of day appeared to have been a time of significantly extra risk for child abuse. The day of the week on which the abuse occurred was not recorded.

The abuse seems to have occurred more frequently when the abuser was alone with the child, but there were a number of occasions when both parents were present. In these cases it was usually the father who had battered the child, and there was very little collusion, as the mothers almost invariably admitted what had happened. In the 6 cases where the child was abused by a caretaker or relative, neither parent was present at the time of the abuse. Three children of single mothers were abused by their biological fathers after they had taken them away from their mothers.

The injuries were more often inflicted with the aid of a stick or other 'weapon' (44%) than with the bare hand (12%). The next commonest modes of injury were burning, throwing and kicking. One child had 'swallowed' 2 needles on separate occasions and 'ingested' insecticide on a subsequent occasion.

Precipitating factors

What emerged from the study was that each case had very individual circumstances and could not be pressed into a common mould. However, many of the psychodynamic mechanisms and precipitating factors were seen which have been described in the literature.

In some cases excessive physical punishment was administered or the borderline between discipline and abuse was crossed, as in the case of the adoptive mother who gave her son a hiding because he had worn and ruined his new shoes, and then

lied about it (11); and the case where the mother burnt her children's hands on the stove after discovering them engaged in sexual play (29,30). With younger children one saw the provocative effect of incessant crying on the parents, who eventually lashed out in desperation, as in the case of the child who cried for food (18) (the mother was not able to afford to buy enough food) and the case of the child who cried because her parents had replaced her old familiar 'dummy' (pacifier) with a new one (8). However one could not really maintain that in these cases it was the child who had provoked the abuse, as the behaviour for which they were abused did not appear to be so abnormal.

Sometimes the abuse was clearly due to displaced aggression, as in the case of the mother who was having an argument with her sister-in-law and turned around and hit the Index child who was crying (2); and in the case of the father who was always picking on the Index child because he didn't believe it was his child (4). Displaced aggression can be very dangerous, as was seen in the case of the biological father who didn't want to pay maintenance to the mother, and took the Index child away and poured boiling water over her (27); and in the case of the Index child's uncle who was angry with her mother for demanding the rent which he owed her, and who abducted the Index child and sexually assaulted and strangled her (49).

Unrealistic expectations of children also led to abuse as in the case of the father who used to ask his 4 year old daughter

to repeat things he had told her weeks previously (33); and role reversal was evident in the case of the mother's boyfriend who hit the 3 year old Index child because he felt the child didn't like him (26). In several cases children seemed afraid of their 'fathers' who sensed this and put them to the test by asking them to do certain things - and when the children didn't do them, probably because they were frozen with fear, they were cruelly beaten. On the whole displacement of aggression and unrealistic expectations of children were more characteristic of the fathers than the mothers, whereas the latter often injured children in the course of their attempts to discipline them.

The role of alcohol and dagga during the abusive episode

Information about the role of alcohol and dagga during the actual abusive episode is incomplete. In only 1 case was the abuser known to be smoking dagga, and in 6 cases known to be drunk at the time of the abuse. It is likely that these figures are an underestimate of the true number of cases in which alcohol intoxication contributed to the abuse, as violent behaviour in Coloured males in the Cape is well known to be associated with alcohol consumption. Dagga is not usually considered to release violence. Hemphill (1980), in a Cape Town survey of male offenders referred for inpatient psychiatric assessment, concluded that dagga is even likely to reduce aggressiveness in alcohol abusers.

The known cases in which alcohol abuse played a part were not

the most serious ones, and it is apparent that severe and fatal injuries can be inflicted without the releasing effect of alcohol. The severity of the injuries appeared to be related to the age of the child. Three of the 4 fatally injured children, and 12 of the 14 seriously injured children were 3 years old or younger. The fatal injuries were all inflicted by males, but the serious injuries showed no marked sex difference.

The characteristics of the abusers

Although the majority of the known batterers were males, the sex difference would probably disappear if one could establish the identity of the 7 unknown batterers, as they were probably mostly females. The male batterers could seldom escape identification as they were usually reported by the Index mothers who were probably afraid of a recurrence of the battering which they would not be able to prevent. As the mothers were often alone with the child, it was not always possible to find proof of battering when they were guilty. When they denied knowledge of battering, they tended to offer no explanation for the injuries or suggest that it was an accident. When they did blame some other person (when they themselves were guilty), it was usually a caretaker, and not their spouse.

Although the identity of 7 batterers was unknown, the relationship of the batterer to the Index child was unknown in only 6 cases, as in one of the cases the injuries could only

have been inflicted by one of the biological parents, probably the mother. The majority of the abusers were one of the biological parents of the child. In 3 cases the Index child was battered by his biological father even though they were not living together. A considerable number of the abusers were step-parents or the mothers' boyfriends, so that it seems as if there is a particular risk for the children of reconstituted families. The stepmother, the adoptive mother and the foster-mother were each the batterer in their families. These findings support reports in the literature that any children who are seen as different are at risk for child abuse. The two relatives who battered were both maternal uncles. Two of the caretakers were women, while the other two were male youths.

The number of cases in the study was too small to permit a valid comparison to be made between battering parents and non-battering parents of abused children. However when the known battering parents (37 cases) were compared to the Control group, all the variables found to be significant for the whole Index group showed a trend towards greater significance. It seems likely that the characteristics of the non-battering parents of abused children would fall somewhere between those of battering parents and those of parents without an abused child, because some of those parents would be abusive and some not, as in the study. For instance, in the case of the 2 year old battered to death by the male caretaker (3) - when the mother brought the injured child to hospital she

first gave a false story to explain the injuries, and gave the true version only when confronted with the obviously abusive nature of the injuries. At postmortem this child appeared to have been neglected and abused for a considerable time prior to the fatal battering by the caretaker, and the mother was suspected. On the contrary, in another case where a woman caretaker had seriously injured a young baby (24), the parents appeared to be caring, stable people, and it was discovered later that the caretaker had previously battered other children in her care.

On the other hand, when one of the *parents* was the batterer there was at least a 50% chance that the other parent had a psychiatric disorder or abused alcohol or dagga. Every known battering-parent with one exception had a psychiatric diagnosis, or abused alcohol or dagga. The exception was the adoptive mother, but the adoptive father was suffering from a depressive neurosis. These findings contradict the suggestion that batterers are just ordinary people under stress, and that everyone is a potential batterer. The parents of physically abused children have clearly more psychiatric disturbance than non-abusive parents, even though they may not have been diagnosed or received treatment.

CHAPTER 18

ASSESSMENT OF THE VALIDITY AND RELIABILITY OF THE STUDY

The aim of the study was to obtain an informed understanding of the nature of physical abuse among Coloured children in Cape Town. Like all child abuse studies, the research design had certain limitations. For instance, it could not be assumed that the Index children were exactly representative of all physically abused Coloured children in Cape Town. However a wide spectrum of injuries was seen, and the circumstances of the abusive episodes resembled those described previously in South Africa and elsewhere, suggesting that the Index group could be accepted as *fairly* representative of child abuse in the Coloured population of Cape Town and elsewhere. Similarly, the Control group was by no means exactly representative of the general Coloured population, yet the fact that the Control children were all suffering from moderate ill-health does not mean that their families were radically different in other respects to the average Coloured family in Cape Town of that social class. Controlling for social class, marital status of the mother (illegitimacy) and the age of the child, enabled factors more specifically associated with child abuse to be brought into sharper focus.

Regarding the research instruments, attempts were made to make the structured interviews as valid and as reliable as possible, but a middle course had to be steered between these two requirements. While trying to obtain precise responses

which would facilitate computerisation, one had to be careful not to restrict the spontaneity of the respondents who were usually anxious or depressed or hostile. Although the Index parents were clearly affected by such emotions more than the Controls (as measured by the ratings for co-operation and reliability at the end of each interview), it was only in the Psychosocial Interview that there was a significant difference (p 0,005) between the two groups regarding reliability. The social worker felt that the Index mothers were not giving honest responses to some of the questions. However this 'denial' enhances the significance level of the positive findings of that interview rather than diminishes it. It must also be borne in mind that many of the factors which influence the validity and reliability of a study are eliminated in a controlled study.

The psychologist rated the mothers for test-set and motivation regarding the IQ test, and found no difference between the two groups. The psychologist felt that she had been able to allay most of the initial anxiety and resistance of the mothers towards the test situation by explaining the nature and purpose of the test, and she judged that most of the mothers understood what was required of them, and were adequately motivated to co-operate.

Inter-rater reliability

The three main interviewers were asked to rate the emotional state of the mother during the Circumstances of Injury/Illness

Schedule, the Psychiatric Interview Schedule, the Psychosocial Interview Schedule and the IQ test. The comparison of their ratings cannot be taken as an absolute indicator of inter-rater reliability as the interview situations were not comparable. However it was felt to be worthwhile to look for the presence of any marked interviewer bias, and on the other hand if the ratings were similar it would tend to serve as an independent confirmation of the reliability of the psychiatrist's mental status examinations - at least, with regard to the assessment of the mothers' mood disturbance.

For depression, there was significant agreement between all three interviewers at the 0,001 level.

For hostility and anxiety, there was significant agreement between the psychiatrist and social worker at the 0,001 level.

For poor self-image, no agreement was reached between the interviewers.

The lack of agreement between the psychologist and the other two interviewers could be due to the very different nature of her contact with the mothers. The IQ test was much shorter in duration than the other interviews, and did not call for as much personal involvement.

The lack of agreement between the interviewers regarding the assessment of poor self-image may be related to the greater

difficulty of assessing this state compared to mood disturbances. The guidelines regarding the assessment of poor self-image were not as specific as those for the mood disturbances.

Replication of Smith's Birmingham study

The similarity between the findings of this study and those of Smith's (Hanson, 1977) is remarkable, especially in view of the very different geographical, ethnic and political circumstances of the Index families in the two studies. The common findings of the two studies are listed below:

Premarital conception of the Index child

Previous suspicious injuries of the Index child

Siblings' previous suspicious injuries

Behaviour problems of the Index child

Lack of family cohesiveness (mother has children by previous liaisons)

Mother is lonely

Mother is dissatisfied with self

Mother regularly uses physical punishment

Mother reports excessive domestic worries

Mother reports housekeeping allowance inadequate (family in debt)

Mother has diagnosis of neurosis

Father has diagnosis of personality disorder

Father has criminal record

Marital dysharmony

Low social class (includes low income, poor housing, unemployment, poor education, low IQ, Illegitimacy and teenage pregnancies)

Apart from alcohol and drug abuse, the findings that were not mutually replicated do not add or subtract substantially from the pattern of the common findings listed above, so that the conclusions of the two studies are essentially the same. Not only does this suggest a common universal mechanism in child abuse that transcends cultural factors, but also validates the research design and instruments employed in the studies.

CHAPTER 19

THE CONCLUSIONS

The study set out to test the hypothesis that the families of physically abused children would show significant differences regarding their psychological, psychiatric and psychosocial characteristics when compared to families who had not been referred because of physical abuse of their children. This hypothesis has been clearly proved. In other words, the significant differences found between the Index and Control families are not the product of chance, but have meaning. The meaning will be examined in the light of the three theoretical models of child abuse described in the review of the literature.

The major positive finding of the study is the abnormal personality functioning and the psychiatric disorders of parents in nearly all the Index families. Most of the significant psychological, psychiatric and psychosocial characteristics of the Index families can be explained on the basis of the abnormal personalities and the psychiatric disorders of the parents. However this main positive finding cannot be considered in isolation from a very important negative finding of the study, namely the low social class of the Index families. It does not mean that, because the Control families were of equally low social class but did not have abused children, that circumstances and factors associated with low social class are not important in the etiology of child abuse.

The following findings of the study can be understood to be the direct effect of the abnormal personalities and psychiatric disorders of the Index parents: the use of regular physical punishment by the Index mothers; the child abuse inflicted by both parents, not only on the Index child but also on his siblings and repeatedly; the physical violence, especially of the Index 'fathers' towards the Index mothers and other adults; the premarital conception of the Index child by the Index mothers, the numbers of children of both parents by previous liaisons, and the parents' lack of family cohesiveness; the behaviour problems of the Index children; the loneliness of the Index mothers, their dissatisfaction with themselves, and their lack of domestic leisure activities; the neurotic symptoms of the Index mothers and their neuroses; the personality disorders of the Index 'fathers', their alcohol and drug abuse, and their criminal convictions; the financial debts of the Index families; and the marital dysharmony.

This explanation of the positive findings of the study supports the view propounded by the Psychiatric Model, namely that factors within the individual abuser are responsible for child abuse. These are called internal mediating factors by the Dohrenwends (1980) and form part of an individual's vulnerability to stress. According to the Dohrenwends unfavourable life-events must combine with an individual's vulnerability to produce stress. Vulnerability may come from internal or external mediating factors.

What is the origin of the abnormal personalities and psychiatric disorders of the Index parents? Psychoanalytic theory would maintain that the abnormal personalities are the result of inadequate or disturbed parenting in the first few years of life, and that the psychiatric disorders became overt or were precipitated in such vulnerable individuals by stressful experiences later in life. The present study did not conclusively demonstrate the existence of significantly more early emotional deprivation in the Index parents (possibly because of methodological deficiencies), but there was a trend in that direction.

If it be accepted that the positive findings of the study can most meaningfully be interpreted as the result of the abnormal personalities and psychiatric disorders of the Index parents, what about the role of low social class? Both Index and Control groups were clearly of lower social class than the Coloured population generally, suggesting that there are factors related to low social class which predispose to child abuse. These factors would be: low income, poor housing, unemployment, illegitimacy, teenage pregnancies, poor educational achievement and low IQ. Where these occur in conjunction with abnormal personality functioning and psychiatric disorder, child abuse is likely to be found. These factors correspond to the external and internal mediating factors described by the Dohrenwends (1980).

Besides low social class, the Sociological Model stresses the

importance of violence in society and stressful life-events as etiological forces in child abuse. The finding of the greater use of physical punishment by the Index mothers, and repetitive child abuse in the Index families, possibly reflects the greater level of physical violence in the Coloured population generally, as well as being related to the abnormal personalities of the Index parents. The study did not specifically investigate the incidence of recent unfavourable life-events, but the Index families did not appear to have experienced a greater number of the kind of unfavourable life-events that *cause* psychopathology as opposed to those that are the *consequences* of psychopathology. Examples of the former would be ill-health or injury, bereavement, loss of a job or enforced rehousing. The latter kind, which would include premarital conception, family violence, family break-up, psychiatric illness and criminal convictions, were more prevalent in the Index group. Therefore it would seem that stressful life events did occur more commonly in the Index families but they were largely the consequences of their abnormal personalities and psychiatric disorders (the psychological characteristics category of the Dohrenwends).

The Social Interactional Model of child abuse stresses the role of inadequate or disturbed parenting and of marital dysfunction, and the effect of the child on the parent. The finding of a significant percentage of behaviour problems in

the Index children would appear to be the result of inadequate parenting and marital dysfunction as the behaviour which precipitated the abuse did not seem to be excessively provocative, and illustrated the inadequate parenting skills of the parents more than the provocativeness of the children. The marital dysfunction displayed by the Index parents appeared to be both the result of their individual abnormal personalities, as well as actively contributing to the child abuse. This was clearly seen in the cases where certain male batterers displaced their feelings of aggression towards the Index mothers onto the Index child even in single parent families. Inadequate or disturbed parenting seemed to be part of the general inadequacy or abnormality of the personalities of the parents rather than a specific deficit in parenting skills or a disturbance of particular parent-child relationships. However there were exceptions, as in the case of the boy with arthrogryphosis (23).

In summary, then, although each case of child abuse has very individual features, the overall conclusion of the study is that a combination of abnormal personalities and psychiatric disorder in the parents (The Psychiatric Model), factors associated with low social class (The Sociological Model) and marital dysfunction (The Social Interactional Model) is the main etiological mechanism in the majority of cases of physical abuse of children. The fact that a similar conclusion comes from Smith (1975) in England and Straus (1980) in America, suggests that the basic mechanism of child abuse is universal.

One comment and one question remain. The comment is that the present study has also confirmed the finding of others that what distinguishes abusive parents from non-abusive parents is not so much the presence of specific abnormal childrearing practices or disturbance in particular parent-child relationships as the presence of a general disturbance of personality and functioning. In other words child abuse is only one of many deviant kinds of behaviour manifested by the parents of multi-problem families.

The question is: It has been shown that many problems beset lower class families, what makes some of them multi-problem families and some not? The answer which makes the most sense is that even within the lowest social classes there is a gradient, with the multi-problem families at the lowest end of the lowest social class. In other words the multi-problem families would be the ones in which the parents have the poorest biological endowment (for instance, health, intelligence and temperament), have the most abnormal personalities and psychiatric disorders, and have contracted the most unfavourable liaisons. The least damaged of their offspring might gradually over many generations climb the gradient, and finally raise themselves out of the poverty subculture. The most damaged of the offspring are prone to suffer further unfavourable life-events, and in this way are multi-problem families perpetuated from generation to generation.

"The iniquity of the fathers shall be visited upon the children, and upon the children's children, unto the third and to the fourth generation" Exodus 34,7

Some implications for clinical practice and future research

The clinical implications of the conclusions of the study are that the treatment of child abuse needs to include the social and psychological problems of the whole family in all spheres of functioning, not just the sphere of parent-child relationships. Unless the parents' abnormal personality in all its manifestations is treated as well as their deficient parenting skills, a meaningful diminution of child abuse in the short-term and especially in the long-term is unlikely to result. Similarly unless action is directed towards the socio-political forces which perpetuate social disadvantage and which keep minority groups from improving themselves, families in the poverty subculture will continue to burden society with the abuse of children and all their other aberrations.

There will always be a poverty subculture so research should focus on the most effective ways of assisting individuals with poor biological endowment to maintain good mental health, and to establish healthy marital and parent-child relationships. Finally, research should be directed at establishing more reliable criteria for the removal of children from detrimental environments, and at determining how present alternative care could be improved so as to break the vicious cycle of emotional deprivation.

PART 4

THE APPENDIX

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

14 February 1977

Dear

RESEARCH SUBJECTS FOR CHILD ABUSE STUDY

Research into the personalities and backgrounds of parents who PHYSICALLY abuse their children is in progress at the Red Cross War Memorial Children's Hospital. Subjects who will qualify for inclusion into the study are parents who are strongly suspected of CURRENTLY abusing their children i.e. where there are injuries which are incompatible with the explanation offered, or where parents confess to or have been found guilty by law of child abuse.

Parents may be told that a study is being made of different types of injuries in children, and their relationship to family make-up. As social class is one of the items to be studied, it should not influence your decision to refer.

All children will be examined initially by a Paediatrician. Children regarded by Dr Robertson as being at serious risk will subsequently be referred to an appropriate social agency, otherwise all information will remain confidential.

You are invited to refer SUITABLE families to Dr B.A. Robertson at the Child and Family Unit, Red Cross War Memorial Children's Hospital. Phone 69-8721 ext 323.

PROFESSOR OF PAEDIATRICS & CHILD HEALTH

PROFESSOR OF PAEDIATRIC SURGERY

CONSULTANT PSYCHIATRIST

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

PHYSICAL EXAMINATION

NAME: ..... AGE:..... SEX: .....

RACE:..... NO.: .....

Presenting complaint and clinical history: .....

.....

.....

.....

Birth Weight: .....

Perinatal History: .....

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.....

Developmental History: Smiled : .....
Sat : .....
Walked : .....
Sphincter control: .....
School Progress : .....

Previous Illnesses: .....

.....

Family History: .....

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Other Information: .....

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Physical Examination: Intelligence .....
Behaviour .....
Speech .....
Hearing .....

C.V.S.: Heart: .....
B.P. : .....

Respiratory System: .....

.....

.....

Gastro-Intestinal System: .....

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C.N.S.: Skull circumference: ..... Spine: .....
Nuchal rigidity : .....
Cranial nerves : .....
Fundi : .....

Limbs : Wasting : .....
Power : .....
Tone : .....
Co-ordination : .....
Abnormal movements:.....
Reflexes : Superficial: .....
Deep : .....

Motor development assessment ..... handedness

Sensations : Touch .....
Pinprick .....

Primitive reflexes: .....

.....

Gait:.....

.....

Investigations: .....

.....

.....

.....

Diagnosis: .....

.....

.....

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

CIRCUMSTANCES OF INJURY/ILLNESS* SCHEDULE

Case No: .....

Red Cross Children's Hospital Folder No. .....

Relevant addresses .....

.....

Name of child .....

Birthdate of child .....

Sex of child .....

Date and time of injury .....

Date of death ..... P.M. Details .....

Date of interview .....

Age of child at interview/death (whichever first).....months

Full name of interviewee .....

Birthdate of interviewee .....

Interviewee's relationship to child .....

Home language .....

* Interview with control parents commences at question No. 11.

1. PRESENTING COMPLAINT

"Was it the injury, or was it some other problem that has brought ..... to the attention of ..... (relevant professional body)?"

0 N.K. 9 N.A.
1 The injury
2 Other Details .....
.....

2. ATTITUDE TO REFERRAL TO RESEARCH UNIT

"How do you feel about being asked to come here because of ..... injury? Are you pleased on the whole, or displeased about it?"

0 N.K. 9 N.A.
1 Pleased
2 Indifferent
3 Displeased

Details .....

3. CAUSE OF INJURY

"What was the cause of ..... injury?"

0 N.K. 9 N.A.
1 Accidental
2 Physical abuse or neglect by acting parent viz .....
3 Physical abuse or neglect by other person viz .....

Details of causation .....
.....

4. ATTITUDE TO CHILD'S INJURY

"How do you feel about ..... getting injured? Do you feel concern for ..... or not?"

0 N.K. 9 N.A.
1 Concerned
2 Unconcerned
3 Negative attitude towards child

Details .....

5. CARE OF CHILD

"In whose care was ..... when the injury occurred?"

0 N.K. 9 N.A.
1 Parent viz .....
2 Other person viz .....
3 No-one

Details .....

6. WITNESS TO INJURY

"Who saw what actually happened?"

0 N.K. 9 N.A.
1 Parent viz .....
2 Other person viz .....
3 No-one

Details .....

7. INTERVIEWEE'S WHEREABOUTS AT TIME OF INJURY

"Where were you when the injury occurred?"

0 N.K. 9 N.A.
1 Busy with the child
2 Present in the same room but not attending to child
3 Elsewhere in house or garden
4 Out of house

Details .....

8. TIME OF INJURY

"At what time did the injury occur?"

0 N.K. 9 N.A.
1 Morning (6 a.m. - 12 p.m.)
2 Afternoon (12 p.m. - 6 p.m.)
3 Evening (6 p.m. - 9 p.m.)
4 Night (9 p.m. - 6 a.m.)

9. CIRCUMSTANCES SURROUNDING INJURY

"Was there any trouble between those present at the time of the injury?"

0 N.K. 9 N.A.
1 No
2 Tension between injured child and others, viz .....
3 Tension between others, viz .....
4 Both, viz .....

Details .....

10. CRYING PRECIPITATED INJURY

"Was ..... crying/screaming immediately before the injury?"

0 N.K. 9 N.A.
1 No
2 Yes

Details .....

11. PREVIOUS INJURIES

"Can you tell me what injuries ..... has had in the past?"

0 N.K. 9 N.A.

Type of injury	Age	Name of doctor	Name of hospital

1 No significant injuries
2 Minor injuries
3 Serious injuries
4 Minor or serious injuries of a highly suspicious nature

Details .....

12. ORDINAL POSITION

"What position does ..... occupy among the children in the family?"

0 N.K. 9 N.A.
1 Only child
2 First
3 Middle
4 Last

13. SIBLINGS INJURIES

"Can you tell me what injuries the other children in the family have had?"

0 N.K. 9 N.A.

Name of child	Type of injury	Age	Name of doctor	Name of hospital

1 No significant injuries
2 Minor injuries
3 Serious injuries
4 Minor or serious injuries of a highly suspicious nature

Details .....

14. ACTION TAKEN

"When was a medical examination requested for ..... injury/illness?"

0 N.K. 9 N.A.
1 No examination requested at all
2 No examination requested till following day
3 Examination requested as soon as possible

Details .....

15. DECISION TAKING

"Who decided that a medical examination should be requested?"

0 N.K. 9 N.A.
1 Person in whose care the child was at the time viz .....
2 Parent viz .....
3 Professional body viz .....
4 Other person viz .....

Details .....

16. PARENTS' ATTENDANCE AT FIRST MEDICAL EXAMINATION

"Who brought .....for the first medical examination?"

0 N.K. 9 N.A.

1 Person in whose care child was at the time viz .....

2 Parent viz .....

3 Professional body viz .....

4 Other person viz .....

Details .....

17. CHILD'S HEALTH

"Can you tell me for what serious illnesses or physical conditions ..... has needed medical treatment or examination in the past?"

0 N.K. 9 N.A.

Nature of illness	Age	Name of doctor	Name of hospital - length of stay

1 No serious illnesses/conditions

2 Serious illnesses/conditions

3 Serious illnesses/conditions requiring special care for more than 2 years

18. SIBLINGS' HEALTH

"Can you tell me for what serious illnesses or physical conditions the other children in the family have needed medical treatment or examination?"

0 N.K. 9 N.A.

Nature of illness	Age	Name of doctor	Name of hospital - length of stay

1 No serious illnesses/conditions

2 Serious illnesses/conditions

3 Serious illnesses/conditions requiring special care for more than 2 years

19. MATERNITY HOSPITAL

"Where was ..... born?"

0 N.K. 9 N.A.
1 Hospital
2 Home
3 Other

20. BABY CLINIC

"What baby clinic do/did you attend with .....?"

0 N.K. 9 N.A.
1 Never attended baby clinic
2 Attends baby clinic viz .....

21. MEDICAL CARE OF CHILD

"What is the name of the doctor or hospital you usually take ..... to?"

0 N.K. 9 N.A.
1 Child has never been to a doctor or hospital before
2 Usually attends (name) .....

22. EATING

"I would now like to ask some questions about the general behaviour of the children in the family. Is ..... normally a good eater?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

23. CRYING

"Does ..... cry a lot, or act miserable?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

24. ACTIVITY

"Is ..... very restless?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

25. TIME OF MAXIMAL ACTIVITY

"When is ..... likely to be most restless?"

0 N.K. 9 N.A.
1 a.m.
2 p.m.
3 evening
4 a.m. and p.m.
5 a.m. and evening
6 p.m. and evening
7 all the time

26. SLEEP

"Does ..... have enough sleep?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

27. TIME OF SETTLING FOR THE NIGHT

"At what time does ..... fall asleep at night?"

0 N.K. 9 N.A.
1 6-9 p.m.
2 9-12 p.m.
3 up and down during the night

Details .....
.....

28. TIME OF RISING

"At what time does ..... wake up for the day?"

0 N.K. 9 N.A.
1 4-6 a.m.
2 6-8 a.m.
3 after 8 a.m.

29. DISTURBANCE OF SLEEP

"How often does ..... wake during the night?"

0 N.K. 9 N.A.
1 Seldom
2 Frequently
3 Almost every night

30. BEHAVIOUR PROBLEMS

"Does ..... have any (other) behaviour or personality problems such as nervousness, naughtiness, stealing?"

0 N.K. 9 N.A.
1 No
2 Yes Details (incl. treatment) .....
.....

31. SCHOOL PROBLEMS

"Does ..... have any problems at school such as learning problems, failing, truanting?"

0 N.K. 9 N.A.
1 No
2 Yes Name of school .....
Details .....

32. SIBLINGS' BEHAVIOUR PROBLEMS

"Do any other children in the family have behaviour or personality problems such as nervousness, naughtiness, stealing?"

0 N.K. 9 N.A.
1 No
2 Yes Details (incl. treatment).....

33. SIBLINGS' SCHOOL PROBLEMS

"Do any other children in the family have problems at school such as learning problems, failing, truanting?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

34. ATTITUDE OF INTERVIEWEE

1 Co-operative
2 Unco-operative Details .....
.....

35. RELIABILITY OF INTERVIEW

1 Reliable
2 Unreliable due to poor understanding
3 Unreliable due to emotional factors
4 Both

Details .....

COMPARATIVE RATING SCALE FOR INDEPENDENT INTERVIEWERS

	1 (within normal)	2 (moderate)	3 (very marked)
Depression			
Hostility			
Anxiety			
Poor self-image			

RESULTS OF THE CIRCUMSTANCES OF INJURY/ILLNESS SCHEDULE

(Mothers)

		Percentage of Index Group	Percentage of Control Group
1.	Referred because of injury	74	N/A
2.	Indifferent or displeased about referral	27	N/A
3.	Injury reported to be accidental	11	N/A
4.	Unconcerned or negative about injured child	4	N/A
5.	Child in parents' care when injured	71	N/A
6.	Parent saw what happened	33	N/A
7.	Parent present when child injured	47	N/A
8.	Child injured during afternoon or evening	65	N/A
9.	Tension between those present at time of injury	65	N/A
10.	Child crying before the injury	35	N/A
11.	Previous suspicious injuries	33	0
12.	First or only child (excludes half/step siblings)	51	29
13.	Siblings' previous suspicious injuries	28	0
14.	Examination not requested immediately	52	54
15.	Professional body requested examination	45	4
16.	Professional body brought child	17	8
17.	Previous serious illnesses	16	25
18.	Siblings' previous serious illnesses	11	17
19.	Born in hospital	81	58
20.	Never attended baby clinic	2	4
21.	Never been to a doctor	4	0
22.	Poor eater	27	21
23.	Excessive crying	31	13
24.	Very restless	58	58

		Percentage of Index Group	Percentage of Control Group
25.	Restless all the time	Question misinterpreted	
26.	Does not have enough sleep	20	8
27.	Falls asleep before 9 p.m.	77	70
28.	Wakes up before 6 a.m.	14	21
29.	Wakes up frequently or every night (poor sleeper)	45	50
30.	Behaviour problems	39	13
31.	School problems	Sample too small	
32.	Siblings' behaviour problems	29	39
33.	Siblings' school problems	Sample too small	
34.	Interviewee unco-operative	21	13
35.	Interview unreliable	37	13

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

CHILD-REARING ATTITUDES SCHEDULE

1. GENERAL ATTITUDE

"Does/did ..... sometimes cry or cling, and prevent you from getting on?"

0 N.K. 9 N.A.
1 Rarely
2 Sometimes
3 Often Details .....

2. RESPONSE TO CRYING

"Some people feel that if you pick up a baby every time he cries, you will spoil him. Others think you should never let a baby cry for very long. How do you feel about this?"

0 N.K. 9 N.A.
1 Generally does not respond negatively to crying
2 Generally responds negatively (rejecting) to crying

Details .....

3. AFFECTIONATE DEMONSTRATIVENESS

"Do/did you hug or play with ..... very much?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

4. SCHEDULING OF FEEDING

"Some people feel babies should be fed on demand, others by the clock. How do you feel about this?"

0 N.K. 9 N.A.
1 On demand
2 By the clock Details .....

5. ATTITUDE TO FOOD REFUSAL

"How do/did you react when ..... refuses his/her food?"

0 N.K. 9 N.A.
1 Does not react negatively
2 Reacts negatively e.g. becomes very emotional, or force-feeds

Details .....

6. ATTITUDE TO TOILET-TRAINING

"By what age do you believe toilet training should be completed?"

0 N.K. 9 N.A.
1 By 1 year
2 By 2 years
3 After 2 years Details .....

7. ATTITUDE TO TOILET ACCIDENTS

"How do/did you react when ..... wets/soils his pants/nappie, or wets the bed?"

0 N.K. 9 N.A.
1 Does not respond negatively
2 Responds negatively i.e. stickler for cleanliness

Details .....

8. ATTITUDE TO CHILDREN'S MESSES

"How do you feel about children getting their clothes messed up, or leaving toys lying around?"

0 N.K. 9 N.A.
1 Does not respond negatively
2 Responds negatively i.e. stickler for cleanliness

Details .....

9. STANDARDS OF OBEDIENCE

"Some parents expect their children to obey immediately when they tell them to be quiet or pick something up. How do you feel about this?"

0 N.K. 9 N.A.
1 Does not expect instant obedience
2 Expects instant obedience

Details .....

10. ATTITUDE TO CHILD'S AGGRESSION TOWARDS PARENTS

"How do/did you react when ..... screams in temper or bites you/hits you or answers back?"

0 N.K. 9 N.A.
1 Does not react negatively
2 Reacts negatively, e.g. becomes very emotional, or hits or bites back

Details .....

11. DISCIPLINE

"How do/did you physically punish .....?"

0 N.K. 9 N.A.
1 Seldom uses physical punishment
2 Gives regular hidings
3 Physically abuses child

Details .....

12. PRAISE

"Do you tell ..... when he's been good?"

0 N.K. 9 N.A.
1 Rarely
2 Sometimes
3 Often

Details .....

RESULTS OF THE CHILDREARING ATTITUDES SCHEDULE

(Mothers)

		Percentage of Index Group	Percentage of Control Group
1.	Child sometimes or often gets in the way	50	37
2.	Over-reacts to children's crying	15	8
3.	Hugs or plays with child frequently	81	100
4.	Believes babies should be fed by the clock	54	42
5.	Over-reacts to child's refusing food	17	24
6.	Believes all children should be toilet-trained by 1 year	20	9
7.	Over-reacts to child's toilet accidents	24	9
8.	Over-reacts to normal messiness of children	27	25
9.	Expects instant obedience	41	46
10.	Over-reacts to child's aggression	35	33
11.	Regularly uses physical punishment on child	26	4
12.	Often praises child	71	90

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

PSYCHIATRIC INTERVIEW SCHEDULE

Case No.: .....

Client's full name .....

Client's relationship to child .....

Date of interview .....

1. HEALTH DURING CHILDHOOD

"As far as you know, did you have any serious illnesses or handicaps as a child?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

2. BEHAVIOUR DISORDER DURING CHILDHOOD

"As a child did you show behaviour problems such as stealing, fighting or bunking school?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

3. NEUROTIC SYMPTOMS IN CHILDHOOD

"Were you a nervous child, for example were you excessively fearful or did you have any other nervous habits?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

4. CHILDHOOD DEPRESSION

"Were you an unhappy child?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

5. BONDING

"Up till the age of 4 years were you ever separated from your mother for more than 1 month?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

6. CONTINUITY OF CARE

"Up till the age of 16 years were you ever separated from either of your parents for more than 2 years?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

7. EDUCATIONAL ACHIEVEMENT

"What standard did you complete at school?"

0 N.K. 9 N.A.
1 Std 2 or below
2 Std 6 or below
3 Std 9 or below
4 Std 10

Specify reason for leaving, and whether special class/ school attended .....

8. RELATIONSHIP WITH FATHER

"How did you get on with your father as a child?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship Details .....

9. RELATIONSHIP WITH MOTHER

"How did you get on with your mother as a child?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship Details .....

10. RELATIONSHIP WITH SIBLINGS

"How did you get on with your brothers and sisters as a child?"

0 N.K. 9 N.A.
1 Good relationship with all
2 Ambivalent relationship with one or more
3 Poor relationship with one or more

Details .....

11. RELATIONSHIP WITH PEERS

"As a child were you outgoing with other children or withdrawn?"

0 N.K. 9 N.A.
1 Outgoing
2 Withdrawn Details .....

12. DETAILS OF OCCUPATION SINCE LEAVING SCHOOL

0 N.K. 9 N.A.

Occupation	Duration	Reason for changing

4 or more jobs in the last 3 years/dismissed from employment during last 3 years because of misconduct.

1 No
2 Yes

13. WORK SATISFACTION

"On the whole are you satisfied with your work?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

14. RELATIONSHIPS AT WORK

"How do you usually get on with your boss and your colleagues at work?"

0 N.K. 9 N.A.
1 Gets on well with all
2 Does not get on with boss
3 Does not get on with colleagues
4 Both Details.....

15. UNEMPLOYMENT

"How many months have you been unemployed?"

0 N.K. 9 N.A.
1 Less than 3 months
2 3 months or more
3 12 months or more

16. DURATION OF ACQUAINTANCE BEFORE MARRIAGE

"How long had you known your husband/wife before you married?"

0 N.K. 9 N.A.
1 Less than 6 months
2 Six months or more

17. MARRIAGE MOTIVES

"Why did you marry your husband/wife?"

0 N.K. 9 N.A.
1 For love
2 Because of pregnancy
3 For other reasons Details.....

18. PREMARITAL PREGNANCY

"Were you/was your wife pregnant with ..... before marriage?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

19. UNMARRIED MOTHER'S/FATHER'S ATTITUDE TO MARRIAGE

"Why have you never married?"

0 N.K. 9 N.A.
1 Intends to get married
2 Desires to be married but unable to
3 Does not wish to be married

Details .....

20. ATTITUDE TO PREGNANCY

"How did you feel when you found you/your wife was pregnant with .....?"

0 N.K. 9 N.A.
1 Delighted
2 Ambivalent
3 Displeased Details .....

21. WISH TO ABORT PREGNANCY

"When you found you were pregnant, did you want to get rid of the baby?" (or for fathers): "When you found your wife was pregnant, would you have liked her to get rid of the baby?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

22. STRESS DURING PREGNANCY

"Were you under any nervous strain during the pregnancy?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

23. HEALTH DURING PREGNANCY

"Were you sick during the pregnancy?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

24. ATTITUDE TOWARDS BABY AT BIRTH

"How did you feel towards ..... when he/she was born?"

0 N.K. 9 N.A.
1 Caring
2 Indifferent
3 Rejecting Details .....

25. ATTITUDE TOWARDS BABY'S CRYING

"How did/do you feel when ..... used to cry/cries?"

0 N.K. 9 N.A.
1 Concerned
2 Indifferent
3 Rejecting Details .....

26. ATTITUDE TOWARDS SPOUSE'S RELATIONSHIP WITH CHILD

"How do you feel when your husband/wife does something with .....?"

0 N.K. 9 N.A.
1 Spouse rejects child
2 Pleased
3 Indifferent
4 Displeased Details .....

27. PERSONALITY OF CHILD

"How would you describe .....? Is he a good baby/child, or difficult?"

0 N.K. 9 N.A.
1 Good child
2 Difficult Details .....

28. RELATIONSHIP WITH CHILD

"How do you and ..... get on?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship Details .....

29. PERSONALITIES OF SIBLINGS

"How would you describe ..... brothers and sisters? Are they more difficult to handle, or easier than .....?"

0 N.K. 9 N.A.
1 All good
2 Some good, some difficult
3 All difficult Details .....

30. CONTRACEPTION

"Are you doing anything to prevent having more children?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

31. FATHER'S AGE (GRANDFATHER)

0 N.K. 9 N.A.
1 30-39
2 40-49
3 50-59
4 60-69
5 70+ Details of death .....

32. FATHER'S SOCIAL CLASS

"What type of work does/did your father do?"

0 N.K. 9 N.A.
1 Social Class I
2 Social Class II
3 Social Class III
4 Social Class IV
5 Social Class V Details .....

33. MOTHER'S AGE (GRANDMOTHER)

0 N.K. 9 N.A. (Dead)
1 30-39
2 40-49
3 50-59
4 60-69
5 70+ Details of death .....

34. NUMBER OF SIBLINGS ALIVE

0 N.K. 9 N.A.

_____
Number. Details of health .....
_____

35. NUMBER OF SIBLINGS DEAD

0 N.K. 9 N.A.

_____
Number. Details of deaths .....
_____

36. ORDINAL POSITION OF PARENT

0 N.K. 9 N.A.
1 Only child
2 First
3 Middle
4 Last

37. CURRENT RELATIONSHIP WITH FATHER

"How do you get on with your father now?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship Details .....

38. CURRENT RELATIONSHIP WITH MOTHER

"How do you get on with your mother now?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship Details .....

39. CURRENT RELATIONSHIP WITH OTHER FAMILY MEMBERS

"How do you get on with other members of the family now e.g. brothers, sisters, uncles, aunts, in-laws?"

0 N.K. 9 N.A.
1 Mostly good with all
2 Good with some, poor with others
3 All poor Details .....

40. CURRENT RELATIONSHIP WITH PEERS

"Do you have many friends?"

0 N.K. 9 N.A.
1 Many
2 Few
3 None Details .....

41. HEALTH

"Has your health been good on the whole?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

42. PERSONALITY

"How would you describe yourself as a person?"

.....

43. SPOUSE'S PERSONALITY

"How would you describe your husband/wife as a person?"

.....

44. NEUROTIC SYMPTOMS

"Do you suffer from nervousness or unreasonable fears, excessive worrying, crying spells or depression?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

45. PSYCHIATRIC TREATMENT

"Have you ever been to a psychiatrist?"

0 N.K. 9 N.A.
1 No
2 Out-patient treatment only
3 In-patient treatment

Details .....

46. FAMILY HISTORY OF MENTAL ILLNESS

"Has any member of your family ever been to a psychiatrist or been in a mental hospital?"

0 N.K. 9 N.A.
1 No
2 Out-patient treatment only
3 In-patient treatment

Details .....

47. MARITAL COMPATIBILITY

"How do you and your husband/wife get on?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship Details.....

48. FAMILY ROLE

"Are you satisfied with the part you play in the running of the home?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

49. DISPLACEMENT OF MARITAL CONFLICTS ONTO CHILD

"Would you get on better with (child) ..... if your husband/wife was more understanding?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

50. IMPULSE CONTROL

"Do you have difficulty controlling your temper?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

51. PHYSICAL AGGRESSION

"Do you ever hit your husband/wife, or have you ever been in fights with other adults?"

0 N.K. 9 N.A.
1 No
2 Hits husband/wife
3 Fights with others
4 Both Details .....

52. CHILD ABUSE

"Have you ever hit any child so severely that you have caused injuries?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

53. CHILD ABUSE BY SPOUSE

"Has your husband/wife ever hit any child so severely that they have caused injuries?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

54. ALCOHOL CONSUMPTION

"How much alcohol do you drink a day/weekend?"

0 N.K. 9 N.A.
1 Minimal amounts
2 Moderate amounts
3 Excessive amounts

Details .....

55. DRUG DEPENDENCE

"Do you use dagga frequently, or any other drug?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

56. FAMILY HISTORY OF ALCOHOL ABUSE

"Has any member of your family ever had a drinking problem?"

0 N.K. 9 N.A.
1 No
2 Parents
3 Spouse
4 Both
5 Other member of family only

Details .....

57. DRUG DEPENDENCE IN FAMILY

"Has any member of your family ever had a drug problem?"

0 N.K. 9 N.A.
1 No
2 Parents
3 Spouse
4 Both
5 Other member of family only

Details .....

58. CRIMINAL RECORD

"Have you ever appeared before a magistrate and been found guilty of an offence?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

59. FAMILY HISTORY OF CRIMINALITY

"Has any member of your family ever appeared before a magistrate and been found guilty of an offence?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

60. ATTITUDE OF CLIENT

1 Co-operative
2 Unco-operative Details .....

61. RELIABILITY OF INTERVIEW

1 Reliable
2 Unreliable due to poor understanding
3 Unreliable due to emotional factors
4 Both Details .....

62. PERSONALITY DISORDER

0 N.K. 9 N.A.
1 No personality disorder
2 Sociopathic personality disorder (psychopath)
3 Inadequate personality
4 Other personality disorder

Details .....

63. NEUROSIS

0 N.K. 9 N.A.
1 No neurosis
2 Anxiety neurosis
3 Depressive neurosis
4 Obsessive-compulsive neurosis
5 Hysterical neurosis, dissociative type
6 Hysterical neurosis, conversion type
7 Phobic neurosis
8 Mixed neurotic symptomatology

Details .....

64. PSYCHOSIS

0 N.K. 9 N.A.
1 No psychosis
2 Schizophrenia
3 Manic-depressive psychosis
4 Other psychosis

Details .....

COMPARATIVE RATING SCALE FOR INDEPENDENT INTERVIEWERS

	1 (within normal)	2 (moderate)	3 (very marked)
Depression			
Hostility			
Anxiety			
Poor self-image			

MENTAL STATE EXAMINATION

1. General behaviour .....

.....

.....

2. Talk .....

3. Mood .....

4. Delusions and misinterpretations .....

.....

5. Hallucinations and other disorders of perception .....

.....

6. Compulsive phenomena .....

.....

7. Orientation .....

8. Memory .....

9. Attention and concentration .....

.....

10. Intelligence .....

11. Insight and judgement .....

.....

12. Dynamic formulation .....

.....

.....

13. Provisional diagnosis .....

.....

.....

RESULTS OF THE PSYCHIATRIC INTERVIEW SCHEDULE

(Mothers)

		Percentage of Index Group	Percentage of Control Group
1.	Serious ill-health as a child	27	33
2.	Conduct disorder as a child	16	21
3.	Anxious as a child	57	35
4.	Unhappy as a child	45	25
5.	Separation from own mother before 4 years	23	17
6.	Family break-up before 16 years	56	50
7.	Standard 6 or less	94	92
8.	Poor/ambivalent relationship with father	40	20
9.	Poor/ambivalent relationship with mother	26	19
10.	Poor/ambivalent relationship with siblings	26	15
11.	Outgoing with peers	24	13
12.	4 or more jobs in last 3 years	Sample too small	
13.	Satisfied with work	Sample too small	
14.	Does not get on with boss or colleagues	Sample too small	
15.	Unemployed 3 months or more	Sample too small	
16.	Acquaintance less than 6 months	18	0
17.	Married for reasons other than love	59	29
18.	Child conceived premaritally	50	14
19.	Intends to get married	52	80
20.	Ambivalent/displeased about pregnancy	58	46
21.	Wish to abort pregnancy	7	4
22.	Stress during pregnancy	50	38
23.	Ill-health during pregnancy	24	8
24.	Indifferent/rejecting towards baby at birth	4	4

		Percentage of Index Group	Percentage of Control Group
25.	Indifferent/rejecting towards baby's crying	17	4
26.	Spouse rejects child	45	19
27.	Child has difficult personality	31	17
28.	Poor/ambivalent relationship with child	17	4
29.	All siblings easier than child	79	80
30.	Practising contraception	76	70
31.	Father's age	Omitted	
32.	Father's social class	Omitted	
33.	Mother's age	Omitted	
34.	5 or more siblings still alive	77	52
35.	5 or more siblings dead	32	0
36.	First or only child	21	37
37.	Poor/ambivalent relationship with father	Sample too small	
38.	Poor/ambivalent relationship with mother	12	20
39.	Good relationship with most relatives	70	90
40.	No friends	31	29
41.	Ill-health	37	17
42.	Personality	-	-
43.	Spouse's personality	-	-
44.	Neurotic symptoms	82	38
45.	Psychiatric treatment	10	8
46.	Family history of psychiatric illness	35	26
47.	Ambivalent/poor marital relationship	63	18
48.	Satisfied with own role	Question misinterpreted	
49.	Displaces marital conflicts onto child	Question misinterpreted	
50.	Difficulty controlling temper	25	25
51.	Physically aggressive to Spouse	14	0

		Percentage of Index Group	Percentage of Control Group
52.	Has abused a child	25	4
53.	Spouse has abused a child	52	5
54.	Abuses alcohol	8	0
55.	Drug-dependence	0	0
56.	Spouse abuses alcohol	43	6
	Parents or relatives abused alcohol	53	35
57.	Spouse abuses drugs	38	7
	Parents or relatives abused drugs	13	10
58.	Criminal record	6	4
59.	Spouse has criminal record	49	6
	Parents or relatives have criminal record	35	13
60.	Interviewee unco-operative	0	0
61.	Interview unreliable	29	8
62.	Personality disorder	8	0
63.	Neurosis	67	33
64.	Psychosis	2	0

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

PSYCHOSOCIAL INTERVIEW SCHEDULE

Case No. .....

Date of Interview .....

Client's name .....

Client's relationship to child .....

Client's maiden name .....

Full name of client's father .....

Full name (including maiden) of client's mother .....

.....

1. MARITAL STATUS OF MOTHER

0 N.K.
1 Single
2 Married
3 Widowed
4 Separated
5 Cohabiting while separated or divorced
6 Cohabiting while single or widowed

Details .....

2. MARITAL STATUS OF FATHER

0 N.K.
1 Single
2 Married
3 Widowed
4 Separated
5 Cohabiting while separated or divorced
6 Cohabiting while single or widowed

Details .....

3. DATE OF MARRIAGES OF MOTHER

0 N.K.
1 .....
2 .....
3 ..... Details .....

4. DATE OF MARRIAGES OF FATHER

0 N.K.
1 .....
2 .....
3 ..... Details .....

5. LEGAL STATUS OF CHILD

0 N.K. 9 N.A.
1 Legitimate
2 Legitimised
3 Not legitimised
4 Born in wedlock, not mother's husband

Details .....

6. WHEREABOUTS OF BIOLOGICAL MOTHER

0 N.K. 9 N.A.
1 Acting mother
2 Deceased
3 Absent, unknown where
4 Absent, known where

Details (name, address) .....

7. WHEREABOUTS OF BIOLOGICAL FATHER

0 N.K. 9 N.A.
1 Acting father
2 Deceased
3 Absent, unknown where
4 Absent, known where

Details (name, address) .....

8. NAMES, BIRTH DATES, ADDRESSES AND SCHOOL STANDARD ATTAINED OF ALL CHILDREN OF THE BIOLOGICAL PARENTS IN BIRTH ORDER
(Include deceased children with date and cause of death)

0 N.K. 9 N.A.

.....

.....

.....

.....

.....

.....

9. ABOVE INFORMATION ABOUT CHILDREN OF MOTHER BY OTHER LIAISONS (State whether half or step siblings)

0 N.K. 9 N.A.

.....

.....

.....

.....

10. ABOVE INFORMATION ABOUT CHILDREN OF FATHER BY OTHER LIAISONS (State whether half or step siblings)

0 N.K. 9 N.A.

.....

.....

.....

.....

.....

11. NAMES, AGES, OCCUPATION AND RELATIONSHIP TO CHILD OF ALL OTHER MEMBERS OF HOUSEHOLD (GROUP ACCORDING TO ROOMS OCCUPIED)

0 N.K. 9 N.A.

.....

.....

.....

.....

.....

12. ETHNIC BACKGROUND OF MOTHER

0 N.K.
1 Asiatic
2 Black
3 Cape Coloured
4 White
5 Other

13. ETHNIC BACKGROUND OF FATHER

0 N.K.
1 Asiatic
2 Black
3 Cape Coloured
4 White
5 Other

14. RELIGION OF MOTHER

0 N.K.
1 None
2 Protestant - specify .....
3 Catholic
4 Jewish
5 Moslem
6 Hindu
7 Other - specify .....

15. RELIGION OF FATHER

0 N.K.
1 None
2 Protestant - specify .....
3 Catholic
4 Jewish
5 Moslem
6 Hindu
7 Other - specify .....

16. PERSONAL SIGNIFICANCE OF RELIGION

"Does religion mean anything to you?"

0 N.K. 9 N.A.
1 Goes to or nominally attached to place of worship
2 Has personal faith

17. RELIGIOUS BACKGROUND

0 N.K.
1 None
2 One or both parents nominally religious
3 One or both parents have/had personal faith

18. INCOME PER MONTH (to nearest rand)

0 N.K. 9 N.A.

Father .....
Mother .....
Siblings .....
Other members of household .....
Pensions/grants (details) .....
.....
Other (specify) .....

Total _____

19. MONTHLY EXPENSES (to nearest rand)

0 N.K.

Rent/Mortgage	.....
Water/Electricity	.....
Hire Purchase	.....
Medical	.....
Insurance	.....
Maintenance	.....
Liquor	.....
Other (specify)	.....
Total	_____

20. ASSESSMENT OF HOUSEKEEPING ALLOWANCE

0 N.K. 9 N.A.
1 Adequate
2 Inadequate

Details .....

21. CARETAKING ARRANGEMENTS SINCE BIRTH (including vacations) (State age of child, whether daily/weekly care, where cared for, and by whom)

0 N.K. 9 N.A.

.....

.....

.....

22. TYPE OF ACCOMMODATION (delete what is not applicable)

0 N.K. 9 N.A.
1 Own house/flat/maisonette
2 Rented house/flat/maisonette
3 Sharing own house/flat/maisonette
4 Sharing rented house/flat/maisonette
5 Lodgings
6 No fixed accommodation
7 Vagrant
8 Other Details .....

23. SIZE OF ACCOMMODATION (whole establishment)

0 N.K. 9 N.A.
1 No bedrooms (1 room house/flat)
2 One bedroom
3 Two bedrooms
4 Three bedrooms or more

24. TOTAL NUMBER IN HOUSEHOLD (whole establishment)

0 N.K. 9 N.A.

_____
Indicate number
_____

25. AMENITIES

0 N.K. 9 N.A.
1 No running water inside own accommodation
2 Running water but no electricity
3 Running water and electricity

26. CHILD'S SLEEPING ACCOMMODATION

0 N.K. 9 N.A.
1 Shares bed with parents
2 Shares bed with siblings
3 Shares room with parents
4 Shares room with siblings
5 Own room

27. NO. OF HOMES IN PAST 3 YEARS, EXCLUDING PRESENT HOME
(Note locality and reasons for moves)

0 N.K. 9 N.A.

.....

.....

.....

.....

.....

28. CONTACT WITH THOSE OUTSIDE FAMILY

(Tick one in each row below)

0 N.K.

	Almost daily	Approx. weekly	Monthly	Infreq.	Never
Parents					
Other relatives					
Neighbours					
Other friends					
Church					

29. LONELINESS

"Are you lonely a lot of the time?"

0 N.K.
1 Yes
2 No Details .....

30. BOREDOM

"Are you bored a lot of the time?"

0 N.K.
1 Yes
2 No Details .....

31. REGULAR SOCIAL ACTIVITIES

"Do you take part in any of the following social activities?"

____ Sports
____ Other clubs, viz.....
____ Evening classes
____ Church
____ Visiting with/from friends
____ Any other social activities, viz.....
____

0 N.K.
1 None
2 One
3 Two
4 Three or more

32. HOBBIES AT HOME

"Do you have any of the following hobbies at home?"

____ Reading
____ Handicraft
____ Other special domestic interest viz .....
____ T.V.
____

0 N.K.
1 None
2 One
3 Two or more

Details .....

33. ANY SIGNIFICANT WORRIES

"Are any of the following worries for you?"

____ Money
____ Domestic friction
____ Own health
____ Health of others, viz .....
____ Housing
____ Employment
____ Marital status
____ Moral or personal
____

0 N.K.
1 None
2 One
3 Two
4 Three or more

Details .....

34. CRISIS SUPPORT

"Who do you turn to when you have problems?"

____ Spouse

____ Parent, viz.....

____ Other relative, viz .....

____ Social Worker, viz .....

____ G.P./Hospital, viz .....

____ Neighbours/friends, viz .....

____ Representative of Church, viz .....

____ Clinic sister, viz .....

____

0 N.K. 9 N.A.
1 Have nobody
2 Spouse
3 Other relative, excluding spouse
4 Neighbour or friends, excluding family
5 Community agency only, e.g. G.P., Church etc.

Details .....

35. ANY CONTACT WITH SOCIAL AGENCIES IN PAST

0 N.K.
1 No
2 Yes Details .....
.....

36. COMMUNICATION

"On the whole do you and your husband/wife discuss important family matters?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....
.....

37. SHARED RESPONSIBILITY

"On the whole do you and your husband/wife come to some mutual agreement on important family matters?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

38. SPOUSE'S RELATIONSHIP WITH CHILD

"How does your husband/wife get on with .....?"

0 N.K. 9 N.A.
1 Good relationship
2 Ambivalent relationship
3 Poor relationship

Details .....

39. AGREEMENT ON CHILD-REARING PRACTICES

"In general do you and your husband/wife agree about the best way to handle .....?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

40. EVALUATION OF SELF

"Do you feel satisfied with what you have made of your life?"

0 N.K. 9 N.A.
1 Yes
2 No

Details .....

41. EVALUATION OF SPOUSE

"On the whole are you satisfied with the way your husband/wife is?"

0 N.K. 9 N.A.
1 Yes
2 No Details .....

42. ANY STRAINED RELATIONSHIP

"Is there any trouble between you and anybody else, within the family or outside?"

0 N.K. 9 N.A.
1 No
2 Within family, viz.....
3 With relatives outside only, viz .....
4 With relatives and/or others outside only, viz ...
.....

Details .....

43. SPOUSE'S DRINKING HABITS

"How much alcohol does your husband/wife drink per day/ weekend?"

0 N.K. 9 N.A.
1 Minimal amounts
2 Moderate amounts
3 Excessive amounts

Details .....

44. CHILD ABUSE BY SPOUSE

"Does your husband/wife hit the children so severely as to cause injuries?"

0 N.K. 9 N.A.
1 No
2 Yes Details .....

45. SPOUSE'S VIOLENCE

"Does your husband/wife hit you, or fight with other adults?"

0 N.K. 9 N.A.
1 No
2 Hits spouse
3 Fights with others
4 Both

Details .....

46. EMPLOYMENT STATUS OF MOTHER

0 N.K. 9 N.A.
1 Not working out of choice
2 Not working for other reasons
3 Working part-time
4 Working fulltime

47. MOTHER'S AGE AT BIRTH OF FIRST CHILD

0 N.K.
.....

48. RELIABILITY OF INTERVIEW

1 Reliable
2 Unreliable due to poor understanding
3 Unreliable due to emotional factors
4 Both

49. ATTITUDE OF CLIENT

1 Co-operative
2 Unco-operative

Details .....

.....

RESULTS OF THE PSYCHOSOCIAL INTERVIEW SCHEDULE

(Mothers)

		Percentage of Index Group	Percentage of Control Group
1.	Mother single	27	29
2.	Father single	3	0
3.	Mother married more than once	3	0
4.	Father married more than once	21	0
5.	Child illegitimate	52	42
6.	Acting mother is biological mother	94	100
7.	Acting father is biological father	70	100
8.	Child has more than 3 full siblings	6	17
9.	Mother has children by previous liaisons	43	4
10.	Father has children by previous liaisons	36	12
11.	Other members of household	Omitted	
12.	Ethnic group of mother	Coloured	
13.	Ethnic group of father	Coloured	
14.	Mother Protestant	59	84
	Mother Catholic	23	8
	Mother Moslem	18	8
15.	Father Protestant	70	74
	Father Catholic	12	13
	Father Moslem	18	13
16.	Mother has personal faith	76	83
17.	Both mothers' parents had personal faith	87	75
18.	Family income less than R50 per month	37	21
19.	Family in financial debt	60	17
20.	Mother regards housekeeping as inadequate	78	50
21.	Child separated from biological mother	6	0

		Percentage of Index Group	Percentage of Control Group
22.	No fixed accommodation/ vagrant	18	13
23.	One-room accommodation	13	21
24.	8 or more in household	38	25
25.	Amenities	Misinterpreted	
26.	Child has own bedroom	19	4
27.	3 or more homes in last 3 years	25	21
28.	Contact with those outside family	Omitted	
29.	Mother lonely	59	21
30.	Mother bored	47	33
31.	Two or more social activities	31	54
32.	No domestic hobbies	27	0
33.	Three or more domestic worries	59	21
34.	No-one to turn to in a crisis	21	17
35.	Contact with social agencies	39	30
36.	Poor marital communication	37	17
37.	No mutual decision-making	43	6
38.	Spouse has poor relation-ship with child	50	6
39.	No agreement about child's discipline	42	0
40.	Mother dissatisfied with self	49	13
41.	Mother dissatisfied with spouse	61	24
42.	Strained relationships	49	25
43.	Spouse abuses alcohol	43	6
44.	Spouse has abused a child	52	5
45.	Spouse has abused mother	51	12
46.	Mother working	45	38
47.	19 years or less at birth of first child	50	50
48.	Interview unreliable	39	4
49.	Interviewee unco-operative	25	4

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

ADDITIONAL DATA SCHEDULE (INDEX CASES ONLY)

Name of child: .....

Case no. .....

7. SOURCE OF REFERRAL

0 N.K. 9 N.A.
1 Hospital - specify .....
2 Social agency
3 Private physician
4 Court/police
5 Self
6 Child Health Care Clinic
7 Other - specify .....

8. SOCIAL CLASS

0 N.K. 9 N.A.
1
2
3
4
5

9. CHILD'S PREVIOUS SUSPICIOUS INJURIES CONFIRMED FROM NOTES OR OTHER RELIABLE SOURCE

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

10. SIBLINGS' PREVIOUS SUSPICIOUS INJURIES CONFIRMED FROM MEDICAL NOTES OR OTHER RELIABLE SOURCE

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

11. BRUISING

1 No
2 Yes - specify .....

12. BURNS

1 No
2 Yes - specify .....

13. CENTRAL NERVOUS SYSTEM INJURY

1 No
2 Yes - specify .....

14. INTRA-ABDOMINAL AND OTHER INTERNAL INJURIES

1 No
2 Yes - specify .....

15. SKULL FRACTURE

1 No
2 Yes - specify .....

16. FEMUR FRACTURE

1 No
2 Yes - specify .....

17. TIBIA AND/OR FIBULA FRACTURE

1 No
2 Yes - specify .....

18. HUMERUS FRACTURE

1 No
2 Yes - specify .....

19. RADIUS AND/OR ULNA FRACTURE

1 No
2 Yes - specify .....

20. RIB FRACTURE

1 No
2 Yes - specify .....

21. OTHER SITES OF FRACTURE

1 No
2 Yes - specify .....

22. SERIOUSNESS OF INJURY

0 N.K.
1 Not serious (i.e. superficial injuries not requiring admission)
2 Serious: No permanent damage
3 Serious: Permanent damage
4 Death

23. HISTORY OF PHYSICAL NEGLECT (only recorded if specifically mentioned in hospital notes)

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

24. CONGENITAL DEFECTS

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

25. CHILD'S BIRTH WEIGHT

0 N.K. 9 N.A.
1 Under 2000 gm
2 2000 - 2500 gm
3 2500 gm or more

26. TREATED AT HOSPITAL FOR FAILURE TO THRIVE/MALNUTRITION

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

27. FREQUENCY OF PREVIOUS ATTENDANCE AT RED CROSS HOSPITAL

0 N.K. 9 N.A.
1 None
2 5 or less
3 10 or less
4 15 or less
5 More than 15 Details .....

28. SIGNIFICANTLY ADVERSE FACTORS IN PERINATAL HISTORY

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

29. SIGNIFICANTLY DELAYED DEVELOPMENT

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

30. SIGNIFICANT DISORDER ON PHYSICAL EXAMINATION

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

31,32. WEIGHT PERCENTILE

33,34. HEIGHT PERCENTILE

35,36. LENGTH PERCENTILE

37. DIAGNOSIS OF CHILD ABUSE

0 N.K. 9 N.A.
1 Certain (i.e. admitted, witnessed or convicted)
2 Certain on medical grounds
3 Highly suspicious

38. PERPETRATOR'S SEX

0 N.K.
1 Male
2 Female

39. PERPETRATOR'S RELATIONSHIP TO VICTIM

0 N.K.
1 Biological parent
2 Step/acting parent
3 Sibling
4 Other relative
5 Caretaker (baby-sitter)
6 Other
7 Foster parent
8 Adoptive parent

40. PERPETRATOR'S AGE

0 N.K.
1 Under 15 years
2 15 - 19 years
3 20 - 24 years
4 25 - 29 years
5 30 - 34 years
6 35 - 39 years
7 40 - 44 years
8 45+

41. PRIMARY MANNER OF INFLICTION OF INJURIES

0 N.K.
1 Beating with hands
2 Beating with instrument
3 Throwing
4 Kicking
5 Burning/scalding
6 Stabbing/slashing
7 Strangling/suffocating
8 Deliberate neglect/starvation/exposure
9 Other

42. ACCOUNT OF ABUSE

0 N.K. 9 N.A.
1 Abuse admitted
2 Abuse alleged by other person, specify .....
3 Accidental
4 No explanation

43. ASSESSMENT OF HOUSING

0 N.K. 9 N.A.
1 Dilapidated
2 In reasonable condition
3 In good condition. Assessed by .....

44. ASSESSMENT OF MOTHER'S CARE OF HOME

0 N.K. 9 N.A.
1 Obsessionally clean and tidy
2 Reasonably clean and tidy
3 Dirty and untidy

45. INFORMATION FROM MATERNITY HOSPITAL

0 N.K. 9 N.A.

___ Mother under 20 at 1st child's birth
___ Recorded emotional disturbance in parents
___ Family referred to maternity social worker at time of birth
___ Newborn admitted to special care baby unit
___ Recorded concern over quality of mothering in maternity hospital

1 One factor
2 Two factors
3 Three factors
4 Four factors
5 Five factors
6 None

46. MAIN FOLLOW-UP AGENT

0 N.K. 9 N.A.
1 None
2 Child and Family Unit
3 Social Agency
4 Day Hospital
5 Child Health Care Clinic
6 Other psychiatric facility, specify .....
7 Department of Justice
8 Combination of agents, specify .....
9 Other, specify .....

47. DISPOSAL OF CHILD RECOMMENDED BY RESEARCH TEAM TO SOCIAL AGENCY

0 N.K. 9 N.A.
1 Casework and supervision
2 To be found "in need of care" and returned home
3 To be found "in need of care" and removed

48. CHILD'S PLACEMENT

0 N.K. 9 N.A.
1 Sent home to battering environment without supervision
2 Sent home, batterer living elsewhere
3 Sent home to battering environment under supervision
4 Voluntary transfer of care
5 Found "in need of care" and returned home
6 Found "in need of care" and removed

49. CASE REFERRED TO POLICE

0 N.K. 9 N.A.
1 No
2 Yes - specify .....

50. PERPETRATOR'S COURT DISPOSAL

0 N.K. 9 N.A.
1 Probation (suspended sentence)
2 Probation with a condition of psychiatric treatment
3 Imprisonment/fine
4 Corporal punishment
5 Acquitted
6 Accused absconded
7 Other - specify .....

51. DURATION OF IMPRISONMENT

0 N.K. 9 N.A.
1 6 months or less
2 1 year or less
3 2 years or less
4 3 years or less
5 More than 3 years

52. COURT'S VERDICT

0 N.K. 9 N.A.
1 Accidental death
2 Common assault
3 Culpable Homicide
4 Murder
5 Other - specify .....

RESULTS OF THE ADDITIONAL DATA SCHEDULE

(Index Group)

		Percentage of Index Group
7.	Referred from Hospital Outpatients	71
8.	Social Class 5	75
9.	Previous injuries confirmed	Sample too small
10.	Siblings' previous suspicious injuries confirmed	Sample too small
11.	Bruising	59
12.	Burns	14
13.	Central Nervous System	12
14.	Internal	6
15.	Skull fractures	8
16.	Femur fracture	2
17.	Tibia/Fibula fracture	0
18.	Humerus fracture	2
19.	Radius/Ulna fracture	0
20.	Rib fracture	4
21.	Other fracture	6
22.	Serious injuries	29
	Fatal injuries	8
23.	History of physical neglect	Sample too small
24.	Congenital defects	4
25.	Birth weight less than 2500 gms	31
26.	Previous failure to thrive	Sample too small
27.	Previous attendance at hospital	Sample too small
28.	Perinatal problems	Sample too small
29.	Delayed development	Omitted
30.	Present ill-health	13
31,32.	Weight percentile	Omitted
33,34.	Height percentile	Omitted
35,36.	Length percentile	Omitted
37.	Certain	69
	Medically certain	19
	Highly suspicious	16

		Percentage of Index Group
38.	Male abusers	62
	Female abusers	38
39.	Abuser is a biological parent	63
40.	Abuser under 27 years	50
41.	Beating with hands	12
	Beating with instrument	44
42.	Accidental explanation	8
	No explanation	12
43.	Assessment of housing	Omitted
44.	Assessment of mother's care of home	Omitted
45.	Information from maternity hospital	Sample too small
46.	Referred to Welfare Agency	32
47.	Recommendation of research team	Omitted
48.	Sent home to battering environment under supervision	63
49.	Police notified	24
50.	Court disposal	Sample too small
51.	Duration of imprisonment	Sample too small
52.	Court's verdict	Sample too small

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

PSYCHOLOGICAL ASSESSMENT

NAME: ..... ENGLISH/AFRIKAANS

DATE: .....

DATE OF BIRTH: .....

AGE: .....

RATINGS

MOTIVATION:

TEST-SET:

WECHSLER ADULT INTELLIGENCE SCALE (Abbreviated)

	Raw Scale	Standardised Scale	Average	±	I.Q.
Verbal Subtests					
Comprehension					
Vocabulary					
Nonverbal subtests					
Block design					
Picture completion					
Full scale					

COMPARATIVE RATING SCALE FOR INDEPENDENT INTERVIEWERS

	1 (within normal)	2 (moderate)	3 (very marked)
Depression			
Hostility			
Anxiety			
Poor self-image			

GUIDE FOR COMPARATIVE RATING SCALE

DEPRESSION

General behaviour:

Little interest in own appearance, or relating to strangers; difficulty in concentrating.

Face:

Sad face, smiles rarely, cries readily.

Movements:

Slow movements, slumps, shoulders drop.

Speech:

Slow, toneless, soft.

Content of speech:

Depressive trend of thought (hopeless, self-disparaging) or actually verbalises feeling sad, or wish to die.

HOSTILITY

General behaviour:

Angry or aggressive towards strangers, or family members (or cold).

Face:

Angry, irritable, smiles rarely.

Movements:

Abrupt, tense, aggressive to child.

Speech:

Rapid, angry tone, raised pitch.

Content of speech:

Aggressive trend of thought (critical of self or others), or actually verbalises aggressive feelings or admits aggressive actions.

ANXIETY

General behaviour:

Restless, fiddles with clothing or body, difficulty in concentrating, tremulous.

Face:

Anxious face, flushes, twitching of facial muscles.

Movements:

Jerky, tense, inhibited.

Speech:

Pressure of speech, hesitancy, stuttering.

Content of speech:

Anxious trend of thought (fearful, expecting disaster, worries) or actually verbalises feeling of anxiety, inappropriate fears).

POOR SELF-IMAGE

General behaviour:

Lack of care over appearance, lack of self-confidence in relating.

Face:

Self-conscious

Movements:

Awkward

Speech:

Lacking assurance

Content of speech:

Trend of thought is self-denigratory, or actually verbalises feelings of dissatisfaction with self.

KEY TO RATING

1 (within normal) - includes anxiety about the interview and 1 or 2 characteristics listed above which are not felt to constitute a deviation from the normal.

2 (moderate) - sufficient of the characteristics must be present to constitute a deviation from the normal.

3 (very marked) - all the characteristics must be present to a marked degree.

DEFINITIONS OF PSYCHIATRIC TERMS

The following definitions are derived from the Diagnostic and Statistical Manual of Mental Disorders, 2nd Edition (DSM - 2), of the American Psychiatric Association, Washington, 1968.

Neuroses

Anxiety is the chief characteristic of the neuroses, and the mechanisms which are used to express or control the anxiety produce symptoms which are experienced as subjective distress and from which the patient desires relief. The neuroses manifest neither gross distortion or misinterpretation of external reality, nor gross personality disorganisation.

Anxiety neurosis: This neurosis is characterised by anxious over-concern extending to panic and frequently associated with somatic symptoms.

Depressive neurosis: This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession.

Hysterical neurosis, dissociative type: Hysterical neurosis is characterised by an involuntary psychogenic loss or disorder of function. In the dissociative type, alterations may occur in the patient's state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue and multiple personality.

Psychoses

Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognise reality.

Schizophrenia, latent type (Borderline psychosis): Schizophrenia includes a group of disorders manifested by characteristic disturbances of thinking, mood and behaviour. The category of borderline or latent type is for patients having clear symptoms of schizophrenia but no history of a psychotic schizophrenic episode.

Schizophrenia, paranoid type: This type of schizophrenia is characterised primarily by the presence of persecutory or grandiose delusions, often associated with hallucinations.

Personality disorders

This group of disorders is characterised by deeply ingrained maladaptive patterns of behaviour that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier.

Paranoid personality: This behavioural pattern is characterised by hypersensitivity, rigidity, unwarranted suspicion, jealousy, envy, excessive self-importance, and a tendency to

blame others and ascribe evil motives to them.

Explosive personality: This behaviour pattern is characterised by gross outbursts of rage or of verbal or physical aggressiveness. These outbursts are strikingly different from the patient's usual behaviour. Such patients are generally considered excitable, aggressive and over-responsive to environmental pressures.

Antisocial personality: This term is reserved for individuals who are basically unsocialised and whose behaviour pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment.

Passive-aggressive personality: This behaviour pattern is characterised by both passivity and aggressiveness. The aggressiveness may be expressed passively, because the individual feels he dare not express it openly.

Inadequate personality: This behaviour is often characterised by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptibility, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.

Alcoholism

This category is for patients whose alcohol intake is great

enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning.

Episodic excessive drinking: If alcoholism is present and the individual becomes intoxicated as frequently as four times a year, the condition should be classified here. Intoxication is defined as a state in which the individual's co-ordination or speech is definitely impaired or his behaviour is clearly altered.

Habitual excessive drinking: This diagnosis is given to persons who are alcoholic and who either become intoxicated more than 12 times a year or are recognizably under the influence of alcohol more than once a week, even though not intoxicated.

Alcohol addiction: This condition should be diagnosed when there is direct or strong presumptive evidence that the patient is dependent on alcohol. The inability of the patient to go one day without drinking is presumptive evidence. When heavy drinking continues for three months or more it is reasonable to presume addiction to alcohol has been established.

Drug dependence

This category is for patients who are addicted to or dependent on drugs other than alcohol, tobacco, and ordinary caffeine-containing beverages. The diagnosis requires evidence of habitual use or a clear sense of need for the drug.

Mental retardation

Mental retardation refers to subnormal general intellectual functioning which originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of mental retardation relates to IQ as follows:

Borderline mental retardation	IQ 68 - 83
Mild mental retardation	IQ 52 - 67
Moderate mental retardation	IQ 36 - 51
Severe mental retardation	IQ 20 - 35
Profound mental retardation	IQ under 20

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