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Child protection by child and family guidance workers

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In 1990 I saw every member of the Child and Family Guidance Service within the Swindon Health Authority to discuss children from their last (unselected) six or 12 families in relation to child protection issues. All 19 professionals were part-time workers, some only doing three, two, or one sessions per week of child and family guidance work. They were seven psychiatrists (consultants and a senior registrar), two psychologists, six psychiatric social workers (including family therapists), and four specialised therapists (family, child psychotherapy, nurture-group and art). There were 14 female and five male professionals.

Some children of families had been referred specifically for treatment following child abuse. These involved 21 children (12 registered child abuse cases) but were more than balanced by other categories of referral unrelated to child abuse; for instance grief counselling, complications of illnesses, and specific learning disabilities.

The study

In all, 204 families with 371 children were considered, close to a quarter of the workload of the service for one year. From these 371, children on the Child Protection Register were as follows:

Currently, at time of treatment	13
In the past	18
Both currently and in the past	30
All	61

There were a further 50 children for whom child protection case conferences had been held but who were not registered. The ensuing numbers show the formally registered categories, with the caveat that combined categories include registrations at any time in the child's life, for combined categories at the time of registration are much under-recorded.

Physical abuse	14
Physical abuse with neglect	4
Physical abuse with emotional abuse	2
Physical abuse with sexual abuse	1
Neglect	9
Neglect with sexual abuse	1
Emotional abuse	5
Sexual abuse	15
Grave concern alone	10
Total	61

Many more children were victims of ill treatment than those 61 who had been officially registered. Definitions were as follows.

Physical abuse (P)

Physical force by parent or carer aimed at injuring or causing suffering to a child; or the practice, encouragement, or tacit permission of any form of physical ill-usage which causes unnecessary suffering, harm or potential harm to a child.

(Severe). Beatings, burns, multiple injuries, fractures, suffocatory abuse, poisonings, torture.
(Not so severe). Some age-appropriate/control component intended by carer; or frustrated outbursts, not sustained or repeated.

Neglect and abandonment (N)

Potentially or actually damaging failure to carry out important responsibilities of parental care, if attributable to sustained or repeated indifference, ill-will or incompetence by the carer.

(Severe). Deprivation of food, warmth, medical care etc, sustained or repeated.
(Not so severe). Inadequate parental care or chaotic family leading to childhood deprivations, albeit lesser than above.

Sexual abuse (S)

The exploitation of the child by parent, carer, (or older person) for sexual gratification.

(Severe). Sexual abuse by parent or direct carer in the home. Child unprotected and undermined; or any violence or threats involved.
(Not so severe). Sex abuse by neighbour, relative or stranger (no violence, threats or blatant coercion) – parent takes early protective action.

Emotional abuse (E)

The use of mental cruelty, or social deprivation, or potentially harmful social interactions or controls by parent or carer on a child, which undermine or aim to undermine that child's happiness or competence.

(Severe A). Sustained rejection, scapegoating, undermining, threatening or hostile rearing. Restriction from avenues of help or pleasure. Corruption..
(Less severe, B). Rejection or scapegoating etc, as above, but intermittent, or parent(s) capable of giving at least some cooperation at times on behalf of their children.

TABLE I
Patterns of maltreatment

	(P)	(N)	(S)	(E)	*All children maltreated*	*Children × types of maltreatment*
Physical abuse *alone* (P)	3	—	—	—	3	3
Neglect *alone* (N)	—	27	—	—	27	27
Sex abuse *alone* (S)	—	—	7	—	7	7
Emotional abuse *alone* (E)	—	—	—	55	55	55
(P)+(N)	6	6	—	—	6	12
(P)+(E)	20	—	—	20	20	40
(P)+(N)+(E)	11	11	—	11	11	33
(P)+(S)+(E)	3	—	3	3	3	9
(P)+(N)+(S)+(E)	1	1	1	1	1	4
(N)+(S)	—	1	1	—	1	2
(N)+(E)	—	24	—	24	24	48
(N)+(S)+(E)	—	8	8	8	8	24
(S)+(E)	—	—	20	20	20	40
	44	78	40	142	186	304

(Less severe, C). Mainly maladaptive harmful parental behaviour, but parent(s) willing to try to modify rearing practices which adversely affect the child.

Findings

There were 186 maltreatment victims of whom 81 were severe cases. Table I shows the extent of the child abuse for it incorporates registered and unregistered children, as well as combined categories occurring at the same or at different times in the children's lives.

Some biases may have influenced myself and those questioned, so the ensuing numbers and paragraphs illustrate unquestionably severe episodes of abuse.

Physical abuse episodes (severe)	22
Neglect episodes (severe)	20
Neglect episodes (severe)	32
Emotional abuse episodes Category A, (severe)	54
All severe maltreatment episodes	128
Child victims of one or more types of severe abuse	81

Examples from these 81 include five children previously battered as babies, two cases of Munchausen-syndrome-by-proxy and six suffocatory abuse cases. Four of these last had been punished by holding under water, and in foster care were so terrified of bath or hair-washing time that they had gone beyond the physiological phase of tension and resistance, into collapsed flaccidity. Part of treatment was explaining this to the foster parents in order to avoid repetition of circumstances reminiscent of past terrors.

One child was not let outside the house for three years, witnessing violence to other children in the home. Two small boys whose mother had been a victim of all types of abuse were deliberately subjected by her to inconsistent rewards, punishments and trials irrespective of their behaviour, to confuse and break any spirit of pleasure in (or control of) childhood life. A boy (10 years old) was hated and totally segregated by a paranoid father who denied paternity; the boy and his sister were often bruised by the mother. One mother turned a blind eye to sexual abuse of three of her children by two partners, and another was present during episodes of sexual abuse on her 12-year-old daughter. There were also familiar old-fashioned vignettes, currently renewed, of hungry, dirty, smelly, infested children. Usually these cases of severe neglect had occurred months or years before clinic attendance. Crises and interventions within the biological settings had often led to alternative care, and clinic work was often performed with foster, step or adoptive parents on behalf of children whose earlier life in their own homes had been appalling.

Comment

Certain themes recurred. "... deprivation ... the gap between the child's needs and the parent's capacity to satisfy these ... most of my parents were victims themselves...." Variations on these were expressed by most of the 19 professionals whom I saw. There

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was a healthy balance expressed between therapeutically positive thinking (such as the family therapies) and recognition of the rights of the child, with much more facility and familiarity with issues of registration, intervention, and actions or procedures to protect children than 10–15 years ago. This balance is exemplified as follows: "... in one sense, nearly all the children I see are emotionally abused to some degree... but we have a lot of (emotionally) deprived mothers who just are not coping. Some (of these mothers) can be helped, but the prognosis is not too good for others, and we have to think of other supports and interventions on behalf of the child".

A short scrutiny of the numbers shows that formal registration procedures are not netting all the serious child cruelty cases, let alone the mass of apparently less severe ones. The principle reason is that Wiltshire registration now emphasises child protection rather than total numbers. Children thought to be in new (and probably safer) settings, child(ren) with the non-abusive parent, relative or foster carers after the abuse, perpetrators separated or off the scene, these are circumstances which all tend to result in non-registration. Other reasons include inadequate previous compilation and collation of information, delayed revelations, delayed verifications, and use of psychiatric or family treatment in place of formal procedures when seen as a more manageable option.

The other main conclusion is that a hefty and demanding proportion of child and family guidance work is concerned with treating the consequences of past child abuse in the home, and with breaking the patterns of any continuing harm to children from their carers.

There have been publications linking child psychiatry with child protection (Kennedy, 1988, 1989 and Nicol, 1989), and our obligations in respect of child sexual abuse (Bentovim, 1987). This short study illustrates that a child and family guidance service in the middle of England is not simply an isolated backwater of arcane deliberations but is broadly committed to tackling child abuse by a variety of approaches.

References

BENTOVIM, A., BOSTON, P. & VAN ELBURG, A. (1987) Child sexual abuse – children and families referred to a treatment project and the effects of intervention. *British Medical Journal*, **295**, 1453–1457.

KENNEDY, R. (1988) The treatment of child abuse in an in-patient setting. *Bulletin of the Royal College of Psychiatrists*, **12**, 361–366.

—— (1989) Psychotherapy, child abuse and the law. *Psychiatric Bulletin*, **13**, 471–476.

NICOL, A. R. (1989) The ABC of child abuse: role of the child psychiatry team. *British Medical Journal*, **299**, 451–452.

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Factors contributing to military casualty rates during war

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Discussion of psychiatric casualty figures in military personnel tends not to distinguish between acute and chronic conditions. Combat-related stress (CRS) responds well to immediate, short-term intervention. Overall psychiatric casualties are approximately 30%. Contemplating the future in 1982, Romo & Schneider suggested casualty figures might be higher. This article considers factors contributing to the incidence of psychiatric casualties.

Military factors affecting number of casualties

The physical deprivations of war as well as the psychological pressures contribute to problems: battle fatigue is simply that, and is treated with rest and sleep and does not imply other problems.

The incidence of psychiatric combat casualties is directly related to battle intensity. This is most