PERSONAL PRACTICE

Classification of child abuse by motive and degree rather than type of injury

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The protection of children may be enhanced if ill treatment is classified by motive and degree rather than by type of injury. Four categories are proposed: A, abuse: premeditated ill treatment *undertaken for gain* by disturbed, dangerous, and manipulative individuals; B, active ill treatment: impulsively undertaken because of socioeconomic pressures, lack of education, resources, and support, or mental illnesses; C, universal mild ill treatment: behaviour undertaken by all normal caring parents in all societies; and D, neglect: defined here as an *unintentional* failure to supply the child's needs. Such a classification could clarify the procedures for investigation and protection, and support the creation of a Special Interagency Taskforce on Criminal Abuse (SITCA) for those suspected of abuse (category A).

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Even in many well resourced countries, there appears to be inadequate protection for children from the most serious forms of ill treatment (abuse).[1–3] In the UK, despite "Working Together",[4 5] cases involving extreme suffering for children continue to occur.[6 7]

Based on our experience,[8] we offer a new classification of ill treatment. Category A is the premeditated cruel abuse of children for gain; category B is the impulsive active ill treatment of children related to societal and personal pressures; and category C is the universal mild hurts inherent in all parenting. Our classification is different from that presently used and based on the mode of ill treatment: physical, sexual, and emotional.[4 5 9]

We define "neglect" as the unintentional failure to supply the needs of the child—differentiating it from what we now call "deprivational abuse", where withholding food, care, or love is deliberate (see accompanying paper by Golden *et al* in this issue).

Our classification is based on motive and premeditation; it allows for "diminished responsibility" resulting, for example, from mental illness. The benchmark of abnormality is based on the concept of what a "reasonable person would do" given the circumstances. Nearly all judicial systems have these same principles of natural justice to underpin their determinations. Civil society, the arms of the law and professional agencies are familiar with these concepts that date back millennia; the problems inherent in making determinations are similar to those applying to other forms of antisocial behaviour.

When abuse is classified according to current divisions of mode of harm, many in a society can develop fear of accusation for apparently normal behaviours. This in turn can damage normal family life; the father who does not hug his teenager or bathe his young daughter and the person who is inhibited from comforting the child who falls over are also victims. The fear of a label of abuse is changing the way we live.

CATEGORY A: DELIBERATE, PREMEDITATED CHILD ABUSE UNDERTAKEN FOR GAIN

This involves seriously harmful acts against children and should be recognised in all countries as one of the most serious of crimes.

Many notorious examples could be quoted. Here is an example from the UK *Independent* newspaper (21 November, 2000).

> "The death of a little girl, beaten with a bicycle chain and made to sleep in a bath because she wet herself was blamed on the police and social workers returning her to her cruel 'adoptive' parents, the Old Bailey was told yesterday … Anna suffered 128 injuries caused by beatings with a belt buckle, trainers and cigarette burns … She was often put in a bin liner with her hands and feet tied and then made to sleep in the bath … Anna was admitted to hospital twice during 7 months of neglect. But despite the involvement of social services, medical staff and the police, she was returned to the care of Ms X and her partner … When she finally died, she had not eaten for two days and had spent 5 months restrained with masking tape, which had deformed her legs. During the last week she was naked in the bath. The bathroom was cold and she was alone in the darkness with the door closed."

For the victim, abuse involves unimaginable, unbearable suffering; for the perpetrator it is deliberate and premeditated; it results in gain or gratification for the perpetrator who may become habituated to abuse, particularly sexual abuse. The abuser is not mentally ill, as legally defined. Some have untreatable psychopathic personality disorders.[10 11] Those whose psychopathic disorder (estimated population prevalence 0.5–1%) is expressed in this way may be dangerous not only to children but also to their partners. Abusers are insensitive to the suffering they cause, may enjoy

inflicting pain, and need to dominate and control. They are people who, in the most extreme of ways, place their needs before others.

Covert video and audio surveillance, used to investigate life threatening abuse, has unequivocally demonstrated its existence, and shown the incredible suffering of the children and the malevolence of the parents.[8 12–14]

Child abusers are fully aware of their actions; they know they face retribution if detected. They establish plausible, elaborate explanations for their children's injuries to avoid detection, weaving faint strands of truth into a lattice of lies. When confronted with equivocal evidence their excuses may seem reasonable. For example, "I sometimes put my hand over my baby's face to ease his crying—this always worked well and did no harm—this time he died". Such explanations are incompatible with the pathophysiological changes of intentional suffocation.[8 12–14]

Some members of the social, health, education, and judicial services find it hard to believe that any parent could deliberately inflict such terrible injuries or emotional damage on their children. This professional reluctance or inability to accept the harrowing reality is partially responsible for the unacceptable delays that can occur before the victims are protected. Professionals are sometimes concerned about making a false accusation that has such serious consequences. All too often, this form of abuse only comes to light after the death of one or several children.[15–17] Later inquiry then finds that professionals have been "seduced" by a plausible abuser into giving inappropriate support and failing the child.

Abusers are expert in manipulation. They "turn on the charm" to entice professionals that show empathy with their fabrications into becoming supporters. When confronted they turn nasty, shout, and use drama to intimidate and isolate the professional who is suspicious. They create doubt and dissent within an overworked team to turn colleague against colleague. Professionals sometimes unwittingly accept lies to make their relationships with such abusers palatable.

Violence may be made more extreme by depression, or drug or alcohol dependence.

Perpetrators may move from one child or family to another reeking havoc. The deliberate abuse by parents[18] or, in some countries, teachers and institutional "carers", includes cigarette burns, scalds, sexual abuse, ritual punishments, savage beatings, prolonged physical isolation, and starvation. This abuse includes the fabrication or induction of illness[19–21] to gain attention and sympathy from doctors, nurses, friends, and relatives. It also includes such severe and sustained emotional abuse (deliberate belittling, repetitive threats, rejection, terrorisation, and isolation) that children become permanently emotionally disabled.[22]

The survivors of abuse often become seriously disturbed and socially excluded. Many contemplate suicide—some succeed. In some parts of the world, victims run away to live as "street children", where they may be further abused.[23] As brutalised adults they may become abusers themselves, without the ability to form relationships and give love, and so may become part of an intergenerational cycle of familial abuse. The cruelties inflicted interfere with the child's emotional and physical development and can result in a dysfunctional adult with low self esteem, emotional immaturity, poor coping strategies, and disturbed mental health that surfaces later.

Category A abuse occurs in all countries and cultures and transcends all creeds.

Yet such abuse is widespread and is a worryingly hidden reality. Enforced child labour within many countries is category A abuse for obvious gain.[24] In West Africa children are sold into slavery to work in cocoa plantations. There are many examples of child trafficking for paedophilic sex; in Mumbai alone 4000–10 000 Nepalese children are repeatedly raped, beaten, and imprisoned in brothels.[25] Incredible abuse follows kidnap to provide child soldiers and "wives" for irregular armies,[26 27] where children are forced to perform sadistic murders as part of their "training". In many countries children are tortured[28] for collective punishment, to extract information on parents/peers, to punish parents, and as entertainment; in homes, prisons, and refugee camps.

There are more than 30 million children in the world (particularly Central and South America, Eastern Europe, Africa, and South Asia)[24] driven to live on the streets by poverty and in a proportion of cases by abuse. They live by scavenging, stealing, begging, working like slaves, dealing in and taking drugs, and prostituting themselves to survive. They are frequently targeted by individual policemen and sometimes killed by vigilante groups employed by local businessmen.[29]

Management of category A abuse

In our view, this must be the primary focus of child protection, involving incisive action and receiving financial support from all governments. Tragically most countries of the world do not have any system in place to identify and protect children from this abuse despite all but two countries being signed up to the United Nations Convention on the Rights of the Child.[30]

We believe that the reasons for our collective lack of protection arise from: (1) the failure to make a clear distinction between the deliberate, premeditated abuse of children and the ill treatment described in categories B and C below; (2) the inappropriate use of the term "abuse and neglect". (Neglect in our classification is unintentional and the term "deprivational abuse" should be used when there is a deliberate withholding of essential physical and emotional needs of the child—see accompanying paper by Golden *et al* in this issue); and (3) the lack of a powerful system to identify the perpetrators of these crimes and protect children from them.

Although the differences between categories A and B appear straightforward, in practice there can be many difficulties in differentiating between them. As a society, we have to reach a value judgement about whether it is better to allow a few children to return to category A abusers to their great peril and suffering,[31–33] or inappropriately to accuse and stigmatise a larger number of families. Neither is satisfactory; each individual diagnostic error, either way, involves harm to the child and family. It is essential that we have both the highest possible sensitivity and specificity when making assessments. This requires highly trained specialists. Nevertheless, the agencies themselves and the public must be aware that some mistakes will inevitably be made.

We propose that a Special Interagency Taskforce on Criminal Abuse (SITCA), which has its own operational authority, be established. This is similar to the multidisciplinary child protection teams proposed by the NSPCC in their response to the inquiry into the death of Victoria Climbie.[6]

Each SITCA should be composed of child protection specialists who have appropriate experience and technical knowledge. They are likely to have been senior police officers, senior social workers, paediatricians, psychiatrists, pathologists, or lawyers trained in the forensic and childcare aspects of their disciplines.

In the UK, all cases of potential abuse are initially referred to Social Services, and this should continue. However, the first step should be a strategy planning meeting, to which parents are not invited, rather than a case conference. Once a case is suspected of being category A abuse, a SITCA unit should take active control.

Recent Part 8 inquiries in the UK (deaths resulting from abuse) and other sources[2 3] indicate that there are insufficient joint investigations with the necessary mix and degree of expertise. We think that neither the social services nor the police should take the lead when dealing with suspected category A abuse. Both services are currently led by and provide generalists, dealing with a heavy caseload of many types of social need and crime respectively. In our experience, the

development of an understanding relationship with the perpetrator, or to use the euphemism "working together with parents", within the ethos of the 1989 UK Children Act[4] and its guidelines ("Working Together", 1991, 1999,[5] "Messages from Research", 1995[34]), is inappropriate for managing any form of category A abuse. Most social workers are ill equipped to deal with criminals.

Those SITCA personnel with police training would be accustomed to violence, less concerned about personal danger from abusers,[22] trained to recognise deception,[35] and be aware of the depths of depravity of many perpetrators. The SITCA units would undertake a forensic analysis of all the social, criminal, and medical data (including medical records of all relevant family members) and interview family and witnesses.

This approach may be more acceptable to some disadvantaged countries where procedures to protect children are rudimentary, often despite relevant legislation. Where police forces are perceived to have little compassion, and protection of children from abuse is rare, training a team of professionals to initiate a SITCA system against category A abuse, could improve the approach of the police force to the needs of children.

CATEGORY B (IMPULSIVE ILL TREATMENT RESULTING FROM ADVERSE SOCIETAL AND PERSONAL PRESSURES)

Category B is where the ill treatment, although not premeditated, would be regarded by "any reasonable person" as excessive because of the degree of physical or emotional harm.

Characteristically, this occurs when parents are themselves under great pressure or depressed, having difficulties with relationships, and lacking family or other support. The actions are impulsive, thoughtless, and selfish. The parent lashes out at his/her child when the child is demanding attention, crying, or screaming. The parent is frustrated and unable to cope with the additional stress. Alcohol or drug dependence is often part of the response of the parent to the stress and sometimes contributes to the ill treatment. The act may cause very serious injury, and occasionally death, especially in infants or young children.

Sometimes a parent is ignorant about the extent of damage the impulsive act may cause. For example, in some societies it is not generally known that shaking of a young infant can tear veins around the brain. This is known within the UK, however, as a result of the widespread publicity about shaken baby syndrome and in this setting, such injuries might best be first considered under category A (especially as other injuries such as rib fractures are often present).

This type of ill treatment is related to such emotional, social, and economic pressures that the parent reaches "breaking point". The isolated, inexperienced, or poorly educated parent is more likely to reach this stage before the established, supported family. However, most normal parents can behave in this way if sufficient pressures are applied.

Such ill treating parents may have been ill treated, abused, or neglected in their own childhood to give a "learned" response to stress and expressed in parenthood. However, with repeated acts, it should become apparent, to even a stressed parent, that the ill treatment is seriously damaging their child. Subsequent failure to moderate their behaviour then becomes deliberate and abusive (category A).

Management of category B abuse

The parent causing category B ill treatment is distressed when they appreciate the impact their behaviour is having on their child and show true remorse. They have shame that may cause them to try to hide their ill treatment, and critically not to repeat it. They cannot cope with their own lives, let alone care for a child demanding care and attention. These parents desperately need professional help.

This is not the kind of ill treatment that in our view should invoke criminal proceedings. However, systems that allow timely identification, provide adequate support to protect the child from further ill treatment, and ameliorate the underlying social problems are essential and widely known and practised in many countries. In the UK, guidelines in 1991 to the 1989 Children Act (updated in 1999)[5] provide an excellent standard of care for children affected by this problem. Similar systems should be installed in all societies to conform to the United Nations Convention on the Rights of the Child.[30] Core management involves family assessments, strategy discussions, case conferences, child support registration, core groups, and supportive measures, and has been well described elsewhere.[4 5 36]

CATEGORY C (MILD ILL TREATMENT UNIVERSAL IN ALL SOCIETIES)

All loving and caring parents occasionally ill treat their children.

Facing a degree of adversity is essential for development; adverse experience equips children to cope with the realities of life, and teaches caution and that everybody has failings. Children need to emerge from the "Wendy House". Even if we, in so called "developed countries", perceive other cultures as being somewhat brutal, the child needs to learn to function within that society. Thus, unlike the other categories of ill treatment described above, category C is culturally dependent. The defining feature for category C is for the ill treatment to be mild, acknowledged, and mitigated by love and care.

Included are: (1) the "reflex" smack of the badly behaved child; (2) the frustrated aggressive shout that stuns the child; (3) the derogatory remark that demeans hurtfully; and (4) conscious "disciplinary" acts accepted by some societies as normal or necessary.

Although we disagree with any violence to children, we accept that caring, loving parents often give "discipline" and that its worldwide elimination is a utopian dream. The campaigns of organisations like EPOCH[37] that advocate against all violence to children are essential for civil society to evolve. However, given that most countries are nowhere near requiring non-violent interaction between parents and children, sanctions against category C ill treatment might inhibit wholehearted support for measures to address crimes against children as in category A above.

Management of category C abuse

Category C active ill treatment requires enlightenment of civil society and not intervention at the individual level. It should be addressed through education (see fig 1).

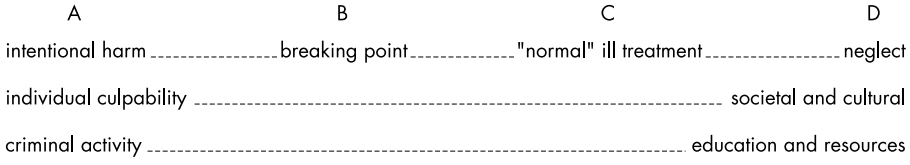

Figure 1 Spectrum of ill treatment.

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