A NEW WAY OF LOOKING AT CHILD ABUSE . . .

We welcome back to these pages Professor David Southall and Dr Martin Samuels. Despite a sustained campaign against their practice which has inevitably restricted important research into child abuse, we are pleased that they and Professor Golden now feel free to submit their proposals for reclassifying this issue.

They suggest moving away from classifying abuse according its effect on the victim, namely physical, sexual, emotional, or developmental. Rather we should look at the apparent motive of the perpetrators and the degree of harm. Four categories are proposed: deliberate premeditated abuse for gain or gratification, as may be conducted by a parent with a psychopathic disorder; impulsive, thoughtless, or selfish acts, resulting from adverse societal and personal pressures but without premeditation; and mild ill-treatment which is universal and may be culturally acceptable.

The authors propose that adopting this approach would rationalise the response by professionals, the courts, and society to individual episodes of abuse. Children would be better protected, families in the second category could be offered help, and those in the third need not fear disproportionate criticism or sanctions.

They also call for the establishment of special interagency task forces on criminal abuse which would take operational control of cases suspected of being deliberate and premeditated. A recent Royal College of Paediatrics & Child Health report advised revising another diagnostic label that may have outlived its usefulness.1 We should not regard this as just another new fashion; what we call a condition often governs how we manage.

See page 101

. . . AND NEGLECT

In the second of their “personal practice” pieces, Golden and colleagues redefine how we might consider “neglect” in a more constructive way. They urge us to disentangle it in our minds and our laws from abuse. Their redefinition implies neglect is non-deliberate; if a child is not supplied with its needs out of malice, he or she should be considered as suffering “deprivational abuse” rather than neglect.

Looking at the issue in this way allows us to understand what Golden calls “the conundrum of child malnutrition with loving and caring parents”. The authors conclude that social service departments are the appropriate agency to deal with neglect, not the criminal justice system.

See page 105

HELPING BABIES SLEEP

The baby who repeatedly wakes and persistently cries may trigger unpunisheded abuse by a parent unable to cope with their own sleep deprivation. This month, authors from the Thomas Coram Research Unit of London University’s Institute of Education describe their attempt to identify factors at the age of 1 week, which predict a poor sleep pattern at 12 weeks. Additionally they report the effects of a behavioural programme targeted at those identified at 1 week as being at risk of sleep disturbance.

The risk factors looked at included social class, maternal age, ethnicity and education, mode of delivery, method of feeding, and amount of crying, sleeping and feeding. Ultimately the only factor which stood up to a statistical battering was feeding more than 11 times a day at 1 week of age.

Applying a simple behavioural programme,2 the number of at-risk babies who slept poorly at 12 weeks were reduced by 21% compared with similarly at-risk controls. The authors outline what we next need to know. Firstly, how does the programme work; secondly how can we unravel the paradox that the behavioural methods used are inconsistent with some current child care practices designed to reduce crying; thirdly, will the programme work for all parents, however strongly held are their own views about baby care?

See page 108

MORE ON DIABETIC KETOACIDOSIS

Several weeks ago we published a paper calling for a summit meeting on managing diabetic ketoacidosis (DKA).3 It seems as though the UN has more on its plate at present but this month we continue the debate by publishing, under our “hypothesis” rubric, a theoretical approach to the problem of delivering the right amount of the right fluid to these vulnerable children. The authors propose risk factors for developing cerebral oedema at different stages in the progress of DKA. They conclude that management should change, advising against bolus insulin and rapid infusion of isotonic saline (except in hypotension). They commend using isotonic saline during the first day, having selected targets for the rise in plasma sodium. If cerebral oedema is suspected they recommend mannitol or a rapid infusion of hypertonic saline.

As before, we look forward to your comments which can be made online through www.archdischild.com, clicking on “full text” and then on “submit a response”.

See page 170

AN UNUSUAL POISON

We report nine children poisoned with Amitraz, an acaricide and pesticide, marketed under proprietary names including Mitaban®, Prevetic®, and Taktic®. A gallop through MEDLINE suggests this is an important problem in Turkey, from which country our report originates. We are not aware of a significant number of cases in Western Europe but forewarned is forearmed. A veterinary colleague informs me that puppies are poorly at 12 weeks were reduced by 21% compared with similarly at-risk controls. The authors outline what we next need to know. Firstly, how does the programme work; secondly how can we unravel the paradox that the behavioural methods used are inconsistent with some current child care practices designed to reduce crying; thirdly, will the programme work for all parents, however strongly held are their own views about baby care?

See page 170

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1 Royal College of Paediatrics & Child Health. Fabricated or Induced Illness by Carers. London: RCPCH, February 2002

Harvey Marcovitch, Editor in Chief