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Community Pædiatric Review

Domestic violence and childhood

VOL 6 NO 4 NOVEMBER 1997

An initiative of the Centre for Community Child Health & Ambulatory Paediatrics, Royal Children's Hospital, Melbourne

EXECUTIVE INDEX

"All happy families resemble one another, each unhappy family is unhappy in its own way."
From "Anna Karenina" Leo Tolstoy

It is an unfortunate fact in this country that the majority of real life violence children encounter will be within the home and family situation – either directly through child abuse or indirectly through witnessing domestic violence. From police statistics, 90% of all violent crime occurs in the family and close acquaintance environment, 80% of all homicides are perpetrated by extended family or friends, and 20% of all homicides are perpetrated by an immediate family member. The family is clearly the centre of most of our joy and sorrow, the creator of our psychological self and the key to unlocking our primitive selves with both nurturant and violent aspects.

The Extent of the Problem The extent of domestic violence is unclear. What is clear is that the majority of episodes remain unreported and the debate about the extent of non-reporting is often based on bias and opinion.

The incidence is further distorted by a lack of clear definition and victims differing perceptions of "violence". Do we just include physical violence causing injury, all physical violence, emotional abuse, sexual abuse, deprivation of liberty, etc? In an intervention trial currently under way in Brisbane, we ask mothers in the immediate postnatal period about each of these forms of violence separately. Six percent of the survey group report current violence but many do not consider themselves victims of domestic violence – they comment "he has never used his fists" or "he's never had a knife or a gun"! Clearly, all of the listed events can have a devastating effect on the individual and the children, but may not be recognised as domestic violence by the victims themselves and hence not brought to any professional's attention.

In any event, domestic violence in this country is exceedingly common. A population survey found 16% of Australian couples experienced violence in the year preceding the survey. In an antenatal care population in Brisbane, 9% of all women experienced domestic violence during the current pregnancy, and 30% reported a lifetime history of partnership abuse. A general practice survey of females in Victoria found that more that one quarter had been victims of physical or emotional partner abuse in the previous year, with one in ten having experienced severe physical violence. Only one quarter had revealed the abuse to their doctor or nurse; the other three quarters did not disclose because they were never asked.

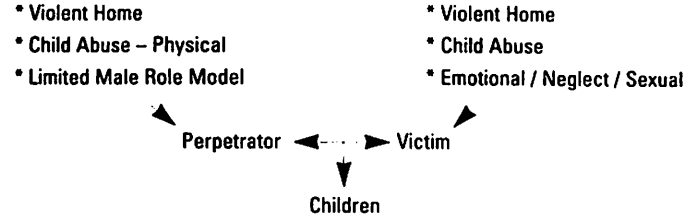
Given that large parts of society overtly and covertly sanction this behaviour and that domestic violence crosses all socio-economic boundaries, it seems that between 1 in 4 and 1 in 5 couples experience domestic violence at some stage.

Origins of the Problem Domestic violence arises from the childhood experiences of both partners. Up to 90% of male perpetrators come from violent, patriarchal homes, 70% have experienced severe childhood physical abuse, and all have limited close male role models. At least 40% of victims come from similar homes but are more likely to have been repressed emotionally, neglected or sexually abused. Together they produce marked effects on the next generation of children. In other words, domestic violence arises because of our failure to protect, nurture and love our children.

Domestic Violence – the Effect on Children's Lives From the moment of conception, violence intervenes – 9% of Brisbane babies are exposed to violence in utero, and, disturbingly, an increased proportion of children in the first year of life.

Figure 1

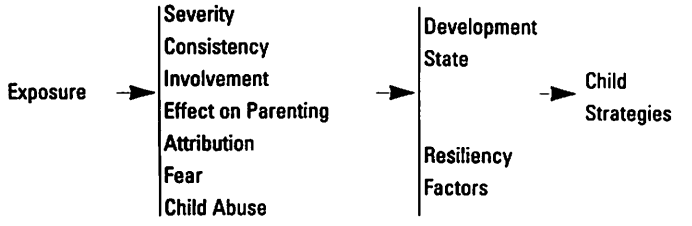
SOCIETAL MILLIEU



There is a clear relationship between partnership violence and prematurity, intra-uterine growth retardation, still birth and abortion. A study in Brisbane has found significant health effects for the baby during the first year of life. This suggests the milieu of domestic violence is one in which all family members suffer. A recent Western Australian study had linked cerebral palsy to pregnancy trauma, and other work clearly establishes the relationship with life-long child disability.

Figure 2

DOMESTIC VIOLENCE AND CHILDREN



"There comes a time when there is no more crying when there seems nothing more to be lost."

From Sue Woolfe, "Learning Towards Infinity".

For too long, we have ignored the psychosocial aspects of pregnancy. To test the urine, blood pressure and fundal height alone shows no duty of care to the unborn child. Until very recently, we have not been ready or didn't know how to ask the question for fear of the answer.

Children are present in more than 90% of violent homes. Almost all of the children witness the violence. There is a 15 fold increased risk of child abuse for children in a domestic violence family at the hands of not only the assailant but also the victim. Child abuse by the mother is an unsavoury fact of the domestic violence equation.

Children need strategies to survive when exposed to domestic violence (Figure 2). The quality and severity of the strategy required is determined by a number of factors including: features of the exposure, severity and consistency of the violence; the effect the environment has on parents' ability to parent; whether they attribute blame to themselves; the level of fear and the associated child abuse; the developmental stage (a baby cannot learn trust when a mother's attention is diverted by her violent partner, older children take responsibility for a parent's actions); and resiliency factors. Through all this, the child maintains a burning passion not only to be loved but to love.

CASE HISTORY

Shane is 9, failing badly at school, particularly in language. His school guidance officer's assessment revealed very poor concentration and he was sent by his general practitioner, with an "ADHD" referral. Shane presented as a shy, anxious boy. His teacher's report confirmed his learning difficulties, and concentration difficulty, but was most strong in her assessment of Shane's withdrawn status, his timidity, his aloneness. "Till 2nd term he never once approached me to ask for anything."

Shane's family included two younger full siblings, and an older stepsibling. They all came to the first consultation with mother. Father was not working but did not come. His mother was anxious and concerned for Shane's future. As part of the assessment I asked Shane to draw a picture for me of his family as animals. Mother was a rabbit, the three children were mice, the father was a bulldog. I spoke with him of this picture and learnt of his fears – a major fear for his mother's safety. Later I spoke with his mum and she confirmed the fear they all lived in. "We walk on eggshells, his temper is so unpredictable". Shane was living in fear of his father's moods – hypervigilant and withdraw, he had developed his strategies for survival.

Strategies used by children include:

Withdrawal: Younger children withdraw. You can see one month old babies who have successfully withdrawn. They present as failure to thrive, with irritability, sleep disturbance, and unusual eye contact.

Acting out / identification with the aggressor: Being aggressive, the school bully.

Intervening and directing attention to themselves: Directing the violence their way to protect their mother.

Denying existence and distraction or by assuming responsibility: With life-long guilt, shame and recurrent depression.

Domestic Violence and Children What this means for child health nurses is that children in a violent family will present in any of these ways:

- intrauterine growth retardation
- cerebral palsy
- child disability
- failure to thrive
- irritable baby / sleep disturbance.

Conclusion Domestic violence is a significant problem in Australian children's lives. As health professionals we have the ability to unlock the truth about the family and to counsel and direct victims to appropriate services for support. By recognising the problem, becoming adept at asking the hard questions, and having a plan of management we can make the lives of our infants and children significantly better.

AUTHOR
DR. KENNETH ARMSTRONG
COMMUNITY PAEDIATRICIAN
COMMUNITY CHILD HEALTH CENTRE
QUEENSLAND

School Readiness

School readiness is a term that is hard to define. When we consider a child's readiness for school we consider attributes like mental and social maturity, the ability to focus and maintain attention on a task or an activity for a reasonable length of time, language competence, the ability to regulate emotion, and a degree of social understanding which helps a child to interact comfortably with peers and adults.

These are personal and social qualities that enable a young child to cope with the many challenges of schools. Tests of these attributes (usually questionnaires) can be used to assess "readiness", but it is not really possible to find a number or a measure which says that: above the line you are ready, and below the line you are not. They are rather better suited to providing a profile of the child's capacities in a range of important areas. Such measures give, at best, a very imperfect prediction of the children who will cope well and those who will struggle.

Chronological age is only an approximate indicator of readiness. Individual differences in pre-school aged children are enormous; some children are ready for school at 4 and others not until 6 or even later. On average, girls will be somewhat more mature than boys at school entry, although the boys catch up over the first few years. Individual differences make the estimation of school readiness very difficult. However, experienced pre-school teachers are generally very skilled at knowing which children might be at risk of a difficult start to school and who would benefit from more time and pre-school experience.

There are some risk signs of difficulties which are helpful in considering the needs of individual children. These include: delayed language development which can handicap a child cognitively and socially and may make learning to read an effort in the early stages; the presence of attentional difficulties such that the child cannot settle to an activity, cannot concentrate, and flits about in an unorganised, unregulated way; and the presence of behaviour problems, especially aggression and poor social skills, leading to the inability to fit in with groups of children and to co-operate in play and in learning. Extreme shyness and separation difficulties may also need special help.

Recognising these difficulties early and seeking effective professional guidance can make a big difference.

While these are comments about the qualities of the child, it is important to remember that when there are difficulties the way that they are managed is critical. Sensitive, patient, and wise handling by parents and by teachers can help a child who is not optimally ready to adjust and to gradually cope with classroom and playground demands.

AUTHOR
PROFESSOR MARGOT PRIOR
PSYCHOLOGY DEPARTMENT
ROYAL CHILDREN'S HOSPITAL, MELBOURNE

ON THE SHELF

RAISING YOUR SPIRITED CHILD

A guide for parents whose child is more Intense, sensitive, perceptive, persistent, energetic.

Author : Mary Sheedy Kurcinka 1992, pp 302

So many children are perhaps spirited children and at times they may be called impulsive, uncontrollable or difficult. But Mary Kurcinka helps us to recognise the individuality that children offer and to understand their spirit and temperamental traits.

The spirited or strong-willed child can easily overwhelm parents, leaving them feeling frustrated and inadequate. But the author offers plenty of emotional support in this well written book as she emphasises progress, not perfection. Raising Your Spirited Child is not about how to change the child but how to interact positively and minimise difficulties; that is how to work and live with spirit.

The last two sections of the book are on socialising with spirit and enjoying spirit. There is helpful advice on how to develop the spirited child's social skills in getting along with other children. Mary Kurcinka provides an inspiring guide and a loving approach to understanding challenging and rewarding children.

HELEN ROWAN
CHILD HEALTH INFORMATION CENTRE
ROYAL CHILDREN'S HOSPITAL, MELBOURNE

Books are available from the Child Health Information Centre, a specialist bookshop, information and referral centre for health professionals, parents, teachers and adolescents.

A booklist is available for mail orders, telephone (03) 9345 6429, open 9.30-4.00 weekdays.

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SUPPORTED BY AN EDUCATIONAL GRANT FROM WYETH HEALTH AND NUTRITION TEL 1800 55 2223

CENTRE FOR COMMUNITY CHILD HEALTH & AMBULATORY PAEDIATRICS ROYAL CHILDREN'S HOSPITAL, MELBOURNE

Editors
Professor Frank Oberklaid
Michele Meehan

Production Editors
Lyn Dredge
Katherine Wositzky

For further information contact the Centre for Community Child Health & Ambulatory Paediatrics Royal Children's Hospital Melbourne Phone 03 9345 5899 or Fax 03 9345 5900