Liaison is another word pervading the College. Child and adolescent psychiatrists seek to work with all those interested in the welfare of children and young people. Still moving towards improved relationships with those traditionally involved in the same clinics, we are also having to branch out and work in co-operation with all those who have responsibility for the care of children, whether their own or other people's. There are many examples of work done with difficult children in their own schools or their own homes, so that those who have day to day responsibility for them, that is to say teachers or parents, are the ones who provide the direct help to the child. Preliminary results are encouraging, and the parents or teachers are more competent at dealing with the next problem than if the child attends a clinic for some mysterious form of therapy. Sometimes the work can be preventive, such as in advising Family Conciliation Services to help parents who are separating make plans for their children and even to educate the legal profession to prevent the adversarial system from using children as weapons. All this takes time that could indeed be spent on treating individuals. How we arrive at a balance between such preventive work and our own individual sessions with children is something each must work out for him or herself. To lose the essential skills and the clinical experience that communication with individual children brings would mean that we had lost our own souls and had blown up like an outsize vegetable marrow which when cooked is found to consist of a mere veneer spread over a mass of hot air.

Emotional Abuse of Children

This Discussion Paper has been prepared by a Working Party of the Section,* convened to consider the implications of the DHSS Circular LASSL (80)4-HN(80)20-2.2c(ii). A new category is to be included in Child Abuse Central Register Systems—'Children under the age of 17 years whose behavioural and emotional development have been severely affected and where medical and social assessments find evidence of either persistent or severe neglect or rejection.'

Previously the legal framework for considering cases of 'emotional abuse' lay in a section of the Children and Young Persons Act, 1969, where grounds for a Care Order in respect of a child can be 1(2)(a) 'his proper development is being avoidably prevented or neglected, or his health is being avoidably impaired or neglected, or he is being ill treated.'

The Working Party were also asked to attempt to define the concept of emotional abuse and the threshold beyond which concern should be expressed, and to recommend a code of practice for child and adolescent psychiatrists.

Responsibilities with regard to At Risk Register systems

In many, if not all cases of physical abuse of children, there is also emotional abuse, and in some families one child may be physically abused whereas another child is emotionally abused. The new category is potentially helpful in dealing with the wider concept of abuse.

In the period following the inquiry into the death of Maria Colwell, inclusion of children on a register was frequently done in an uncritical way, with no set time limit. The work of the Area Review Committees then led to refinement and limitation of criteria, anxiety diminished, and more effective use of registers developed, with monitoring and with criteria for removal of families from registers. The problems of confidentiality and legal rights of parents as well as children have been openly and constructively discussed. The work of Area Review Committees has been subject to local variations because of differences in their composition and differences also in the communities they serve.

It is not known to what extent child psychiatrists may already be represented on Area Review Committees. If children who are victims of severe emotional abuse are to be helped by at-risk procedures, then active involvement of child psychiatrists in local committees is essential.

Problems of diagnosis

Child psychiatric disorder has a variety of antecedents and there is no picture pathognomonic of emotional abuse. It is necessary for diagnosis to have knowledge both of the child and the family, and establish a connection between the child's state and the parents' behaviour.

'Good enough' parenting

Very few parents, if any, can meet *all* the needs of *all* their children *all* the time or refrain from ill-timed, inappropriate responses to children. Most parents can be expected to achieve parenting which does not impede or seriously damage development. In the vast majority of situations it is clear that a child being reared in his family is faring better in terms of happiness and human development than a child reared in an alternative setting, such as, a children's home.

Parent care and child rearing practice should be seen not as an ideal and needing to follow one particular pattern, but in terms of being adequate for a particular child.

Some children are undoubtedly more difficult to manage by virtue of their temperamental characteristics. Certain other factors may jeopardize a child's status in the family, such as, prematurity, physical abnormalities and chronic

*Members of the Working Party were: Drs Ann Gath (Convenor), Dora Black, Arnon Bentovim, Joan Wells and Stephen Wolkind.

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illness, brian damage and intellectual impairment. Emotional abuse may be more damaging to a child with other problems to contend with than it would be in a normal child.

Basic needs can be simply listed: (i) physical care and protection; (ii) affection and approval; (iii) stimulation and teaching; (iv) discipline and control which are consistent and age-appropriate; and (v) opportunity and encouragement gradually to acquire autonomy. *Neglect* may be seen where some or all of these areas of basic need are not attended to. *Rejection* implies negative attitudes and practices in relation to the basic needs. It is manifest in threatening or abusive communications and deliberate withholding of approval, attention and affection. A label of cruelty might be applied in some instances, particularly where belittlement, morbid teasing and constant punishment take place.

Parental behaviours can interfere seriously with the *self-esteem* and movements towards *competence* which are part of a child's growth. These behaviours include over-protection and exploitation by the parents for their own emotional needs and exploitation sexually and/or commercially.

Investigation

Examination of children should always be accompanied by observation also of family relationships. A child who is not in his own family must be observed with his substitute caretakers.

Examination of family functioning calls for experience and skill. Attention needs to be focused particularly carefully in certain circumstances:

(1) *Ethnic and religious minority groups:* Customs, attitudes and practice with regard to child rearig may be less familiar to the observer and hence more difficult to evaluate.

(2) *Situations of multiple caretaking:* It is particularly important to evaluate whether the attachment needs of children are being adequately met.

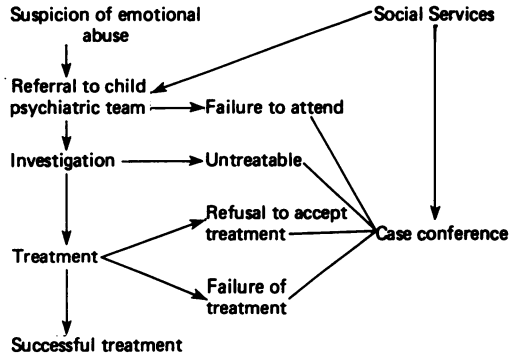
(3) *Severe matrimonial conflict:* Issues include the witnessing of violence and the involvement of children as go-betweens and hostages by the protagonists. Stress on a child can be severe without apparent marital breakdown, and can persist after dissolution of a marriage because of continued conflict.

(4) *Psychiatric disorder in parents:* (a) Psychosis—where parents are caring for children, involvement of children in delusional systems may have important implications. (b) Depressive illness—where illness of a mother caring for her baby is prolonged and severe it must be determined whether or not the baby's needs are being met, particularly in relation to affective contact, stimulation and communication. (c) Personality disorder—the extent to which a parent can exert consistent care and control and the effects of repeated threats and other acting-out behaviour on children must be evaluated.

Procedure

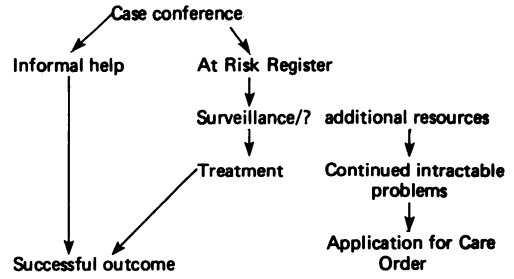
The emphasis is on successful treatment of the family, when possible.

A.



The case conference is held when effective help cannot be given to the family.

B.



Conclusions

1. The diagnosis of emotional abuse is difficult.
2. The proof of emotional abuse is even more difficult.
3. Investigation is called for where there is suspicion of emotional abuse.
4. Child psychiatrists will be needed in the evaluation of such cases.
5. Where treatment refusal and treatment failure occurs, child psychiatrists have a responsibility to initiate action with regard to case conferences, etc.
6. Child psychiatrists should be represented on each Area Review Committee.

Practical examples

A. Sharon, aged 14

1. Alert—poor school performance and misery noted by school. Parents advised to see their general practitioner.
2. Referral by GP to child psychiatric team.

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3. Investigations, including diagnostic family interview, reveal scapegoating, constant denigration and refusal to allow child to have social contacts outside school hours.
4. Parents refuse family therapy and will not bring Sharon to clinic.
5. Case conference—suspicion of emotional abuse confirmed. GP's information reveals long-standing and apparently intractable personality problems of parents. Local social worker appointed who is able to visit regularly. School undertake to bring Sharon for individual treatment, to which parents agree, provided they do not lose time from work.
6. Informal agreement reached—At Risk Register not used.
7. Continued monitoring by school, visiting social worker and psychiatrist seeing Sharon. Scapegoating diminished. Happier, more normal life for Sharon.

B. Carol, aged 6

1. Alert—by GP after mother's frequent complaints about Carol. Home visit by health visitor increases concern.
2. Referral to child psychiatric team.
3. Investigation—Carol's fearful, silent and watchful behaviour in presence of mother noted. Carol's normal, happy behaviour in school, with father and with friendly adults noted. No evidence of physical abuse or of neglect. Mother's own ill treatment at hands of her mother whom Carol resembles. Mother seen to function normally with both boys in family.
4. Treatment offered—(a) Family therapy greatly increased mother's hostility and Carol's fear; (b) Individual psychotherapy offered to mother in Adult Psychiatric Department.
5. Failure of treatment.
6. Case conference—decision to place Carol on At Risk Register and to provide intensive social work support to mother, father and family in home, a scarce resource locally, in addition to work of child psychiatrist.
7. Carol sent to neighbours but brought home and punished after she had settled down, being punished for being happy away from home. The problems persist and are intractable.
8. Care Order applied for—Carol placed with foster parents and allowed to stay there.

C. Anne, aged 4

1. Alert—request by mother for Anne to be taken into care under Section 1, i.e., voluntarily.
2. Anne seen to be almost mute, very limited in social development although physically well.
3. Social workers referred child to child psychiatrist asking if she was autistic.
4. Investigations reveal Anne's potential to socialize normally, and mother's severe personality disorder noted.
5. Rapid improvement in care of foster mother.
6. Parental rights assumed by Local Authority. Anne remains with foster mother who hopes to adopt her.

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Trainees' Sessions at Annual Meeting

As in previous years, the College wishes to encourage psychiatrists in training to present short papers at the Annual General Meeting in London in July. Please submit work of an original nature which should take no longer than ten minutes to present, but contain sufficient material to invite constructive criticism and helpful advice. Papers of a suitable standard will be considered for publication in the *British Journal of Psychiatry*. Further details may be obtained from Miss Jane Boyce at the College. Please send précis with title to Dr A. J. Poole, Moorhaven Hospital, Ivybridge, Devon PL21 0EX as soon as possible.

Psychiatry honoured

In March this year Professor Sir Desmond Pond took up a new appointment as Chief Scientist in the Department of Health and Social Security. He succeeds Professor Arthur Buller, Professor of Physiology at Bristol University.