Building a Caring Community for the Protection of Children

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Each country represented at the conference, whether "rich" or "poor" or somewhere in between, has committed its government and its citizens to providing protection from what UK legislation describes as "significant harm". The UN Convention on the Rights of the Child talks of the need to protect child victims of "any form of neglect, exploitation or abuse", and lists possible causes of maltreatment as having their origins in social and legal systems as well as resulting from the acts or inaction of parents.

The commitment unites us, but beyond that, each country has to work out for itself the reasons why its children suffer significant harm, and decide, in the light of available resources, which strategies it will develop to protect them. Will it emphasise prevention and family support or will it rely on rescue? Will it rely heavily on professionals or on building protective communities, using the ideas behind the new discourse of "civil society" and "capacity building"?

In this paper I shall consider the following themes:

- Which children may need protection?
- The centrality of needs assessment
- Multi-level responses to childhood adversity
- From assessment to choice of service options
- When to use formal protection systems?
- The importance of preventative strategies

Assessment of Need: the First Imperative

Put simply, assessment comprises two tasks:

- Understanding what it is in any society, local community or family, which leads to children's health or development being significantly impaired;
- Deciding how to make best use of whatever resources are available.

Assessment at Community Level

Who are the children in adversity in your country – those who may, to use UNICEF's phrase, be in need of special protective measures? Recently a television
programme made up entirely of the voices of children shocked UK viewers. Three sisters aged 6, 7 and 9, who bore on their faces all the signs of serious neglect said, when asked how life was for them: "All right. The heroin is worse than the beer". 'No', said the younger one "the beer is the worst". When asked if you could ask the Prime Minister to do something to make you life better, what would it be? The seven year old replied: "A nice house and a quiet place and them [parents and visitors to the house] not doing drugs. Ask him to change things that happen that are bad. Ask him to change the whole thing. Ask him to make everybody forget what they have done in their whole life that's bad." A ten year old boy, who it was all too easy to envisage beating his own children in the not-too-distant future said: "When you get smacked all the time you get used to it – not bothered whether they hit you or not." And then, with pride, "I'm not saying I'm tough, but I can take a good beating".

In Britain, perhaps more than most countries, we responded to the problem of child maltreatment by putting our trust in formal procedures to identify cases of child abuse. The Department of Health commissioned research (summarised under the title: Child Abuse: Messages from Research) which told us that we were spending ever more resources in detecting abuse but less and less on helping those who had been abused, or preventing it happening in the first place. The identification of risk was almost exclusively confined to risk of acts of physical or sexual maltreatment by parents or parental figures.

Other causes of significant impairment to children's health or development were left unattended. Bullying or racist taunts in school, for example, have lead to the deaths through suicide of children whose caring parents were turned away when they sought help because, they are told, "we only work with child abuse cases". Children who had been sexually assaulted by the mother's boyfriend were "investigated" and "conferenced" but offered no further help when it became clear that the abuser was no longer in the home. Cases of neglect and emotional maltreatment were identified but rarely received a longer term service, despite the clear evidence that long term impairment is highly likely to result from persistent physical or emotional neglect. Worst of all, despite unassailable evidence that the children whose health or development was most likely to be most significantly impaired were those who came into the care of the local authorities when older, these children were often not allocated to a social worker's caseload. They were "safe" (that is, apparently safe from further parental maltreatment) and the harm to which they continued to be exposed, in most cases as a result of system inadequacy or their own risk-taking behaviour rather than deliberate abusive acts, received too little attention.

Unlike the situation in many parts of the world where the major reason for child prostitution is family poverty, in the UK it is largely explained by family dysfunction and the failure of our child welfare system to pick up early enough on serious family problems and provide appropriate help. (I shall return to this point later.) It took the recent Utting Report People Like Us, to draw to the attention of Government the fact that a large proportion of runaways and children living on the streets were running away from state "care". "People like us", the report pointed out, do not turn our children out at the age of 16. We continue to be there for them for as long as they need us.

Before I go on to look more closely at the UK response to this research, I will answer my earlier question in respect of UK children. Who are the children in adversity for whom we must build a caring community? This list will resemble your lists in some respects but be different in others. The point is, we can not use our resources effectively to build caring communities until we first identify who are the children in need of protective measures and the possible causes for this.

Table 1 shows the reasons why UK children come to the attention of social services departments, either because their parents seek help or because a neighbour or a professional believed they may be at risk of suffering significant harm.

In support of this, Table 2 is taken from two cohort studies, respectively of children newly identified as suffering or likely to suffer significant harm, and of children referred for family support or because of concerns about emotional maltreatment or neglect.

The response of the UK government to this research-led agenda has been to "refocus" its child welfare and child protection services. At the community level, it is important for professional agencies, NGOs, and representatives of

<table>
<thead>
<tr>
<th>Table 1 Groups of children “in need” who may also be in need of protective services</th>
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<tbody>
<tr>
<td>• Maternal deprivation/disadvantage/stigma</td>
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<tr>
<td>- poverty/irregular income</td>
</tr>
<tr>
<td>- unemployment</td>
</tr>
<tr>
<td>- poor housing</td>
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<tr>
<td>- poor/unsafe environment</td>
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<tr>
<td>- victims of crime</td>
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<tr>
<td>• Poor socialisation/attachment problems of parents</td>
</tr>
<tr>
<td>• Criminality (of parents; of young people)</td>
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<tr>
<td>• Addictions (of parents – including paedophilia)</td>
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<tr>
<td>• Addictions of young people</td>
</tr>
<tr>
<td>• Parental conflict (emotional abuse and violence)</td>
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<tr>
<td>• Mental ill-health (of parents; of children)</td>
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<tr>
<td>• Learning and physical disability (of parents; of children)</td>
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<tr>
<td>• Persistent truants/those excluded from school</td>
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<tr>
<td>• BEING “IN CARE” (LINKED WITH ABOVE).</td>
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vulnerable groups and service users to get together to understand the nature of the risks in their own communities. In the light of these consultations, each local authority must produce annually a *Children’s Services Plan*. In the light of this plan, the health, education and social services departments must prioritise needs in the light of available resources and jointly commission services to meet the identified needs. Vulnerable communities may be geographical areas with high levels of deprivation and social exclusion, or they may be “communities of interest” such as parents of children with disabilities or who are HIV positive, or homeless young people or care leavers. A set of performance indicators (the *Quality Protects* indicators) inform these plans and are used to measure their effectiveness. At least, that is the rhetoric, but to date, most plans are dominated by professionals and it is rare for service users to be involved. However, small steps are being taken, encouraged by the government guidance on family participation, *The Challenge of Partnership* (DH, 1996). For example, in the area in which I live parents of children on the child protection register have been invited to be members of a working party designing leaflets to inform parents about child protection investigation and conference processes.

### Assessments of Children in Need

In individual cases, the Children Act 1989, inspired by the principles in the UN Convention on the Rights of the Child, provided the framework for a shift in emphasis from “risk assessment” to “needs assessment”. This is not that we are to turn our backs on child maltreatment, but rather that children’s needs for protection should be firmly located within their other needs and those of their parents and siblings.

Figure 1 illustrates the framework which will be used for assessing the needs of all children referred for a service, including a child protection service. The preliminary assessment may take an hour or it may take a week. But it must go beyond the narrow assessment of risk of abuse to cover all these areas, without being any more intrusive into family privacy than is necessary to get a full enough picture on which to base a decision about appropriate intervention in each particular case. Amongst the basic principles for assessment is the statement that help should start immediately and be revised in the light of further assessment. This is in response to the research which found that families requesting a very specific practical service were often told that nothing could be done to help them until lengthy assessments had been completed.

Your response to this assessment framework may well be – but what is new about that? It is the “ecological model” of the early 1980s or the “unitary model” or systems approach; person in environment or psycho-social casework. Maybe in your countries it is not necessary to restate the basic principles of assessment. But in the UK, for several years the emphasis on the investigation of risk

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**Table 2** Incidence of specified family problems in two research populations

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<tr>
<th></th>
<th>Significant Harm Study (all ages)</th>
<th>Family Support Study (children under 8)</th>
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<tbody>
<tr>
<td>Mental health problem</td>
<td>20%</td>
<td>30%</td>
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<tr>
<td>Alcohol or substance abuse</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Rutter “malaise” high score</td>
<td>60%</td>
<td>55%</td>
</tr>
<tr>
<td>Gibbons family problem (health)</td>
<td>52%</td>
<td>42%</td>
</tr>
<tr>
<td>Parent has disability or chronic health problem</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td>Marital/Partner discord</td>
<td>47%</td>
<td>38%</td>
</tr>
<tr>
<td>Emotional problems</td>
<td>39%</td>
<td>12%</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>33%</td>
<td></td>
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<tr>
<td>Kovacs child depression inventory</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>37%</td>
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of parental assault had squeezed out the more careful assessment of other family needs. I welcome it because it gets us away from over-reliance on "quick fixes", whether through procedures or magic cures – the latest therapy or the dream of "rescue" represented by the "permanence" approach of terminating parental rights and contact and placing for adoption.

Central to the assessment framework is an appraisal of the strengths as well as the weakness in the family and also in the community. What family, community and professional resources are there, and how can they be harnessed to ensure that this particular child's welfare is not further impaired and any damage already done is repaired?

As part of the assessment, the professional resources previously available to family members have to be appraised. If the family is well known to the welfare and mental health agencies, a careful social work history needs to be compiled, from the records and the family members. It is essential to know about the services provided and the therapeutic methods used in the past, noting those which have been found useful and those which were seen to be unhelpful. (Evidence-based practice is essential if best use is to be made of scarce resources.) A singular weakness of social work recording identified by researchers is the lack of evaluative summaries and case closure summaries. A new worker picking up a re-referred case can not benefit from the assessment of the previous worker as to "what worked" amongst the different intervention methods tried.

Voluntary Action or Coercion?

We have learned from the research that our formal processes and the negative impact on self-esteem which often results when children's names are placed on the child protection register, are themselves damaging to parents. Sometimes it is necessary to inflict this further damage in order to ensure that parents realise that they are damaging their children and that society, in the shape of the protective agencies, cannot stand by and let them continue to do so. But our UK research showed that we were alienating parents by these procedures, especially registration and the use of court orders, in cases where combinations of parenting education, negotiation, support, practical help, casework and therapy would have had the same or a better result. The emphasis in the new draft of Working Together (DH, 1999) is on using negotiation rather than coercion to arrive at a support and protection plan whenever possible. At each stage in the assessment and protection process, the question is to be asked, is the formal child protection process necessary or could the same result be achieved by voluntary agreement? Is it necessary to undertake a child protection inquiry or can a voluntary agreement be reached about the appropriate child protection plan? Is a child protection conference necessary? Is registration necessary? Is court action and supervision necessary? Is it necessary for the child to be placed away from home, and if so is it necessary to seek a care order or can the same results be achieved by voluntary arrangements? (As an aside, it is important to note, for those interested in international comparisons of child abuse statistics, that the UK Child Abuse Registration figures do not give information on all the children believed to have been abused or maltreated. They can only tell you about those who have been or are likely to be maltreated and for whom a formally sanctioned protection plan is considered by a multi-disciplinary conference to be necessary.)

From Assessment to the Provision of Services: Making Best Use of Scarce Resources

At the community level and the level of the individual child and family, an appropriately full assessment leads on to a service plan. I shall first look at a community level plan for two groups of vulnerable children: child prostitutes and children who are at risk of harm because of exposure to extreme or persistent parental conflict or violence.

The research I have cited has shown that the second of these is a more substantial problem in the UK, whereas in some countries of South East Asia the "child sex trade" is numerically a much bigger problem. Both should feature in any Children's Services Plan (or whatever the equivalent is in your countries). The plan should provide an analysis of the main reasons why these problems exists, and the response at the following levels:

Child Prostitution

Looking first at child prostitution, the analysis in UK, as I have indicated earlier, suggests that the majority of children drawn into the sex trade are from families who could broadly be described as "dysfunctional". Using

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<th>Table 3</th>
<th>Levels of intervention</th>
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<tbody>
<tr>
<td>Primary</td>
<td>- Universalist Family support to children &quot;in need&quot;</td>
</tr>
<tr>
<td>Secondary</td>
<td>- targeted at risk populations, neighbourhoods, disability</td>
</tr>
<tr>
<td>Tertiary</td>
<td>- individual families - high levels of stress - on child protection register</td>
</tr>
<tr>
<td>Quaternary</td>
<td>- children &quot;looked after&quot; - restoration - group care or family placement</td>
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economic language, it is the "push factors" which have to be tackled. Children leave environments (their family homes or children's homes) because they find them intolerable. Once on the streets, "pull factors" come into play. The UK government no longer provides financial support, other than in exceptional circumstances, to young people aged 16 and 17 living away from their families. If unable to find employment, the young person has to chose between asking to go into local authority care (which many have already run away from) or finding some more dubious source of housing and food. They become exposed to the "pull" of the pimp or of the adult willing to pay for casual sex. Poverty, therefore, is only a secondary cause of child prostitution in the UK. In South East Asia the position is reversed. Poverty is the major cause, though the pull factor of "easy money" and the sex trade is also very strong. Sale of children by parents or relatives (sometimes linked to poverty, sometimes to cultural norms, sometimes to dysfunctional relationships) is a bigger cause of child prostitution in South East Asia than in the UK. But it does exist amongst some families where a culture of inter-generational use of children for the sexual gratification of adults has become accepted. Some of our most high profile child abuse scandals have included the introduction of children into sexual activity by parents and other adults who are well-known to them.

The point I am making is that creating a caring and safe community will differ depending on the reasons which underlie the particular risks. In the East a major response to child prostitution will be at the primary, societal level. Both the push factor of poverty and the pull factor of a thriving sex trade with a ready supply of "customers" has to be a major plank in any policy. Civil society has a crucial role to play in persuading governments that the earnings from "sex tourism" can have no place in their plans to improve the health of their economies. The physical and mental health of a nation's children are infinitely more important.

In the UK, our approach has emphasised services at the secondary, tertiary and "quaternary" levels of intervention, with halfway houses and casework and education services. Because the major problem is dysfunctional families and problems with our care system, the response to child prostitution at the secondary and tertiary levels is the same as our response to other forms of child maltreatment. A range of models of family support and family casework, direct work with the children themselves, together with attempts to improve quality of services in children in care, are appropriate preventive services for all forms of child maltreatment, including child prostitution. But we have been slow to take up the challenge of adapting our child abuse services to tackle the "pull" factor of pimps and "customers" looking for sex with children. We are moving in that direction, but we have still not yet persuaded our government and police service to totally stop prosecuting the young women as criminals, and to treat them as abused children and their "customers" as sexual abusers.

**Parental Conflict and Violence**

In the UK I might go so far as to say that "exposure to parental conflict and violence" is the latest category of parental behaviour recognised at "child abuse". In the new version of *Working Together* there is a separate paragraph of guidance, and it is beginning to appear as a heading in Children's Services Plans. So what might be a multi-level approach to children whose development has been impaired, or is at risk of being impaired, because of marital violence. I think that, unlike child prostitution there would be many similarities to the broad approach in different countries, though different cultural approaches to marriage and male/female relationships would lead to differences in the detail.

At the primary level, public education has an important part to play. How about a television commercial – "Do you want to know how to scar your child for life? Just go on taking out your temper and bad moods on his mother and you will succeed." An advertising consultant would make a better job, but I think you know what I mean. Whilst many parents don't stop to think whether they are emotionally damaging their parent by psychological or physical assaults, most do not want to harm their children. It just doesn't occur to them in the heat of the marital row, that that is what they are doing. In our study of emotional maltreatment we asked parents what they thought was meant by "significant harm". These three responses (Thoburn et al, 1999) indicate that parents who emotionally neglect their children because of their own preoccupations understand that it is harmful. To them, emotional abuse meant:

- *Being put down or upset by your parents' attitude to each other if they row a lot – emotional blackmail from parent to parent;*

- *If parents are rowing all the time...if they are seeing violence;*

- *I suppose that is like emotional blackmail if a child was being torn between mother and father – being made to choose.*

A publicity campaign might get to them before the children have already been harmed, and perhaps push them into seeking help or leaving a violent relationship. With conflict and violence a protection plan would include intervention at all levels. At the tertiary level, when it becomes clear that children are being harmed by
parental conflict, it is unlikely to be helpful in most cases for the formal child protection system to be used. The new *Working Together* does not have it as a separate category for registration but includes it under emotional abuse – though I think in most cases it would fit better under emotional neglect. There is also some risk of physical harm if a child gets caught in the cross-fire.

**Intervention at the Family Level: What Works?**

Moving on to intervention at the individual level, after the assessment of the problems and strengths of the family and the resources available to them a view will need to be taken about the sort of services which may be helpful. This means going beyond the reasons for referral and specific identified needs to make a professional judgement about the sort of family under consideration. Some risk and need questions to be answered are:

- What is the extent of impairment to health or development of each child?
- Is harm or impairment actual, suspected, or likely?
- Is it impairment to physical, emotional, behavioural, intellectual or sexual development?
- Is there a danger to "life or limb"?
- How imminent and how likely is that danger?
- Who is or is suspected to be culpable/responsible for any maltreatment or neglect?

*Table 4* (From Thoburn et al, 1999)

<table>
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<tr>
<th>Typology of families</th>
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<tr>
<td>With long-standing and multiple difficulties (25%)</td>
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<tr>
<td>In acute distress (10%)</td>
</tr>
<tr>
<td>Single issue (40%)</td>
</tr>
<tr>
<td>Short-term (20%)</td>
</tr>
<tr>
<td>Not &quot;in need&quot; (5%)</td>
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The cost of a service will be important when we decide whether the threshold to a service should be "guarded" by a parent or child, who will ask themselves the question: do I think it is worth my while attending this holiday club, this class on how to separate from my husband without harming my child? etc.

At the other end of the continuum, placing a child in long term care is both costly and possibly harmful and the professional will have a major say in whether it should be provided. In the middle, when children have not yet been seriously harmed, early intervention which makes use of short-term methods, such as solution focused therapy or a period of cognitive behavioural therapy or counselling, should be decided upon jointly by the family members and professionals. Here, careful thought is needed about prioritisation. Therapeutic services of this nature are expensive, but leaving the situation to get worse can be even more expensive. In our emotional abuse study, some families were turned away eight times in the course of the year, at which stage the situation was so bad that a care order had to be sought.

**In Conclusion**

In conclusion, I return to the question: what do we know from research about "what works?" in broad terms there is an overarching message: the older the child, the longer we delay intervention, the more difficult will it be to reverse the harm the child has suffered; the less effective will be our interventions and the more costly.

Which brings us back to the importance of each community, each culture, getting together to decide about the sources of potential harm to children and the societal and cultural factors which give rise to them. The proper resourcing of early intervention strategies is essential if we are to do more than provide an ambulance service for the child casualties of our ever more complex world. And that means people as well as finance, which is why civil society is so important. It also means learning from our own part successes and failures and those of others who have faced similar problems in similar circumstances.
Promoting Family Well-being - Future Direction on Family and Child Welfare Services

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Introduction

I am most privileged to have this opportunity to share with you the trends and challenges faced by families in Hong Kong, our guiding principles and policy objectives of family and child welfare services, the current provision and service delivery system, and the future directions and strategies adopted by the Hong Kong Government in promoting family well-being.

The White Paper on "Social Welfare Into the 1990s and Beyond" (1991) recognizes the family as "vital component of our society". It is the basic unit which provides physical care, mutual support and emotional security. It provides the most natural and nurturing environment for the growth and development of its members, particularly, children. There have been numerous discussions over what constitutes a "Family". I do not think we should waste our time over rhetorics. Our emphasis should be on the functions of the family rather than the form in which it exists. Parental love, guidance and supervision as well as positive relationship with siblings and other family members are important elements in promoting physical, emotional and intellectual development of children. In promoting the best interests of the child, it is important to preserve the strengths of the family and enhance its functioning. Children today are the parents of tomorrow. What we are doing for our children today is an investment for social stability and development, which will definitely extend beyond us, and will have far reaching effects in ensuring the well-being of our future generations.

Trends and Challenges Faced by Families in Hong Kong

Decades ago, families in Chinese communities were primarily extended families which performed the functions of caring of the young and the old, educating children, disciplining deviant behaviour of their members, cultivating relationship, and organizing productive activities. Families were generally self-contained and external influence was minimal. With rapid socio-economic changes, and advances in technology, the structure and functions of the family have undergone significant changes. The characteristics of families in Hong Kong today are:

References


• household size is getting smaller: decreasing from 3.7 in 1986 to 3.4 in 1991 and 3.3 in 1996;
• continuous increase in number of nuclear family households from 59.2% in 1986 to 61.6% in 1991 and 63.6% in 1996;
• more families are living in new towns in the New Territories: increasing from 35% in 1986 to 42% in 1996;
• more families with both parents working

Like other societies in the world, socio-economic changes have also brought along stresses and challenges to families in Hong Kong. The population of HK is ageing. In 1998, the crude birth rate was at 7.9 per 1000 and expectation of life at birth was 77.2 for male and 82.6 for female in 1998. As a result of economic restructuring and growth of service industry, there is an increasing number of women in the labour force, with more than 1.3 million representing a labour force participation rate of 48.5% among female, and a 39% among the economically active persons in 1998. With economic independence, the status of women is raised and the role of men and women in the family is undergoing changes.

In the past few years, there is migration of population from Mainland China to Hong Kong (about 55,000 per year), as well as movement of families, especially young families, from older parts of Hong Kong Island and Kowloon Peninsula to the new towns in the New Territories. The relocation of families brought about split families, adjustment and integration into a new living environment and lack of support from families of origin.

Incidents of domestic violence such as child abuse and spouse battering are emerging. The number of single parent families is increasing with rising divorce rate (with 5098 divorce cases in 1988 to 13230 in 1998). There are more reports on family tragedies arising from inability of individual families in handling crisis and more youth problems such as runaway youth, juvenile delinquency and youth suicide. The stresses and strains in urban life is undermining the mental well being of individuals, weakening inter-personal relationships and affecting the quality of life.

While some families have the strength and resilience to cope with the challenges, others which are vulnerable and less capable to face these stresses and strains have to seek help from outside the family.

Guiding Principles and Policy Objectives

In meeting these challenges, the Government is adopting a few guiding principles. These include the recognition for the role of the family, the strive for self-reliance and mutual support. It also believes that prevention is better than cure, and the need for early identification of problems and timely intervention. The Government is wary about intruding and intervening in private life and intimate emotion of the family and always conscious that the Government is not there to substitute the family.

The major objectives of family and child welfare services, as stipulated in the White Paper "Social Welfare into the 1990s and Beyond", are:

• to preserve and strengthen the family as a unit so that they may provide a suitable environment for the physical, emotional and social development of their children;
• to promote family well-being and resilience through developing caring interpersonal relationships;
• to provide for needs which cannot be met from within the family and give assistance to families at risk;
• to enhance family functioning through supportive services so that it can cope with difficulties in family life; and
• to restore families in trouble.

Current Provision and Delivery of Services

Over the years, the Social Welfare Department has developed a comprehensive network of welfare services to cater for the various needs of the family. The total recurrent expenditure on social welfare in 1999/00 is $28.9B, representing 16.1% of the total Government expenditure. When compared to that in 1995/96, which was $12B, representing 9.7% of total Government expenditure, there is a 141% of increase over a period of five years. In 1999/2000, the Department is spending $1.6B on family and child welfare services, constituting 6% of the total welfare expenditure including social security, or 20% of expenditure on direct services. A breakdown of expenditure in the various services under the family and child welfare programme is shown in the slide.

In providing family and child welfare services, a three prong approach is adopted:

• promoting family well-being and resilience and preventing family problems;
• supporting families to enhance family functioning; and
• restoring families in trouble.

We can see the continuum of service, from preventive services at one end, to supportive services and remedial services at the other.
Promoting Family Well-being and Resilience

Family resilience is the strength of the families in overcoming stresses and crisis. The healthier and stronger the members, the more resilient the family. Parental competence, harmonious relationship among family members and good support network for the family are positive indicators of family resilience. In order to promote family resilience for the well-being of its members, we shall continue to provide family life education to equip family members with self-understanding, cultivate positive family values, promote harmonious family relationship and enable the acquisition of knowledge and skills in performing their respective roles and functions in the family.

Programmes on sex education, preparation for marriage and parent education and public education through publicity campaigns, the mass media are organised both at territory wide and district level to heighten public awareness and enhance family functioning.

Community support is another important aspect contributing to family resilience. Nowadays, most families are pre-occupied with earning their living and spending less time, not to mention quality time with their families. It is not uncommon that family members do not interact, they may not know their neighbours and live alienated life. Social networking and mutual help in the community provides support to families in the locality and are more readily available in meeting urgent needs of the families. Single parent groups and mutual child care groups, are examples of social networks and should be encouraged to provide opportunities for sharing and mutual support.

Supporting Families to Enhance Family Functioning

With increasing number of female in the labour force, families with children, elderly or disabled members very often have to turn to outside for support in discharging their responsibilities in taking care of these members.

In helping families with child care need, for example, a range of child care services is available. This includes day creches and day nurseries for children aged below six, occasional child care service providing short-term and ad-hoc care to children aged under six years, and after-school care programmes for children aged six to 12. Fee assistance is also available to low income families with a social need to place their children in full day care.

There are other community support services to assist the families in performing their functions. For instance, the home help service provides domestic help for those who are infirm or weak, and for whom help from family members or friends is not readily available. For needy individuals and families who require training in self-care, household management and care for family members, they can make use of the family aide service to acquire and develop their skills through systematic training programmes. Carer support centres, parent resource centres and Family Care Demonstration and Resource Centre provide resource material, training in a “home-like” learning environment for individuals to enhance their skills to care for themselves and their family members.

Restoring Families in Trouble

The third approach is restoring families in trouble. For families failing to respond positively to the changes and unable to cope with family life, timely intervention to resolve the family crisis and prevent family tragedy, provision of tangible assistance (such as financial and housing assistance) and restoration of family relationship and functioning are required. Family service centres located all over the territory provide counselling service, using casework and group work methods to suit the specific needs of the service recipients.

The Hotline of the Social Welfare Department, apart from the various hotlines operated by NGOs, will be further enhanced into a Family Crisis Helpline to provide immediate telephone counselling to family in crisis and to follow-up as appropriate.

For those individuals who are suffering from psychological problems, the clinical psychological service will provide assessment and treatment. Psychosocial group therapy for the victims and their families will also be provided to enhance the treatment process. The social workers of the Child Protective Services Units and family service centres will deal with cases involving domestic violence with input and co-operation from other professionals. Residential child care services are provided to cater for those children who are in need of temporary care away from homes.

Future Directions and Strategies

With the emphasis on child-centred, family focused and community based services, the government is adopting the following strategies in the future development of family and child welfare services:

- integration of services;
- multi-disciplinary approaches;
- family participation and customer feedback;
- community involvement;
- quality assurance and continuous improvement;
- from input control to output control and outcome measures;
- research, evaluation and information systems; and
- need for constant review to meet changing needs.
Integration of Services

An integrated approach of service delivery will help address the difficulties caused by the compartmentalization of clients’ needs and fragmentation of service provision. A holistic approach is adopted in dealing with the individuals in the family, geared towards meeting the various needs of the individual through different methods of intervention. This is essential to avoid duplication of efforts and ensure maximum and flexible deployment of resources to achieve cost-effectiveness. The provision of one-step service will make it convenient for the service recipients. Integration also means better coordination and collaboration.

Multi-disciplinary Approach

Multi-disciplinary approach is particularly essential in handling complex problems, such as child abuse, the causes of which are multi-faceted. In combating the problem of child abuse, the Government has adopted a multi-disciplinary approach both at the policy level and service delivery level with input from different professionals. The Committee on Child Abuse is a multi-disciplinary and inter-agency body to advise Government on measures to combat the problem and monitor implementation of measures with a shared vision, mission and values in protecting the best interest of children. This co-ordinating mechanism has developed multi-disciplinary protocol to facilitate understanding and co-operation in handling the problem of child abuse. Joint training programmes are organised for professionals concerned to strengthen the working relationship among professionals for the betterment of the abused children and their families.

Family Participation

Involvement of the family is essential in the enabling process to assist the families to cope with crises. Families could best be motivated to work together on problems which they have jointly identified and shared the ownership of the problem and the task. In the helping process, contracts between the professionals and the family members will facilitate the setting of goals. For example, in child abuse cases, families are invited to attend the case conference to work out an agreed action plan. Families are also involved in the treatment process and case review meeting, when they give feedback to assess customer satisfaction and readiness to engage in the rehabilitation process.

Community Involvement

Community has resources which can be tapped on for the protection of the children and the families. Community participation can be achieved through promotion of the public awareness, through community education and publicity, whereby community groups are encouraged to involve themselves in combating child abuse. The setting up of district committees and community based mutual support network among families are measures to involve the community. Promotion of volunteerism through community participation is an empowerment process which helps to develop strengths and potential of the individuals, and also help to promote a caring community.

Quality Assurance and Continuous Improvement

There is a recognition for quality assurance and with the joint efforts of the whole welfare sector, Hong Kong has drawn up 19 service quality standards and a service performance monitoring system for all the welfare services provided by the department and the NGO sector. Formal Funding and Service Agreements have been drawn up to set out the roles, responsibilities and expectation of the funder and service provider. A two-step performance assessment process comprising self assessment and external assessment is put in place in phases, starting April 1999. There is a will to strive for continuous improvement with training, bench-marking and sharing of good practice.

From Input Control to Out Control and Outcome Measures

The current subvention system is an input control system which is complex, inflexible, time-consuming, discourages innovation and flexibility. We are currently in the process of introducing a more flexible and accountable system whereby output control replaces input control, both in terms of quality and quantity. We are also aiming at developing outcome measures and performance indicators which are essential to assess whether policy objectives are achieved in a cost-effective manner. The introduction of service performance monitoring system and output control and outcome measures is a fundamental change in the way we deliver services and involves the change of mind set in the whole sector. Training is essential to facilitate the management of change.

Research, Evaluation and Information Systems

There is a growing recognition for research studies to be conducted to provide pointers for policy formulation and demand assessment. Evaluation on effectiveness of service in terms of service delivery model and methodology are essential for the sector to strive for continuous improvement and good practice. In order to facilitate systematic compilation and analysis of data, there is the need to set up information systems such as client information system, financial management system and management system. With comprehensive statistics, we will be in a better position to assess the demand for service, understand the profile of the service recipients, to manage cases more effectively and provide pointers for planning and formulation of policy decisions.
Need for Constant Review to Meet Changing Needs in Society

What we have planned in the past and are providing at present may no longer meet the needs of the society. With rapid social changes faced by the family, there is always the need for the sensitivity to objectively review our service provision and delivery system, and redirect our resources to the areas of priority. Recently, there has been calls for social/family impact analysis so that our social policies are meeting the needs of the families at present and in the future. We can make better use of the 5-Year Plan Review mechanism and with the active input from the Social Welfare Advisory Committee and various working groups and committees, for example, the Committee on Child abuse, Committee on Services for Youth-at-Risk and Working Group on Battered Spouse, we will be in a better position to map out the blueprint for the future direction for welfare services in Hong Kong. In the past weeks, I have been meeting academics and service providers to initiate discussions on the review of our family services to meet the changing needs of our society, for example, the influx of new arrivals from Mainland China, increase in single parent families and growing incidence of domestic violence. The deliberation of this Conference will definitely stimulate our thinking and provide much food for thought in our coming exercise to review our family services to achieve the objective of promoting family well-being in Hong Kong.

Conclusion

To conclude, I want to reaffirm our commitment to develop and provide a child-centred, family focused, and community based Family and Child Welfare Programme to promote well-being of families in a most cost-effective manner to meet the challenges that I have described. It is only with an open mind, sensitivity and readiness to manage change, strong sense of commitment and accountability that we can demonstrate to our community that we are really investing now and working for the well-being of families in Hong Kong, and we are sure to reap the fruits of our efforts in the years to come.

Reference


Awareness of Psychological Abuse and Promoting Mental Health in Families

D Glaser
Great Ormond Street Hospital for Children NHS, United Kingdom

Defining the Task of Parenting

Fulfillment of the needs of dependent, developing/changing children:
- Basic needs provision: food, stable shelter, healthcare
- Protection including from abuse
- Response to attachment needs
- Ensuring family tasks and functioning

Family Tasks and Functioning

Consistent and Age-appropriate:
- Caring, nurturing, and stimulating
- Setting of boundaries
- Clear communication and affective expression
- Hierarchies and inter-generational boundaries
- Intra-generational alliances
- Balance between family cohesiveness and connectedness with outside world
- Models of non-violent conflict resolution

What is Child Abuse and Neglect

- (Wo)man-made and potentially avoidable harm to children
- Different forms may exist discreetly or co-exist
- All forms of CAN involve psychological harm
- Omission & commission forms of CAN:
  - neglect
  - physical abuse/non-accidental injury
  - sexual abuse
  - emotional abuse and neglect
  - factitious illness

Emotional Abuse and Neglect Refers to:

- Parent-child RELATIONSHIP (not event or single interaction)
- Characterises the relationship
- Heterogeneous collection of different forms of interaction
- Both omission and commission
- Physical contact not required
- Actually or potentially harmful to the child

Abuse threshold reached when the viability of the relationship is questionable without some intervention.

Thresholds

Definitions are culturally relative. In the UK, threshold criterion is **Significant Harm**. **III Treatment** physical, mental or sexual AND/OR impairment of the child's physical or mental health, or physical, intellectual, emotional or behavioural development, attributable to the care given or likely to be given.

Impairments of Child's Health and Development by Emotional abuse and Neglect

**Ranked in Decreasing Order of Frequency**
- Emotional state
- Developmental/educational attainment/poor late school attendance
- Behaviour
- Peer relationships
- Physical symptoms/poor growth

American Professional Society on the Abuse of Children

- Spurning
- Terrorizing
- Exploiting/corrupting
- Isolating
- Denying emotional responsiveness
- Mental, health, medical and educational neglect

The Child's Needs which are Violated by Emotional Abuse & Neglect

- The child as a person who EXISTS
- THIS child
- Child as a developing CHILD
- The child as an INDIVIDUAL
- The child as a SOCIAL BEING

Categories of Emotional Abuse and Neglect

I. *Emotional unavailability, unresponsiveness and neglect*

II. *Hostility, harsh punishment denigration and rejection of a child*

Child perceived as deserving these based on persistent negative beliefs about, attributions or misattributions to the person of the child.

III. **Developmentally Inappropriate or In-consistent**
- Developmentally inappropriate or inconsistent expectations of, impositions on, and interactions with the child.
- Exposure to confusing or traumatic experiences.
- Failure to provide adequate cognitive stimulation and/or opportunities for experiential learning.

IV. **Failure to recognise or acknowledge the Child's Individuality and Psychological Boundary**
- Inability to distinguish between the child's reality and the adult's belief.
- Using the child for the gratification of the parents' emotional needs.

V. **Mis-socialisation of the child within the child’s context by failing to promote the child’s social adaptation (including isolating) or actively promoting mis-socialisation (corrupting)**

Impeding the Appropriate Socialisation of the Child within the Child's Context

- Active corruption
- Failing to promote socialisation

Two Questions to Ask of the Classification

I. First question to ask of a classification: **What holds the classification together?**

   In EA/N:
   (i) Does not require physical contact.
   (ii) It takes into account the essence of childhood dependency and development.

II. Second question to ask of a classification: **What keeps the categories apart? i.e. the categories must be discrete.**

   (i) Different aspects of the child's needs.
   (ii) Different motivations in the carer.
   (iii) Different treatment approaches for the interaction/relationship.
   (iv) We hypothesis, different harmful consequence for the child.
Can We Ask Children to Describe Emotional Abuse?

“Biting the hand that feeds you”
- Emotional abuse not recognised/defined by society
- Abuser = primary carer
- Child loyal to/dare not upset primary carer
- Difficult to acknowledge awfulness of being rejected, unloved, exploited
- Threat to own survival and self worth
- Cannot reflect on it or describe abuse (procedural memory)
- Abuse rationalised by self-blame, denied, re-framed

Reasons for Registration

3 tiers of concern
1. Parental attributes or risk factors
2. Categories of ill treatment or mediating mechanisms
3. Impairment of child's development or evidence of harm to child

Child Protection

Implies the cessation of danger to the child which can only be achieved by:
- Ensuring the perpetrator(s) of abuse/neglect, or their circumstances, have changed sufficiently to no longer pose a risk to the child or
- Effectively supervising all contact between the child and perpetrator(s) of abuse/neglect ("supervisor" must believe in abuse) or
- Separating child from perpetrator(s) of abuse or neglect

Process of Professional Involvement in Emotional Abuse and Neglect: Working Towards Protection

Child Protection

Implies the cessation of danger to the child which can only be achieved by:
Ill. Family’s Capacity for Change

In parental risk factors and relevant category(ies) of ill-treatment, by means of a time-limited trial of intervention.

Therapy
- Individual work with the child
- Parent-child and family work
- Individual work with parents

Process of Professional Involvement in Emotional Abuse and Neglect: Working Towards Protection

Assessment:
Time limited trial of intervention towards change

- Sufficient change
- Insufficient change
- Lack of co-operation

Child remains at, or returns home
Statutory Child Protection Conference

- Child remains at, or return home as least detrimental alternative
- Child looked after by local authority

Note
1. Article has been revised by author on 22 March 2001.

Therapeutic Interventions in Emotional Abuse

Category 1: Emotional Unavailability
- If no associated Category 2, explore underlying cause (s) and address those
- If associated Category 2, approach as Category 2

Category 2: Negative Attributions
- Explore with carer(s) what child's view of him/herself might be and how to alter it

Category 3: Developmental
- Parenting management

Category 4: Psychological Boundaries
- Explore with parent what child's perceptions
- Look for ghosts from the past
- Look for maintaining factors for parent

Category 5: Impeding Socialisation
- Explore with parent, child’s experience in her/his environment

Treatment for the Emotionally Abused Child

Child's Status:
- Protected within family after sufficient change in parent interaction with the child
- Protected by move to another carer or family
- Not protected, but less detrimental to remain at home than to move

In therapy for child, now possible to talk about the abuse. If abuse continues, therapy can help child with coping.

Protective Factors
- Child's innate resilience (including good ability)
- Brief duration of abuse (early successful intervention)
- Late onset – earlier "good" experiences
- Other significant non-abusive relationships

YW Choi
Breakthrough, Hong Kong

Introduction

We are all aware of the developmental crisis that each adolescent needs to work through during this relatively stormy period of their life. However, as Hong Kong is undergoing a rapid socio-political transition with major changes in the value system, economic structure, job market, and media consumption habits, there are signs to indicate that more adolescents are potentially at risk, and the family system as a whole becomes less stable than before.

The following figures allow us to catch a glimpse of the phenomena of "adolescents at risk" and "families in crisis".

1. Adolescents at Risk

<table>
<thead>
<tr>
<th>Mental Health:</th>
<th>Depression</th>
<th>&gt;50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide: Ideation</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Attempts</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Eating disorder</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>(adolescent girls)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Unemployment: | 15-19 years | 25% |

<table>
<thead>
<tr>
<th>Drug Abuse:</th>
<th>1998: 16964 reported cases under 21 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.7% (upward trends of amphetamines and psychotropic substances abuse)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Youth crime:</th>
<th>Crime rate by 7-20 years:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people under Police Super-intendents Discretion Scheme:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Juvenile gangs:</th>
<th>Night drifters in certain district:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach social workers:</td>
<td></td>
</tr>
</tbody>
</table>

| Potential at risk: | 18% of Form 1 students |

2. Families in Crisis

(Statistics gathered by HKCSS)

2.1 Divorce

- No. of divorce applications
  - A 64% increase in 5 years: 1993 8,626, 1998 14,115
- No. of decrees absolute issued
  - A 76% increase in 5 years: 1993 7,454, 1998 13,129

2.2 Mental health

- New outpatient psychiatric cases
  - A 22% growth in 2 years: 1995/96 12,323, 1997/98 15,060

- Reported cases of domestic violence
  - A decline from 1995 to 1997, but suddenly suicidal death increased in 1998:

2.3 Domestic violence

5. Reported cases of domestic violence

- A decline from:

2.4 Child abuse and neglect

6. Reported cases of child abuse

- An increase of 31.5%:
  - 1996 146, 1997 162

7. Reported cases of child sexual abuse

- An increase of 11%:
  - 1997 146, 1999 162

8. Unattended children

Some 110,000 children aged 12 and below in about 73,900 households had been left unattended at home during the period April to July 1997. (There were 716,592 households with one or more children under 15 in 1996)

2.5 Suicide

9. A decline from 1995 to 1997, but suddenly suicidal death increased in 1998:

<table>
<thead>
<tr>
<th>1995</th>
<th>1996</th>
</tr>
</thead>
<tbody>
<tr>
<td>776</td>
<td>794</td>
</tr>
<tr>
<td>597</td>
<td>868</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1998: aged 60 and up:</th>
<th>32.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 20-59:</td>
<td>63%</td>
</tr>
<tr>
<td>Aged 19 and below:</td>
<td>51.2%</td>
</tr>
<tr>
<td>Unemployed: (444)</td>
<td>46.7%</td>
</tr>
<tr>
<td>(279)</td>
<td>50.4%</td>
</tr>
<tr>
<td>(400)</td>
<td></td>
</tr>
</tbody>
</table>
2.6 Single parent families

10. No. of families with father/mother being widowed/divorced/separated and with one or more children aged 18 or below
   An increase of 22.6% in 5 years: 1991 34,500
   1996 42,300

11. No. of families with one parent staying away from HK and with one or more children aged 18 or below
   An increase of 23% in 5 years: 1991 63,200
   1996 78,000

2.7 Extra marital affairs

12. Usage of Caritas EMA Hotline
   An increase of 76.6% in 3 years: 1996 17,204
   1997 28,786
   1998 30,396

2.8 Cross-border employment

13. Hong Kong residents working in Mainland China
   An increase of 28.6% in 4 years: 1995 122,300
   1998 157,300
   An increase of 2.4 times in 10 years: 1989 45,600
   1998 157,300

14. Median number of trips per year
   24 (Council’s study)

15. Median number days of absence from home
   156 (Council’s study)

2.9 Unemployment rate

The unemployment rate has sharply increased:
   1997 2.2%
   second quarter of 1999 6.3%

In view of the observable trend of increasing instability of the family system, we are searching for new approaches to help the younger generation to work through their adolescent crisis. The following are abbreviated reports of attempts to experiment with new approaches. There are three key elements in these pilot projects: targeted, systemic, and integrated.

Targeted Approach

Prevention is better than cure.

There have been a lot of talks about the delivery of primary, secondary, and tertiary preventive programs. One major difficulty is how to direct our programs to the intended targets of services.

Primary prevention would be very costly if we put every single child through such programs. The issue is how to detect those children who are potentially at risks and direct our preventive programs for this specific target group. Everyone knows the difference in cost between putting a child through such preventive program and trying to provide corrective service for child at risk who needs to be institutionalized.

1. Development of a Set of Screening Tools

The following is an abstract of a research project which attempted to develop a new instrument for large scale screening of potentially at risk students. The key concept of the project was: “early detection, and early intervention”.

In July of 1994, The Understanding the Adolescent Project was commissioned by the Coordinating Committee for the Welfare of Children and Youth at Risk under the auspices of the Health and Welfare Branch of the Hong Kong Government. The purpose of the study was to determine if an integrated approach to the identification of socio-emotional risk among adolescents would be useful in the Hong Kong context.

The study based itself on the literature related to epidemiological research which has been conducted over a number of years in a variety of world contexts in the area of adolescent psycho/social dysfunction. This body of literature has repeatedly attributed adolescent dysfunction to a number of associated variables related to family background and developmental history. Remarkably, the literature has not, in the past, found the research focus to be situated on the school context. To the extent that the research literature has been grounded in mental health research, it has not viewed the school as a place of data collection, nor has it seen school as a place of intervention. For the most part, the research in this area has served only to identify relationships among various factors and dysfunction and has not sought to facilitate intervention.

The Understanding the Adolescent Project, as an applied study, sought to demonstrate that the data collection may begin at the school level and further that there are avenues for intervention beginning in the school and opportunities for liaison among service providers based on the initial data collected at the school.

In order to carry out the study two student information forms were authored. The Student Information Form - Student Edition (SIFS) provided additional information concerning family background and demographic information through a school registration form. The Student Information Form - Teacher Edition (SIFT) provided additional information a behavioural checklist completed by teachers. In addition to the two authored forms, the Achenbach Child Behaviour Checklist (CBCL) and the Diagnostic Interview Schedule for Children (DISC-2.3) were translated into Chinese for use in the study. Information derived from the Student Information
Form Student Edition (SIFS) and Student Information Form Teacher Edition (SIFT) were compared to information obtained from the Achenbach Child Behaviour Checklist and the DISC-2.3. The analysis of the results obtained on the two authored forms in comparison with the two standardized measures will serve to validate the forms prepared for use in Hong Kong.

The study included a pilot study of some 580 Secondary I students in 8 secondary schools in Hong Kong and a main study of 3621 Secondary I students in 48 schools in Hong Kong. For the pilot study, data was collected in June to September 1995. For the main study the data was collected in December 1995 through April 1996. The study itself was conducted in three phases as identified in the accompanying table.

The results from the study strongly suggest that a general screening for adolescents at risk is indeed feasible and that the measures of risk which are generated from such a screening process are highly compatible with generally recognized standardized assessment protocols. The analysis of the two forms demonstrated that when used in concert, some 18% of the adolescent population could be identified as in need of some form of intervention.

The study demonstrated that the school is indeed an appropriate starting point for the generation of information concerning students emotional well-being. Schooling, by its nature, is a group oriented process. This study allowed for the development of interventions which may be targeted on groups of students without singling individual students unnecessarily at too early a stage. At the same time, there was opportunity for some students who appear to be at greater risk to be referred immediately to in-school services offered through social work and educational psychology. The process is driven by a collation of data provided by school professional staff as well as an assessment of risk provided from the student registration forms. The procedures in place in such a screening approach provide a further link to clinical psychiatry for those students who are subsequently found to be at extreme risk through the secondary screening measures employed by educational psychology and social work.

### 2. Development of a preventive program

Currently we are developing a set of preventive program for the potentially at risk adolescents. The conceptual frame we have adopted is "resilience".

The following is the key concept in a most condensed form:

**Resilience**

- **Building inner personal strengths**
  - The feelings of competence, belonging, usefulness, potency, and optimism;
- **Promoting protective factors in environmental resources (family, school and community) that include caring and supportive relationships, positive and high expectations, and opportunities for meaningful participation.**

Together with the development of the preventive program we are experimenting with a set of operation guidelines, and a set of outcome measure instruments, so that this model can be applied in the different districts of Hong Kong. This preventive program will be school based, counting on the partnership between school teachers, parents, and social workers.

<table>
<thead>
<tr>
<th>Population</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening of all students</td>
<td>Selected cases of the potentially at risk students</td>
<td>Selected clinical cases</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Tools</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Information Forms (Student, Teacher) (SIFS, SIFT)</td>
<td>Achenbach Child Behaviour Check Lisk (CBCL)</td>
<td>Diagnostic Interview Schedule of Children (DISC)</td>
<td></td>
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<table>
<thead>
<tr>
<th>Programs</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>School-based Group preventive program (18%)</td>
<td>Individual and family counseling (11%)</td>
<td>Individual and family psychotherapy (2%)</td>
<td></td>
</tr>
</tbody>
</table>
Systemic Approach

As we attempt to usher adolescents through their developmental crisis, we cannot afford to ignore the impact of the four important systems behind each adolescent – family, school, peer and media.

1. Family

The disintegration of the family system is detrimental to the personal development of the adolescents. We attempt to strengthen the family as the most important support system behind the adolescents as they go through the developmental crises.

The following are some of the issues we have encountered in our attempts to build up the family system.

1.1 The Unmotivated Parents:

We have difficulty in engaging the unmotivated parents (approximately 50% of the parents with children potentially at risk) in the delivery of the educational and preventive programs.

1.2 The Role of Fathers:

It is confirmed that the father have a crucial role in the sexual and moral development of the adolescents. Again, we face the difficulty of getting the fathers involved in the various programs.

1.3 The Therapeutic Skill Required in the Delivery of Adolescents and Family Counseling:

The increasing complexity of the counseling problems demands increasing sophistication of family therapeutic skills. More vigorous training programs for front-line workers are required.

1.4 The Age and Space of Front-line Workers:

Parents of adolescents are at the their forties, struggling with their mid-life crises. The age and experience of the front-line worker is an important factor in determining the success of the preventive or therapeutic programs. The increasing case loads give no room for the social workers to deliver more in depth counseling services.

2. School

The school system plays a vital role in the development of the adolescents. The Hong Kong school system put a lot of emphasis on academic achievement at the expense of neglecting the other dimensions of the development of the adolescents.

The current education reform recognizes the need to put an emphasis on the holistic development of the students. The Chief Executive of Hong Kong Special Administrative Region also affirmed the importance of informal and non-formal education in helping the student to develop.

There is an increasing awareness of the need to develop a student's multiple intelligences, and the emphasis to meet the physical, mental, social and spiritual need of each student. There is an increasing demand to strengthen the partnership between teachers, parents and social workers to deliver holistic education through the formal, informal and non-formal education systems.

The following diagram is an attempt to conceptualize the relationship between formal, informal, and non-formal education. The social workers have an important role to play in the realm of informal and non-formal education, which will contribute significantly to the adolescents as they face their development crises.

3. Peer

The peer group constitutes a most important support system for the adolescents. Peer influence can be constructive as well as destructive. The destructive power is most obvious in the areas of drug abuse, and juvenile delinquent behaviours.

Currently, there are studies conducted to understand the factors behind the emergence of "juvenile gangs", and the way to tackle the negative influences of such gangs. Outreach social workers, and the Integrative Teams will have an important role to play.

The school social workers can also help to strengthen the support systems among peers in the school setting. The workers in the child and youth centers can also contribute towards the rebuilding of such peer support systems.

4. Media

As we enter the era of information explosion propelled by the development of information technology, we cannot under-estimate the role the media play in shaping the values and development of the adolescents.

Let me quote from a recent "study on the influence of media on youth", conducted by the Youth Commission:

"Respondents said their average leisure time per week day was 3.9 hours, a considerable percentage of which was spent on media activities. Most of them spent two to three hours watching television each day. Some spent about two hours on the computer while others spent a few hours on electronic games, listening to pop music and the radio, or about 45 minutes reading newspapers. They watched VCDs, LDs and DVDs regularly, and would read a few magazines and extracurricular books a month. Occasionally, they went to the cinema and read comic books."

"Evaluation of electronic games: Most respondents clearly knew the advantages (92%) and disadvantages (94%) associated that playing electronic games are both a good and a bad thing, 19% considered it slightly bad,
while 17% considered it to be good thing. Heavy users and male respondents tended to consider it bad for young people. In general, the better educated group (post-secondary) tended to adopt a more balanced viewpoint, and 65.9% of them regarded it as both a good and a bad thing."

Another study conducted earlier this year, indicated that approximately 70% of adolescents tend to believe the negative concepts prompted by television soap opera (Breakthrough, Oct., 1999).

Therefore, we must attempt to protect the adolescents from the destructive influences of the media by means of media education, and guided media exposure. Moreover, we need to give the adolescents alternative choices by the production of media products which are attractive as well as constructive.

We have a long way to go in our attempts to tackle the media as a system that influences the development of the adolescents.

**Integrated Approach**

In order to deliver this targeted, systemic approach to educational, preventive, and remedial services for adolescents, we have attempted to integrate the resources available in families, schools, health and welfare, as well as the media sector. Integration demands the determination of the policy makers to reallocate resources, and the innovation and stamina of service providers.

The following diagram represents an attempt to construct an integrative model by means of strategic alliance based on the concept of maintaining the continuum of service.

**Conclusion**

In a very condensed form, I have attempted to put forward a targeted, systemic, integrated approach to help the adolescent to work through their developmental crisis for family stability. Certain parts of this conceptual framework have been researched and field tested, and we are satisfied with the outcome of these pilot projects which resulted in the development of a set of screening tools, a framework for preventive program, and a set of outcome measure tools. We are still trying to refine these tools and programs.

We still have a lot of mileage to cover in the areas of adolescent and family counseling, media education, media production, strategic alliances between government and non-government agencies, partnership between parents, teachers, and social works, and continuum of service.

The key words are: "integrated", "holistic", "targeted", "systemic", "early detection", and "early intervention". We need to pay the price of research and development; and in the present scenario of limited resources, insightful prioritization, tactful reallocation of resources, and well planned training are essential before the actualization of this model is feasible.
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In Peace and Stability We Develop Our Total Fitness
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Against Child Abuse, Hong Kong

Introduction

"Yesterday is history. Tomorrow is a mystery. Today is a Gift. That's why it's called the Present." Let's maximize what we have today to create peace and retain stability with children for their total fitness.

I am very honoured to be given this opportunity to present the first paper on this country paper session. This is two years after 1997. Hong Kong a once borrowed place on borrowed time, with 6.8 million people, reunited with its motherland China and became a Special Administrative Region. We have been promised: one country two systems 50 years unchanged, guided by our basic law with a highly autonomous administration.

While every country and community is enthusiastically preparing to face challenges of the new millennium, we are here today to explore the status of our children. It is important to find out whether we in Hong Kong and you in your country provide a safe and healthy, peaceful and stable environment for this youngest group to develop their total fitness. Whether children in Hong Kong and children in your country are fit and healthy and whether they are well prepared with inner strengths, strengths in the system, adequate knowledge and skills to adequately manage threats and challenges confronting them.

Overview of Child Protection in Hong Kong

Twenty years ago a child was considered healthy if the child was not sick or malnourished. Physical fitness was what one cared for. Twenty years ago child abuse was not only considered a family affair, but also a problem unreal to Hong Kong. The term "child abuse" was only used in extremely serious if not fatal cases with children in horrific situations. Physical injury was what people looked for.

The majority of cases handled in the past two decades were intra-familial physical abuse cases. (87.2% among 429 cases in 1990 and 50.4% among 804 cases in 1998). Child sexual abuse cases rapidly increased only in the 90's, from 2% of all child abuse cases in 1990 to almost 30% of all child abuse cases in 1998. Neglect in the form of unattended children received considerable discussion because of fatal cases hitting the headlines. The Coroner's Report recorded a total of 135 children died unattended from 1989 to 1997. The neglect situation though prevalent was not widely reported through the years (4.6% in 1990 and 6.1% in 1998). Psychological abuse remained the lowest in reported rate in our child protection registry (1.6% in 1990 and 3.2% in 1998) because of its complex nature and the harm done on children may not be readily observable. The situation of child suicide, has increasingly hit the headlines and aroused discussion about the emotional crisis of our young.

A piece-meal and remedial approach was adopted in the past. Action was only taken when one simply could no longer remain inactive. This attitude of denial had deprived many of our little ones of their right to adequate provision, protection and participation. Our little ones were therefore left to fend quietly and painfully for themselves and some of them have already carried their bitter experience into adulthood, if not parenthood, and perpetuated the vicious cycle of aggression, violence and neglect.

Child Protection Pioneer

From a policy of looking at society's concerns in a generic approach, child protection progressed into a specialized service since the International Year of the Child, 1979. As a specialized non-governmental organization, the Against Child Abuse in the past twenty years demonstrated the importance of four significant roles: the role of a child protection agent, a counselor/therapist, an educator/trainer and a child advocate. From a remedial, piece-meal approach, it recommended a strategic prevention approach tackling all three levels of prevention, primary, secondary and tertiary stressing the importance to save a child by the entire community: GOs and NGOs, professionals, volunteers and lay public, adults and young people themselves. With limited resources and support, the agency piloted prevention projects well documented as effective in other parts of the world such as the Healthy Start Home Visiting Projects, the child empowerment project called Let the Dolphin Lead and Training of Trainers in the prevention of child sexual abuse.

State Policy and Intervention

The abuse statistics and cases handling reflected that some parents and carers were harming children, inadequately performing a responsible role, or covering up abusive incidents for whatever reasons. We could no longer leave our children merely to their discretion. A laissez faire approach is considered passive and undesirable.

The life stories of children and enthusiastic child advocates made children's voice known to the community and eventually also to the legislators. There were at least 6 major debates in the Legislative Council on child safety,
Policy, Service Delivery System and Training of Professionals

Recognition that children have rights, they are unique and should not have been considered subordinates are an unusual advancement in our history.

The government has moved towards a specialized role by setting up specialized team and units to handle child abuse situations:

- First in 1983 by setting up their Child Protective Services Unit (CPSU) under the Social Welfare Department (SWD),
- The Police set up their Child Abuse Policy Unit (CAPU) and the Child Abuse Investigation Unit (CAIU) in 1995,
- The Hospital Authority appoints their Medical Coordinators on Child Abuse (MCCA) in 1996,
- Interdepartmental procedures for GOs and NGOs were introduced in 1981, revised through the decades and the new procedure stressing working together and trusting each other including specific guidelines to handle sexual abuse – formulated in 1995 and was revised in 1998.

Child Related Legislation

We do not have mandatory reporting of suspected child abuse situation in Hong Kong. We do not have a central data bank reflecting child health indicators nor do we have a central and independent body analyzing such data, disseminating them and working out proactive prevention and treatment strategies. We do not have a registry for child minders. Vigorous discussion about their pros and cons are lacking but needed.

The government before and after 1997 had no time for a comprehensive review on child legislation because of other more pressing political issues such as the Public Security Ordinance, the interpretation of Basic Law regarding children born in Mainland by Hong Kong residents, etc. The urge for a Children's Act similar to the one introduced in UK was rejected. However through the years there were significant legislative reforms which reflected community's changes in perception of children and their related treatment.

- The Hong Kong courts have abolished flogging of delinquents in 1990.
- The Education Ordinance abolished corporal punishment in schools in 1991.
- The Protection of Women & Juveniles Ordinances was renamed as the Protection of Child & Juveniles Ordinance and amended to include a wider context for the state to intervene protecting children: attending to physical and psychological well-being of a child.
- The new Criminal Procedure Ordinance in 1995 took advantage of high-tech advancement in the best interest of children. It made better provisions to protect vulnerable witnesses including child abuse victims to install life television links in courts and made the video taping of their interviews in child friendly police suites admissible in courts.
- Control of Obscene and Indecent Article Ordinance (COIAC) was passed in 1995.
- The Crimes (Amendment) Bill 1997 introduced into the Legislative Council on March 1998 proposes to increase the maximum imprisonment terms of certain sexual and related offences to 10 years. It was also proposed to increase the maximum penalty of incest with women between the age of 13 and 16 from seven to 20 years.
- The Child Care Centres Ordinance (cap 243) was amended in 1997 and renamed as the Child Care Services Ordinance. The amendment was to facilitate the formation of mutual help childcare groups to attend to the situation of unattended children. The Ordinance also prevents certain unsuitable categories of persons as child minders (e.g. those convicted of specific offences).

There were other advancements impacting upon children such as the extension of the UN Convention on the Rights of the Child to Hong Kong by Britain in 1994, providing a global framework on children's rights. There were advancements, perhaps less directly, such as the Privacy Ordinance and the establishment of the Equal Opportunity Commission ensuring protection of privacy and equal opportunity of women and the disabled in the community.

The Hong Kong community is looking at areas such as the age of criminal responsibility since the current age of seven is among the youngest group in the world exposing our very young unnecessarily to criminal consequences. Some child advocates and the Hong Kong Committee on Children's Right suggest.

The current consultation on Guardianship and Custody recommended the provision of mediation services for family disputes resolution and new provisions in relation to child abduction. The best interest of the child should be the paramount concern in all proceedings and joint-parenting and parental responsibilities should be the benchmark in the future parent-child relationships and not parental rights.
The proposed legislation Against Child Pornography and Child Sex Tourism is also most timely. It creates new offences in respect of the procurement or employment of children for such purposes and criminalises the arranging and advertising of child sex tourism-giving extra-territorial effect to the existing legal provisions against child sexual abuse.

The Role of the NGO

While we applaud the Government taking a more active role and we are proud to witness the legal reforms in the past two decades, we urge that the unique facilitating and preventive role of the NGOs must not be undermined. Families in their early prognosis and families hesitant to turn to statutory services could obtain non-punitive services from the NGOs.

Innovative prevention projects at different levels were also spearheaded by the NGOs and found effective arousing public concern and encouraging community participation. Effective therapy and treatment models must be explored and developed. Resources must be devoted not only to investigation and criminalization of abuse but more to therapy and treatment of all parties involved.

Community Education and Community Participation

The Swedish Anti-Spanking policy did not convince Hong Kong to abolish hitting of children in families. Though corporal punishment is no longer considered the only means of discipline yet, a large number of families still considered it an acceptable and effective means of discipline. Cases with minor injuries were not considered as abuse. Leaving children unattended is still not considered abuse by at least half of the respondents of a major opinion survey conducted by the Hong Kong Chinese University in 1996. Continued community education with emphasis on a caring and non-violent relationship targeted at different sectors is essential.

The realization of child and family participation through various stages of intervention has come too slowly. Though written into policy documents this must be more honoured in action. Busy professionals must be provided with more time and support to ensure quality communication with children and families in assessment, management, treatment and prevention. An automatic practice to involve the family, including the child, must be more widely promoted. Professionals should overcome their doubt and reservation by involving parents in child protection case conferences and in permanency planning of children.

A well informed, well-strengthened community provided with channels of participation is what we all strive for Community and children empowerment programs strengthen citizens, including our children and youth, to be well informed and to voice their views and feelings in a caring and non-violent manner.

Threats and Challenges

In the past, we have focused on intra-familial threats and harm to our children. Facing the many challenges into the millennium, perhaps we need to adopt a macro view and identify threats in a wider context and turn them into opportunities. Threats and challenges appear in different forms: in physical, social, psychological, moral and spiritual forms.

Natural Calamities and Human Disasters

Typhoon is so common in Hong Kong that we sometimes under-estimate the harm done. Yet Typhoon York turned Shek Kep Mei Public Housing Estates residents homeless overnight. They were evacuated from home totally unprepared.

The natural calamities and human disasters such as the hill fire of Indonesa, the Taiwan and Los Angles Earth Quakes, the battle in Timor, the fighting and bombing in Kosovov were heart breaking and soul fetching.

Perhaps we cannot stop the natural catastrophe but we can try to minimize the harm done and we must try to prevent the human disasters from adversely affected our children and families. When the world is getting smaller and we get closer, we could take these challenges and lend each other a hand.

Economic and Environment Concerns

The Chief Executive of HKSAR, Mr Tung Che Hwa, in his policy speech Quality People, Quality Home (Positioning Hong Kong for the 21st Century), October 1999, reviewed the two major challenges we encountered in the past two years: implementing the one country, two systems and the considerable readjustment to our economy triggered by the regional and even global effects of the Asian financial crisis. That these two happened almost simultaneously made them all the more difficult to manage. As his long-term strategy he stressed that Hong Kong should not only be a major Chinese City but a World Class City with a vibrant economy and financial strengths comparable to New York and London. In his speech he stressed Cultivating Talents for a Knowledge-based Society and Making Hong Kong an Ideal Home. One third of efforts of the policy speech landed on Pollution and Environment Protection.
Our physical environment poses a serious threat to the total fitness of our children. System, mentalities and practices must be revamped to restore peace and stability and to create a safe environment with the involvement of our little citizens in an early stage.

Nevertheless other than the financial and physical aspect of an Ideal Home, we must not over-look important emotional and psychological aspects.

**Transition in Family System and Structures**

The vigorous and diversified changes in the family system and in young people's perception of marriage, sex and families if not properly handled pose great threats to our children in the next millennium. Unattended and inadequately cared for and supervised children were left alone to tackle their own problems and to face their own boredom. The increase in divorce rate, the aggressive and sometimes horrific ways in the handling of family break ups have shaken the community's heart and our children's souls. The saddest case was that of a Mrs Chan who threw their two children and then herself from the high-rise as a protest to Mr Chan who had an affair in the mainland. Even sadder was Mr Chan's lack of affect and remorse after learning the tragic episode.

Exposing children to constant conflicts and domestic violence is becoming more frequent and the harm caused was observed in some self-mutilation, bullying and child suicide cases. Some children resort to drug abuse, runaways or becoming an abuser in the long run.

Furthermore the massive number of split families and children born in China to Hong Kong residents (200000 to 1.67 million as reported at different times) impacted upon the community.¹⁵ Their unification and adjustment with their families in Hong Kong must be properly supported. Some local families including young children were sadly isolating and rejecting these new comers, a situation that must be stopped.

**Education Reforms**

In August, 1999 the announcement of 22000 secondary students failing flat in all the subjects they have sat for their form 5 examination has not only broken their parents' heart but also shaken the entire community's conscience. Adequate care and support, academically and emotionally, must be made available for our children to find meaning in learning as well as in living. We should be socializing secure, responsible, independent, dignified and caring children and assisting them to acquire inner peace and strength in addition to the necessary know-how to support a decent life.

Learning brings enjoyment, learning creates opportunities and learning for life are the proposed aims and direction of education by the Hong Kong Education Commission, September, 1999 after receiving a total of 14,000 submissions for a current public education consultation.¹⁶ The public is indeed very concerned whether our education system is adequately preparing our children to face new challenges and to develop their total fitness.

**Media and Information Technology**

We must also acknowledge the developmental role, responsibility and power of all forms of media to inform, entertain, educate and influence. We must also acknowledge that all media should protect and respect the diverse cultural heritage of a society and make such information accessible to all children, including children in difficult circumstances.¹⁷

The Hong Kong Media have always been very active and aggressive in general and specifically in the area of child protection. The 10-year-old battered girl who stumbled into a police station in 1979, the International Year of the Child was brought to the lime light by the media and led to changes mentioned above. The vigorous reporting of Kwok Ah Nui, a 6-year-old girl contributed to the review of the Mental Health Ordinance.

The media have an active role in advocacy of children's rights, which is often not used properly. A recent opinion survey of a group of young people¹⁸ reflected that 70% of respondents watched TV at least three hours almost every night. Over half of them considered the stories in soap operas as genuine. Over 40% of the respondents imitated what entertainers do and how they behaved. TV is affecting our young people's knowledge and cognition about the world and how they would behave when they grow up.

The fact that children and families were too easily exposed to sex, violence and sensational reporting of news led an advocacy group to campaign against unethical media reporting. Some of these reports were accused to be fictitious, others obtained at the cost of people's privacy.

The Hong Kong Media at a crossroad lately has to strike a delicate balance of protecting freedom of press on one hand and not going too far to disseminate harmful information to our children and the community. Who should check on the press has become a current debate. The Law Reform Commission is looking at the Regulation of Media Intrusion and exploring the need to set up a monitoring body.¹⁹ The Media preferred self-censorship and internal monitoring. In this meaningful review and debate, we urge the media to adopt a child perspective to include voices and needs of children more carefully and more intensively.

The high technological era brought new concerns physically, psychologically, socially and morally to children. It also made information widely accessible. Such technology has also changed our social network and
affected our means of human contacts. Adults need to make time available, and be adequately prepared to guide and supervise to maximize the benefit of the technology and minimize the harm done to mankind.

Conclusion and Recommendation

We need a child perspective in the community and the recent Harvard Consultancy Report on Health Care Reform in Hong Kong reviews Hong Kong’s current health care system and its financing and recommended 5 options.20 The report adopted an administrative and finance oriented approach, an approach indeed very important to the long-term benefit of the community but regrettfully, without adopting a child perspective at all. Furthermore administrative and financial concerns should not remain the only areas of concerns. Preventive, primary health care and the discussion of total fitness are essential.

If we are steering our community into the next millennium in a wrong direction, then we are heading for destruction. External stresses and threats if predictable must be prevented but often times they are unpredictable. It is fundamental to create internal peace and stability and strengthen the capability of our children not only academically or intellectually. In order to create internal peace and stability and strengthen our children, parents, teachers and our media’s positive influence are essential. Parents must be adequately supported through their parenthood. We must not leave this solely to the hands of mothers. Effective parenting programs must be made available for as wide a spectrum of parents, including fathers. Teachers must be trained to be caring and effective educators and role models.

We aspire to become a fair and democratic society, which provides opportunities for all children, not just for the talented ones. We consider a home and a society ideal, not only because it is physically safe, or economically sound, but also because it treasures you and gives you self-worth. You receive care, support and guidance when you need it. It is only in this environment that you acquire positive life values and a healthy life style and it is with this environment that peace and stability can be created and our children can stand tall and feel free.

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Shaken Baby Syndrome: the Local Perspective
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Summary

The medical profession in 1972 first described the shaken baby syndrome (SBS). Since then, SBS has been recognized as one of the most severe types of child maltreatment and is the most common cause of death in abused children. It refers to a form of severe head injury when a young child is shaken vigorously by a grown-up. The shaking produces a shearing force to the immature brain and tears the underlying nerve fibres and blood vessels. The more characteristic signs include bleeding in the subdural space (subdural haematoma) and the retina (retinal haemorrhage). Superficial bruises and fractures may provide important clues to the abusive nature, but these features are often absent. A confession by the abuser is almost never obtained. Hence, a heightened awareness is needed to identify the child with SBS. Although suspected cases of inflicted head injury in children have been mentioned, it was only first reported in the local medical literature in 1995. Because of the increased concern by the paediatric specialty, more cases were reported in the last four years. It is clear to the medical profession that the proper recognition and diagnosis of SBS require an expertise in the area of child abuse. A review in our hospital indicates that SBS occurs at an annual incidence of 1.4 per 100 000 children under the age of 15. It accounts for 5% of the abuse cases admitted into our hospital. 30% of the cases died and the others were left with significant neurologic handicaps. Many child protection workers in the social welfare, the law enforcement, and the health care disciplines are still unaware of or unfamiliar with the SBS. Misconceptions about childhood head injury and inexperience in handling the deceptive nature of most abusers are common among the caseworkers. The true incidence and the underlying factors predisposing to the occurrence of SBS are largely unknown. Because of the relatively uncommon occurrence of SBS in Hong Kong and the specific nature of this kind of maltreatment, individual expertise in the social welfare department, the law enforcement, and the medical discipline is required. Successful management of SBS calls for the effective collaboration among these disciplines. There is still much room for research concerning the prevention and follow-up of the SBS.

Introduction: What is Shaken Baby Syndrome (SBS)?

SBS refers to the constellation of symptoms and signs when a young child presents with clinical features of head injury (Table 1), together with specific features that suggests a shaking and deceleration mechanism (Table 2), with or without an obvious impact injury. An account of an antecedent injury is often absent, or is grossly incompatible with the severity of head injury.

How Was SBS First Recognized as a Form of Child Abuse?

Like the majority of cases of child abuse, the perpetrator is unlikely to tell the true story about the abusive event. Unlike the older child who is able to describe what has happened in him/her, the young infant or the severely injured child cannot tell the caseworker what actually happened. Not surprisingly, SBS is a relatively new clinical entity that first appeared in the medical literature 28 years ago. Guthkelch in the United Kingdom first noted that severe head injury in the young infant could be the result of vigorous shaking. He speculated that the abuser might found it more acceptable to boggle a child's brain than to bruise him on the face. In the next year, Caffey quoted twenty-seven cases and described that shaking seems to be instinctive, almost

<table>
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<tr>
<th>Table 1</th>
<th>Clinical features of head injury in young children</th>
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<tr>
<td><strong>Less specific features</strong></td>
<td><strong>More characteristic features</strong></td>
</tr>
<tr>
<td>Altered consciousness like drowsiness or coma</td>
<td>Broken skull bone(s) or skull fracture(s)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Bleeding inside the cranium (intracranial bleeding)</td>
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<tr>
<td>Convulsions or seizures</td>
<td>Contusion of the brain</td>
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<th>Table 2</th>
<th>Specific features that suggest the occurrence of shaking</th>
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<tr>
<td><strong>The clinical feature</strong></td>
<td><strong>Documentation</strong></td>
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<tr>
<td>Bleeding in the retina (retinal haemorrhage)</td>
<td>Ophthalmoscopy</td>
</tr>
<tr>
<td>Bleeding in the subdural space (subdural haematoma)</td>
<td>CT scan</td>
</tr>
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<td>Broken nerve fibres (diffuse axonal injury)</td>
<td>Autopsy</td>
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CT=computed tomography; MRI=magnetic resonance imaging
reflex, violent actions by angry adults in the commission of willful assault. After Caffey’s classic description, the SBS became an established clinical condition and the medical profession started to learn about it. More cases were recognized and the basic biomechanical factors leading to SBS were studied. Thus, despite the relatively short history, SBS has become a well characterized clinical condition with lots of supporting evidence not just to the medical profession but also other disciplines in child protection.

**How Does SBS Occur? Why is it Harmful?**

It is hard to know why the perpetrator has chosen shaking as a way of abusing young children. Our current understanding of the SBS, however, has indicated that shaking is a robust way of "calming" a crying and demanding infant. Vigorous shaking results in boggling of the infant's head around his neck. This produces strong shearing or tearing forces with different magnitudes upon the deeper and superficial parts of the brain. An impact to the head, with sudden decelerating forces, adds to the tissue damage. Impact is probably present in the majority of cases as abusers seldom put down the shaken baby gently after the shaking. However, clinical signs indicative of impact is often hard to find in the living child.

In terms of clinical relevance, the shearing forces also tear the blood vessels that pass between the hard and soft coverings (dura) at the surface of the brain. This produces the characteristic subdural haematoma or bleeding (Figure 1). Sometimes the bleeding takes place under the soft covering and is called subarachnoid haemorrhage. Both bleeding signs can be picked up by CT scan of the brain. Magnetic resonance imaging (MRI) is a more sensitive way of detecting these haemorrhages and has the added advantage of determining the "age" of the haemorrhages. Although there are other medical causes of acute subdural haematoma, child abuse has been found to be the most common cause of subdural haematoma and the other causes are often obvious from the history or laboratory investigations.

Shaking also tears the blood vessels on the retina, the innermost covering of the eyeball which is a light-sensitive area that conveys visual signals to the central nervous system. Retinal haemorrhages are best detected by ophthalmoscopy, a special magnifying glass for examination of the eye, by the bedside. Indirect ophthalmoscopy, a more sensitive and detailed examination, is best carried out by the eye specialist (ophthalmologist).

However, the most dreadful consequence of shaking occurs in the brain substance. Because the young infant’s brain has not fully developed and the nerve fibres lack the protective sheath (myelin) that is present in the older child and adults, these shearing forces can cause widespread damage to the nerves (diffuse axonal injury). Sometimes diffuse axonal injury may be detected on MRI, but it may only be documented at autopsy when the child dies. Because of the diffuse injury to the brain, the infant would lapse into unconsciousness very soon after the shaking. Swelling of the brain (cerebral oedema) often sets in and makes the situation worse. Death occurs in a significant proportion of cases and survivors are often handicapped from the brain injury. For instance, out of the 10 cases of SBS reported from our hospital, there were three deaths and the other children were mentally handicapped.

**Other Associated Injuries**

Early descriptions of SBS in the medical literature often depicted it as part of the battered child syndrome. Therefore, subdural haematoma was found among other injuries such as multiple bruises and fractures. However, with improved understanding of the SBS and more cases were recognized, the clinical scenario changed. Because of the way shaking takes place, external signs of injury need not appear. For instance, firm gripping produces local and temporary redness but not necessarily bruises. Depending on the way the chest wall is gripped, the typical posterior rib fracture is seldom seen. The appearance of other signs of bruises or fracture would depend on whether the child has been abused in other ways. As a whole, associated superficial or internal injuries are not found in over two-thirds of the cases reported in our hospital. Therefore, although these injuries are useful clues to the malicious nature of the injury, their absence is by no means exclusive of maltreatment.

Figure 1 The various forms of intracranial bleeding
Problems in Handling SBS by Child Protection Workers

In our encounter with most child protection workers, including the health care professionals, SBS is still a poorly understood entity. There may be a number of reasons for this. Firstly, most child protection workers do not receive formal training in the subject. As SBS has not been mentioned in the local medical literature until 1996, it is perhaps not surprising that even the average medical practitioner does not understand the tactics in the diagnosis of SBS.

Secondly, both the perpetrator and the victim are extremely unlikely to tell what has happened. As mentioned in the previous section, in the majority of shaken babies, not even a trace of suspicion can be found on superficial examination. Thus, the diagnosis relies heavily on the medical specialist which, in most cases in Hong Kong, belongs to the paediatric discipline. On the other hand, the abuser often makes up stories to confuse the caseworkers. Observational studies in medicine, however, have shown that most, if not all, of these stories are false.11,12

Will Falls from Short Distance Cause Severe Head Injury

One of the most common excuses given by caretakers concerning the occurrence of head injury is fall. However, free falls from heights of three to five feet in children rarely cause severe head injury. If severe head injury does occur after short distance falls, they will almost always involve a skull fracture or an epidural haematoma.13 This conclusion is drawn from carefully designed observational studies looking at large number of children presenting with corroborated histories of fall,14 and children who are subjects of unintentional falls from hospital cribs.15 On the other hand, acute subdural haematoma seen in SBS is a rare form of head injury in children.16 Clinical studies on children admitted into intensive care units17 or died of injury18 indicate that subdural haemorrhage usually, but not necessarily, occur in children falling from excessive heights or victims of high speed traffic accidents. Indeed, child abuse is the most frequently identified cause of acute subdural haematoma in young children.19,20 For the various forms of bleeding inside the cranium, please refer to Figure 1.

Future Direction

Since SBS occurs uncommonly, it is unlikely that any significant improvement in handling will be made with a haphazard approach of management. The complex and unique nature of the offence can only be tackled effectively and efficiently by a team of experienced child protection workers. Thus, experience should be built up in each of the medical, social welfare and law enforcement disciplines. In public hospitals, the Medical Coordinators on Child Abuse, most of which are senior staff, have already taken their responsibility. We strongly recommend that the senior members of the Child Protection Services Unit and the Child Abuse Investigative Unit to take up, or continue to assume, this responsibility. Only with the collaborative expertise from these departments will successful handling of SBS be expected.

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Psychological Intervention for Sex Offenders in the Correctional Services Department

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Introduction

While sex offenders represented about 1.5% of the penal population (as of 31.8.1999, there are 156 sex offenders amongst 10,172 inmates in the department), they received continuous attention from the psychological services in view of the nature of their offending behaviours and the positive outcome of psychological interventions in reducing re-offending (Marshall, Jones, Ward, Johnson & Barabaree, 1991). In this paper, I shall describe the profile of incarcerated sex offenders in particularly those who offended against children and the psychological treatment provided for them in the Correctional Services Department.

Profile of Incarcerated Sex Offenders

Incarcerated sex offenders are normally in their twenties to thirties and were mostly convicted of rape and indecent assault. About 48% of them had history of prior offences and amongst them, 18% of them are involved in sexual offences. For their current offences, about 1/3 of them had offended against children under 14. Amongst those who offended against children, 15% are involved in intra-familial sexual offences, i.e. the victims are their daughters. Amongst all cases involving children as victims, 66% involving one victim whereas about 33% involving two or more victims. The majority of the victims are aged 10 to 14.

In working with sex offenders who have offended against children, we have come across two distinct groups which are worth noting. One group being those having the diagnosis of pedophilia and the other group having committed sexual violence within their own families. Pedophiles are individuals who have recurrent intense sexual urges and sexually arousing fantasies involving sexual activity with children. The profile of pedophiles under our custody are compatible to those described in other literature in that they are more psychosocially immature, socially alienated and had difficulties in maintaining satisfying intimate heterosexual relationship (Prendergast 1991). They are usually more comfortable in the company of younger age group peers and their offending behaviour is well planned to seduce the children and this may included involving themselves in occupations working with children. Similar to the pedophiles, offenders involved in intra-familial sexual
violence also led a rather withdrawn and socially isolated life style. Personalitywise, they are found to be more self-centered, has degrading attitude towards women and are insensitive to their children’s emotional needs. Relationship with their spouse are usually unsatisfactory and frequently there are prolonged separation from their spouse (including desertion by their spouse). Relationship with their children including the victims of their offence are frequently problematic and characterized by extremes i.e. some could be over enmeshed and others are controlling and punitive.

Treatment for Sex Offenders

Sex offenders including those who offended against children shared similar psychological problems in that they have deviant sexual interest and deficiencies in their relationship skills as well as distorted cognition and attitude towards their victims.

In the past, treatment to sex offenders are provided largely on an individual basis. However, in the course of intervention, it is found that group treatment are more effective particularly in addressing the denial of sex offenders. In order to more systematically address the treatment needs of the sex offenders, a Sex Offender Evaluation and Treatment Unit (ETU) was set up in the Correctional Services Department in October 1998. The ETU provides comprehensive evaluation and treatment services for sex offenders. All newly admitted offenders will go through a two weeks orientation programme for assessing their re-offending risk and treatment needs as well as to enhance and consolidate their motivation for seeking treatment. Following the evaluation, they will be assigned to respective treatment programme according to their readiness for treatment and their re-offending risk. Those who are classified as having moderate risk for re-offending will be arranged to go through a two to sixteen week self-help programme where they will be assigned reading materials and exercises targetting their psychological deficiencies relating to their offending behaviours. They will also be assigned a psychologist as a tutor to follow-up on their progress. Motivated individuals from the self-help programme will be selected to attend relapse-prevention groups to reinforce their learning. Those who are classified as having high risk will be placed in the core treatment programme where they will participate in intensive group treatment for a period of eighteen weeks. Though the two programmes operated on a different format, they aimed at reducing their offending behaviour through addressing the following issues:

i) Modifying the thinking errors and attitude of the offenders towards their victims and to increase their victim awareness and empathy.

ii) Re-conditioned their deviant sexual interests through better understanding of their sexual needs and improved sex knowledge.

iii) Developing their self-efficacies through improving their relationship skills and mood management skills.

iv) Preventing relapse by understanding their offending cycle and consolidating their relapse prevention skills and means in soliciting social support.

Considerations in Working with Sex Offenders

One of the major challenges in working with sex offenders is to engage them in treatment. With denial of their offending behaviour and minimization of their responsibilities being the most commonly seen problems amongst sex offenders (Perkins 1991), they are generally reluctant to be in contact with mental health professionals and to seek treatment. For those who admitted their offences, some may tend to think that self-control and will power will suffice in ending re-offending and hence is also not forthcoming in seeking treatment. Amongst sex offenders, the above-mentioned problem are more profound amongst those involved in intra-familial sexual offences. At present, the orientation programme at ETU provided an opportunity for these offenders to better understand their offending behaviours and the role of treatment in reducing re-offending in an open and supportive environment. This group learning and sharing had effectively reduced their denial and resistance which is an important first step in engaging them into treatment.

In order to ensure treatment success, continuous follow-up after their discharge is most important. At present, case conferences are held together with staff from the social services agencies for cases involving intra-familial sexual offences to identify issues of concern amongst the family when the offender returns to the community and to plan necessary remedial action. Follow-ups are more easily arranged for those under statutory supervision and there are concerns for those discharged cases without statutory supervision as they may default treatment. For successful rehabilitation of sex offenders and prevention of sexual abuses, the communities’ awareness and support in encouraging early identification of abusers and in providing needed intervention for the offenders are most essential.
References


Intra-familial Child Sexual Abuse in Hong Kong: a Descriptive Study of 23 Cases Referred for Psychological Treatment

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Social Welfare Department, Hong Kong

Introduction

The present paper presents a retrospective, descriptive study of 23 clinically established intra-familial child sexual abuse cases referred for psychological treatment to the author in her position as clinical psychologist in the Clinical Psychology Unit of the Social Welfare Department of the Hong Kong SAR Government. The paper aims to identify some common characteristics and patterns in victim, abuser and family associated with these clinically established cases. The second part of the study tries to look at the treatment outcome of these cases and how they may be related to victim and family factors.

All 23 cases in this study were genuine intra-familial child sexual abuse cases established by majority of opinion in multidisciplinary case conferences attended by professionals from the law enforcement, medical, social work and psychology disciplines. The victims were all girls under 18 years of age at the time of disclosure. Detailed information on the victims, abusers and abuse was always included in the minutes of the case conferences which were routinely passed to the author in preparation for follow up psychological service. A retrospective survey of the 23 treatment case files provided the data for the description of these clinical cases.

Victim Characteristics

All victims were girls between the ages of 7 and 17 at the time of the disclosure. All were residing with the abusers who were close family members in the care giving position. After the disclosure, all victims were brought to the attention of the Juvenile Court. Care and Protection Orders under the Protection of Children and Juvenile Ordinance were initiated to put them under statutory protection of a social worker with conditions that the family would be followed up for welfare or treatment services. Their details were entered into the Child Protection Registry for record and case checking. Severity of the sexual abuse in these clinical cases ranged from fondling 26% (6/23), to attempted genital penetration 5% (8/23) and genital penetration 26% (6/23), taking the most serious form of abuse in each case. In one case the abuse involved both vaginal and anal penetration, and in another case the recurrent abuse resulted in a 20-week pregnancy in the child.
From Table 1 it could be seen that most intrafamilial child sexual abuse cases have female victims typically in the pubertal age range and the typical sexual abuse history showed a gradual progression or grooming from exposing the child to pornography or adult sexual activity, to fondling and sexual stimulation of the child's breasts and genitalia, and in some serious cases to genital penetration. As reported by the victims, the progression from the abuser showing initial sexual interest in the child to eventual penetrative sexual abuse ranged from a few months to a year. This gradual progression seemed to have varied depending on whether the child had put up verbal or physical resistance and whether the child was ready to talk about the abuse to other adults. The sexual abuse was predominantly recurrent 92% (21/23) and some might have lasted over three to four years 17% (4/23) before the child finally made a disclosure, or before the abuse was accidentally discovered. Most victims reported other forms of child abuse prior to the sexual abuse or co-existing with the sexual abuse:- physical abuse was reported by 10/23 victims; psychological abuse by 9/23 victims; and gross neglect by 5/23 victims. The pattern seemed to be that the abusers would use some form of violence to threaten the victims and to establish their power prior to the onset of the sexual abuse. However, little physical violence was used during the actual sexual molestation. In fact, some victims were so successfully groomed that they believed that they caused the abusers to attack them. This pattern of victim characteristics is similar to those reported in the research literature (Finkelhor, 1986; MacFarlene, 1986).

From Table 2 it could be seen that child victims did not know what to do after being sexually abused. There was always a delay in disclosing, sometimes up to three to four years before the child was old enough or brave enough to reveal the abuse. The most commonly cited reason for not telling was that nobody would believe what they had been forced to go through. During the delay period most victims went through a mental struggle trying to balance the pros and cons of a possible disclosure. Many of them hoped that the abuser would feel sorry for their acts and would stop by themselves. One victim wrote down the sexual abuse details in a diary together with reasons why she would forgive her father each time. However, after her father attempted several genital penetrations she got so frightened that she finally gave the diary to the teacher. Three other victims, with submissive personality, never intended to disclose the secret but were accidentally discovered by other family members. Most of the disclosures were unplanned precipitated by fear of pregnancy or an outburst of anger at the abuser. A few victims were so ignorant about sexual matters, understandably because of their tender age, that they made a disclosure only after attending sex education groups.

### Table 1  Demographic and abuse characteristics of the treated children (n=23)

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls</td>
<td>23</td>
</tr>
<tr>
<td>Boys</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;8 Years</td>
<td>3</td>
</tr>
<tr>
<td>8-10 Years</td>
<td>3</td>
</tr>
<tr>
<td>11-13 Years</td>
<td>12</td>
</tr>
<tr>
<td>14-16 Years</td>
<td>4</td>
</tr>
<tr>
<td>17 Years and over</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of Abuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>6</td>
</tr>
<tr>
<td>Digital penetration</td>
<td>3</td>
</tr>
<tr>
<td>Attempted genital penetration</td>
<td>6</td>
</tr>
<tr>
<td>Genital penetration</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of Abuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 Year</td>
<td>10</td>
</tr>
<tr>
<td>1-2 Years</td>
<td>9</td>
</tr>
<tr>
<td>3-4 Years</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of Abuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>2</td>
</tr>
<tr>
<td>Recurrent</td>
<td>21</td>
</tr>
</tbody>
</table>

### Table 2  Disclosure Dynamics

<table>
<thead>
<tr>
<th>Delayed Disclosure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No delay</td>
<td>0</td>
</tr>
<tr>
<td>&lt;1 Year</td>
<td>7</td>
</tr>
<tr>
<td>1-2 Years</td>
<td>10</td>
</tr>
<tr>
<td>3-4 Years</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disclosure made by child to</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>teacher</td>
<td>8</td>
</tr>
<tr>
<td>friend</td>
<td>5</td>
</tr>
<tr>
<td>parent</td>
<td>1</td>
</tr>
<tr>
<td>relative</td>
<td>3</td>
</tr>
<tr>
<td>neighbour</td>
<td>1</td>
</tr>
<tr>
<td>social worker</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main reason for not telling earlier</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No one will believe</td>
<td>10</td>
</tr>
<tr>
<td>Fear of family breakdown</td>
<td>4</td>
</tr>
<tr>
<td>Fear of revenge</td>
<td>6</td>
</tr>
<tr>
<td>Shame</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main reason for telling</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of pregnancy</td>
<td>7</td>
</tr>
<tr>
<td>After receiving sex education</td>
<td>5</td>
</tr>
<tr>
<td>Fear sister will be abused</td>
<td>4</td>
</tr>
<tr>
<td>Abuser beat child</td>
<td>4</td>
</tr>
</tbody>
</table>
Abuser Characteristics

Not all abusers denied their abusive acts. Of the 23 cases eight abusers (35%) admitted their abuse, were convicted and had received legal penalty. However, admitting the acts did not mean that they admitted their pathology nor took responsibility for it. None of the abusers in this sample made explicit apology to the victim. Most of them excused themselves by claiming that they had succumbed to their sexual impulses because they had no sexual partner or that they were drunk. Some of them were spouse abusers as well and had successfully coerced the non-offending parent in their blaming of the victims. All abusers were extremely resistant to treatment even during or after their jail sentence. Of the 23 abusers four had met the author for assessment interviews, but then only for one or two sessions. A detailed description of their pathology was therefore out of the scope of the present study.

From Table 3 it could be seen that all abusers were adult males living with the victims during the time and period of the abuse. They were given the authority and the chance to spend time alone with the victim and in some cases they were actually the only adult in the family, playing the role of both the father and the mother. In this clinical sample the biological father formed the largest group of child sexual abusers 52% (12/23), with the second largest group being step fathers or mother’s partner 31% (7/23).

Table 3  Demographic of Abusers (n=23)

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>0</td>
</tr>
<tr>
<td>Males</td>
<td>23</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>21-20 Years</td>
<td>2</td>
</tr>
<tr>
<td>31-40 Years</td>
<td>8</td>
</tr>
<tr>
<td>41-50 Years</td>
<td>9</td>
</tr>
<tr>
<td>51-60 Years</td>
<td>4</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td>Relationship with Victim</td>
<td></td>
</tr>
<tr>
<td>father</td>
<td>12</td>
</tr>
<tr>
<td>stepfather</td>
<td>4</td>
</tr>
<tr>
<td>mother’s partner</td>
<td>3</td>
</tr>
<tr>
<td>uncle</td>
<td>2</td>
</tr>
<tr>
<td>adoptive father</td>
<td>1</td>
</tr>
<tr>
<td>grandfather</td>
<td>1</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td>3</td>
</tr>
<tr>
<td>Manual</td>
<td>14</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
</tr>
<tr>
<td>Living with Victim at Time of Abuse</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Prosecution</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>Court Disposal</td>
<td></td>
</tr>
<tr>
<td>Jail sentence</td>
<td>13</td>
</tr>
<tr>
<td>Non-custodial sentence</td>
<td>2</td>
</tr>
</tbody>
</table>

Characteristics of Non-offending Parent

All biological non-offending parents, 22 mothers and 11 fathers apart from one who was deceased before the onset of the abuse, claimed that they knew nothing about the abuse before the disclosure. However, some victims 17% (4/23) insisted that they had told their mothers before they told someone outside the family. One victim reported that the mother forced her to take contraceptive each time after abuse, but later told the police that she had not heard of the abuse. The clinical impression of these non-offending parents, whether they be mothers or fathers, gave a consistent pattern that they were handicapped in their parenting and nurturing role due to a host of similar personal or family problems.

Table 4 gives a general picture of the non-offending parents and describes a number of high risk factors both

Table 4  Demographic and Personal Characteristics of Non-offending Parents (n=33)

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>11</td>
</tr>
<tr>
<td>Females</td>
<td>22</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>31-40 Years</td>
<td>13</td>
</tr>
<tr>
<td>41-50 Years</td>
<td>19</td>
</tr>
<tr>
<td>51-60 Years</td>
<td>1</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
</tr>
<tr>
<td>Divorced</td>
<td>19</td>
</tr>
<tr>
<td>Remarried</td>
<td>8</td>
</tr>
<tr>
<td>Reason for Inadequacy as Parent</td>
<td></td>
</tr>
<tr>
<td>Divorced and deserted child</td>
<td>15</td>
</tr>
<tr>
<td>Divorced and depressed</td>
<td>13</td>
</tr>
<tr>
<td>Unemployed</td>
<td>14</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>5</td>
</tr>
<tr>
<td>Blind</td>
<td>1</td>
</tr>
<tr>
<td>Mentally ill</td>
<td>4</td>
</tr>
<tr>
<td>Working night shift</td>
<td>5</td>
</tr>
<tr>
<td>Non-Chinese mothers</td>
<td>4</td>
</tr>
<tr>
<td>Drug addicts</td>
<td>3</td>
</tr>
<tr>
<td>Abused by spouse</td>
<td>6</td>
</tr>
</tbody>
</table>
in the parents themselves and in the family environment before the onset of the sexual abuse. The victims all came from high risk families-of-origin where there were multiple problems in the biological parents and in the family system. There were a considerable number of families with marital discord, parental separation, family violence, mental or physical disability in parents, unemployment and drug abuse, so much so that the child was made vulnerable and exposed to exploitation either by her own parent or other relatives. The physical or psychological absence of one or two parents had greatly undermined the protection and care the child could normally receive from the family.

Treatment Outcome

All 23 victims and the majority of non-offending parents received follow up psychological treatment from the author over periods ranging from six months to three years. They exhibited varying degrees of severity in the 9 traumatic symptom groups described in the literature (Beverly, 1989): (1) Traumatic sexualization; (2) Betrayal and Loss; (3) Stigmatization; (4) Powerlessness; (5) Self-blame; (6) Destructive Acting Out; (7) Loss of Body Integrity; (8) Signs of Dissociative Disorder; and (9) Signs of Attachment Disorder. Treatment included behavioral therapies for their anxiety and depression symptoms, resolution of their guilty and shameful feelings towards the abuse and more in depth psychotherapy of their distorted sexuality, low self-esteem and lack of trust in relationship. Parental counseling was also given to non-offending parents to give emotional support to victims.

Treatment outcomes were reported by memo to the referring social workers at the time of case termination and were divided roughly into Good Outcome, Average Outcome and Poor Outcome groups according to clinical assessment of the case on various aspects of personal and social functioning. Of the 23 clinical cases, 11 were assessed to show Good Outcome, seven were Average and five were regarded to have Poor Outcome. In order to explore what factors might have contributed to Outcome a non-standardized checklist on 13 victim and family factors was drawn up to assess these cases. Data in the case files describing the victim and her family at the time of case closure were checked and endorsed against the list of 13 factors. The following Table 5 is the findings so obtained.

The above findings could only be looked at as an exploratory exercise. The choice of the 13 factors represented the author’s clinical impression of what might have contributed to better therapeutic outcome. Because of the small and uneven sample size, lack of a consistent measure over treatment outcome, non-standardized measure of the contributing factors and examiner bias, the result could not demonstrate that these 13 factors actually have discriminative or predictive validity of the treatment outcome of child sexual abuse cases. Having said that, the result seemed to lend support to some current research findings which had associated certain individual and family variables to treatment outcome. In this clinical sample there were some factors which were endorsed with a much higher percentage in the Good Outcome group than in the Poor Outcome group: (1) the ability of the victim to attribute responsibility to the abuser and to perceive pathology in the abuser; (2) victim has no depression symptoms; (3) has supportive non-offending parents; and (4) has average or above self-esteem.

The trend in (1) lent some support to the findings by McMillen and Zuravan (1997) that attributions of blame and responsibility for child sexual abuse had some correlation with adult adjustment in victims. They separated attribution of the abuse into self-blame, perpetrator-blame and family-blame and reported some correlation between self-blame and poor psychological adjustment. In the present clinical sample, some victims in the Good Outcome group were able to talk about the abuse in wider perspectives and had been able to ask

<table>
<thead>
<tr>
<th>Table 5</th>
<th>Victim and Family Factor in the 3 Outcome Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good n=11</td>
</tr>
<tr>
<td>Has supportive non-offending parents</td>
<td>64</td>
</tr>
<tr>
<td>Has no depression symptoms</td>
<td>64</td>
</tr>
<tr>
<td>Attribute responsibility to abusers</td>
<td>64</td>
</tr>
<tr>
<td>Able to perceive pathology in abuser</td>
<td>82</td>
</tr>
<tr>
<td>Has average or above self-esteem</td>
<td>45</td>
</tr>
<tr>
<td>Motivated for treatment</td>
<td>55</td>
</tr>
<tr>
<td>Has not exhibited sexualized behaviour</td>
<td>64</td>
</tr>
<tr>
<td>Has not suffered prolonged abuse (&lt;6 mths)</td>
<td>45</td>
</tr>
<tr>
<td>Has average or above intelligence</td>
<td>45</td>
</tr>
<tr>
<td>No regret about disclosure</td>
<td>55</td>
</tr>
<tr>
<td>Performing average in school</td>
<td>36</td>
</tr>
<tr>
<td>Has average or above social skills</td>
<td>55</td>
</tr>
<tr>
<td>Has returned home at case closure</td>
<td>55</td>
</tr>
</tbody>
</table>

(all in percentages)
questions about pathology in the abuser. Victims in the Poor Outcome group remained rather rigid in their attribution style and continued to hold self-blame attributions; for example, that they had actively participated in the sexual activity; had failed to avoid the abuse or failed to seek help. Victims in the Good Outcome group were more able to perceive pathology in the abuser despite other good things that they might do to the victims. Victims in the Poor Outcome group, on the other hand, were highly confused by the abusers' apparent kindness and concern, might feel extremely guilty about causing the abuser to be apprehended and punished.

Another factor which received a higher percentage of endorsement in the Good Outcome group when compared to the Poor Outcome group was related to the attitude of the non-offending parent. Many studies had highlighted the important role played by the non-offending parent in the rehabilitation of child sexual abuse (Faller, 1990; Faller, 1993) and some researchers even believed that it was the single most important therapeutic factor. In the present sample, 7/11 of the victims in the Good Outcome group had emotionally supportive non-offending parents who believed in the child's allegation of sexual abuse; but none 0/5 of the non-offending parents in the Poor Outcome group was believing. Non-believing parents in the Poor Outcome group denied and refused to reconcile with the facts of the sexual abuse; they refused to recognize the damage done to their child; they sent counter-therapeutic messages and sometimes prevented or discouraged the child from treatment. The attitude of the non-offending parent was often cited as a determinant of successful adjustment of the abused victims (Conte & Schuerman, 1989; Gil & Johnson, 1993) and gaining their support was undoubtedly a major challenge to the therapist. Other therapeutic factors might include higher functioning in the victims' personality, emotions or temperament in the pre-abuse stage which might have buffered them from severe psychological damage. In the Good Outcome group a greater number of victims were described to have average or above self-esteem, free from depression and free from acting out sexually on other people. Whether they were motivated for treatment was endorsed positively in both the Good Outcome and Average Outcome groups and might mean that those who were motivated for treatment had a greater chance to benefit from it. Endorsement in the other factors did not give a very clear picture of their significance (whether the victim has suffered prolonged abuse; has average or above intelligence; has no regret about disclosure; has been performing well at school; has average or above social skills and whether victim has returned home at case closure).

In sum the typical victim with improvement seemed to be one with emotionally supportive non-offending parents; with a flexible cognitive style to attribute responsibility of the abuse to the abuser and to consider pathology in the abuser rather then in herself; to have maintained stable emotions and to be able to rehabilitate herself on distorted sexualization. Future trend in comprehensive and effective treatment of child sexual abuse case in the local scene will surely require: (1) focusing intensively on support and therapy for non-offending parents; (2) highly specialized treatment programs for victims, both individual treatment and group treatment; (3) pre-treatment and post-treatment assessment tools which yield reliable and valid measurements of treatment efficacy to augment clinical judgment. Treatment for the abusers remains a challenge. It is important for local expert to consider a mandatory treatment program or a pre-trial diversion program (Cedar Cottage NSW, 1998) where the abusers could receive specialized treatment for their pathology.

References


The Influence of Ethnicity, Gender, Personality, Life Satisfaction, and Number of Children in the Family on Child Abuse Potential

BS Chua and HO Abdul
Universiti Malaysia Sabah, Malaysia

Introduction

Child abuse is one of the serious social problems and has become a universal problem. Child abuse is not a new issue, since it has emerged a long time ago. Although child abuse is an old issue, it only gets attention in the 19th century when the number of cases has been increasing each year.

Children are accorded their rights by the international community through "Declaration 10 Issues About Children's Rights", which was announced at a general assembly of United Nations in 1959, with its slogan "People should give children their best rights".

Hence, people keep agitating for children's rights and recently, UNICEF chose "Children's Right International Protection" as the theme for The International Children's Day in 1989. The young generation really has their rights to obtain their primary needs. Although the society has given the declaration for their rights, each year about 60 to 100 thousand children all over the world become victims of child abuse (Hasan Baseri Budiman, 1991).

Since there is increasing concern of this problem, numerous studies were conducted. In Malaysia, studies of this nature is still lacking. Hence, the researchers feel that this study is necessary since this issue is becoming more serious and brings negative effects physically and psychologically.

The purpose of this study is to find out the influence of personality factor, demographic characteristics, such as gender, ethnicity, number of children and life satisfaction in child abuse potential.

Related Literature

Numerous studies of child abuse have been done in the west. Milner, Robertson and Rogers (1990) found that there were no significant correlations between the child abuse potential and gender, age and level of education. Russell (1983) and Wyatt (1984) found that there is no difference in child abuse potential among different ethnic groups. Smith, Hanson and Noble (1974) also studied the influence of demographic characteristics towards child abuse. Their findings show that families with more children tend to abuse more than the average family. Anna and Helen (1987) conducted a study to identify the personality and intelligence of the parents prone towards child abuse. They found that mothers who tend to abuse were shy, fearful, lacks discipline, self-conflicting and low in self-control. Bowen (1981) showed that single parents who were satisfied with their life had good relations with their children.

Method

Research Design

This study seeks to examine the influence of personality characteristics, demographic characteristics and life satisfaction on child abuse potential. In this study, personality factors, demographic characteristics such as gender, number of children, ethnic background and life satisfaction are the independent variables and child abuse potential is the dependent variable.

Location

This research was conducted in two Malaysian universities where there were suitable subjects for this research.

Subjects

In this study 107 married students and staff were selected as research subjects. Subjects were randomly selected according to the ethnic groups in Malaysia.

Instrument

One set of questionnaire comprise four parts: Part A, consists of respondent's personal particulars; Part B, is The Child Abuse Potential Inventory (CAP) (Milner, 1990); Part C consists of items in Eysenck Personality Questionnaires (EPS) (Eysenck, 1986) and Part D, consists of items from satisfaction with life scale. The instruments were translated into Malay, according to the procedure suggested by Brislin (1980).

Data Analyses

The data was analyzed by using Statistical Package for Social Science-Extra (SPSS-x) and CAPSCORE computer programs. The two-way ANOVA method was used to compare child abuse potential by personality and gender factors, and by ethnic and gender factors. The Pearson correlation method was used to identify the relationship between number of children in a family and life satisfaction towards child abuse potential. The t-test was used to identify whether there were gender differences in child abuse potential.

Results

Results from two way ANOVA (Tables 1, 2 and 3) show significant differences in child abuse potential...
Proceedings

(F (1,103) = 8.45, p<0.05) according to personality. The F- ratio test was used to show that introverts (Mean = 139.60) have higher potential in child abuse as compared to extroverts (Mean = 102.27). The results also show that there is a difference in mean score between male and female subjects but was not significant (F (1,103) = 2.75, P>0.05).

Further analyses show an interaction effect of personality factors and gender towards child abuse potential. Figure 1 shows these interactions were significant (F (1,103) = 6.94*, P<0.05). These two factors have different effects on child abuse potential.

Results also show that male introverts have higher mean scores on child abuse potential than male extroverts. In contrast, female extroverts scored higher on child abuse potential than the female introverts.

Table 1 shows the results for Two-way ANOVA indicating no significant difference in mean score for child abuse potential between Malay and non-Malay subjects (F (1,103) = 0.005, P>0.05). However, if the ethnic factor is considered the findings show significant differences in mean scores between males and females. F ratio test indicates male (mean = 128.03) has higher potential in child abuse than female (mean = 103.00) (Table 7).
As for the interaction effect, Figure 2 shows ethnic and gender factors show no interaction effect upon child abuse potential ($F_{(1.10)} = 0.12$, p>0.05). This result shows the ethnic factor is independent of the gender factor in explaining the child abuse potential.

The t-test analysis was used to identify the difference in mean scores between male and female subjects on child abuse potential. Results show that there is significant difference between male and female in child abuse potential ($t = 2.19$, p<0.05). Males show higher (mean = 128.02) mean scores in child abuse potential than females (mean = 103.00).

To identify the relationship of child abuse potential between life satisfaction and number of children in a family, Pearson correlation analysis was used. The results show significant inverse relation between child abuse potential and life satisfaction. Results also show that the relationship was significant for male subjects, not in female subjects ($r = -0.21$, p>0.05).

With respect to number of children and child abuse potential factor, the overall results show a weak correlation and is not significant ($r = 0.03$, p>0.05). Both in male ($r = 0.04$, p<0.05) and female subjects ($r = -0.01$, p<0.05), the relationship between number of children and child abuse potential shows weak correlations and are not significant.

Discussion

The results of this study show that there were differences in child abuse potential between extroverts and introverts. The findings suggest that introverts tend to have suppressed feelings, antisocial, isolated, fearful and worry, easily upset and hurt, apathy, and low self-esteem.

These findings corroborate Even's study (1980), which also found that abusive mothers have low self-concept, tend to feel nervous and apathetic if compared to normal mothers. These findings also support previous studies which show that abusers tend to isolate themselves (Spinetta, 1987; Milner and Wimberley, 1980).

As for the ethnic factor, results show that there is no significant difference in child abuse potential between the Malay and non-Malay. Thus, the results also imply that the ethnic factor is not important to identify the child abuse potential. Every ethnic group has the potential for abuse.

This findings do not support most of the local studies which show that there is a difference among Malay, Chinese and Indian in child abuse potential (Abdul Ramlan Sanusi, 1987; Mohd. Sham Kasim, Haliza Mohd. Shafie; Irene Cheah, 1994 and Gunasegeram, 1993). Milner's study (1976) also shows that there is difference between different ethnic (White and Black) groups in United States in child abuse potential.

This study also indicates the significant difference between males and females on child abuse potential, and the results found that males have a higher potential than females.

The findings is parallel with Creiston's (1979) study based on those who have case records of abuse and normal people. The potential for males is higher than females. This can be explained by the typical male attitude of being more aggressive, likes to fight or competitive and dominant. Although, the findings of this study do not corroborate Milner et al. (1990) and Nealex (1992) studies on the abuse potential in the two sexes, it is perhaps due to the difference in role, responsibility and stress of life in the western and eastern societies.

The findings also indicate that there is no significant relation between number of children and child abuse potential. This result also implies that number of children could play a minor role in child abuse potential.

The results of this study supports Hunlock's study (1973), suggesting that family size or number of children in a family is not a factor in child abuse. However, Newberger, Reed, Demel, Hyde and Roteschudk (1977) and Staur (1982), show that families involved in abuse have more children.

Indeed, there are many studies which show that families involved in abuse have quite a number of children if compared to average families (Altermier, Viets, Shemed, Sander, Falsen and O’Commor, 1979; Smith, Hanson and Noble, 1974; Gil, 1970; Straus, Gelles and Steinmets, 1980). No firm conclusions can be drawn yet based on these studies.

The findings on the relation between child abuse potential and life satisfaction imply that those who are satisfied with their lives are lower in abuse potential than those who are not satisfied with their lives. The significant relation between life satisfaction and abuse potential, for males and not for females suggest that life satisfaction is not important in identifying the child abuse potential for females.

![Figure 2 Interaction Effect Between Personality and Gender Factor on Child Abuse Potential](image-url)
The results appear to support a study by Kirkham et al. (1986), which shows that those not satisfied with life, tends towards abuse. Bowen (1981), also indicates that single parent who are satisfied with life have good relations with their kids.

The present study also shows that there is significant relation between personality and gender factors towards child abuse potential. The effect also shows that both factors interact in child abuse potential. The relationship between gender and personality, show that introverts has higher potential for child abuse than extroverts. Female extroverts have higher potential for child abuse than female introverts.

On the relationship between ethnic and gender, the results indicate no interaction for ethnic and gender factors towards child abuse potential. The ethnic factor is independent of the child abuse potential.

Conclusion

In conclusion, personality, gender and life satisfaction factors do have some influence on child abuse potential. However number of children and ethnicity do not have a major influence. The factors that influence the child abuse potential are not isolated, but interact with other factors. In other words, no single factor can explain an individual's potential for child abuse.

References


Youth Empowerment – "Let the Dolphin Lead"
J Ho
Against Child Abuse, Hong Kong

Introduction

"A French physician is said to have always taught his paediatric students, 'Listen to the mother: she is giving you the diagnosis'. In the context of our present topic, he might have said: 'Listen to the child: he or she may hold a key to your understanding of the problem – and to its resolution'.” (Davie, Upton & Varma, 1996)

"Each of the three will have different knowledge, wishes, expectations, concerns and feelings which will influence the resultant interaction (Pearce, 1994). The child's, parent's and professional's voices do not, however, carry equal weight, and are not equally articulated, heard or acknowledged. Nor are their positions necessarily independent of each other's.” (Davie, Upton & Varma, 1996)

When you were a child or a teenage, have you ever thought of what kind of society you expect to live in? Have you had some thoughts that you would like to tell your parents and teachers, but you dare not to say? Children and youths have their own feelings and thoughts regarding people and issues around them, but are there enough opportunities and channels to voice their views and do they feel safe enough to reveal their inner world in our society?

In the United Nations Convention on the Rights of the Child (CRC), it clearly stated that all rights apply to all children without exception. It is the State's obligation to protect children from any form of discrimination and to take positive action to promote their rights. (Art. 2) The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child. (Art. 12) The child has the right to express his or her views, obtain information, make ideas or information known regardless of frontiers. The States shall respect the child's right to freedom of thought, conscience and religion, subject to appropriate parental guidance. (Art. 13 & 14) Education shall aim at developing the child's personality, talents and mental and physical abilities to the fullest extent. Education shall prepare the child for an active adult life in a free society and foster respect for the child's parents, his or her own cultural identity, language and values, and for the cultural background and values of others. (Art. 29)

Youth Empowerment – Let the Dolphin Lead

We believe that children have rights and as adult working with and for children have obligations. It is important to develop a commitment to children's rights and this commitment has to come from the heart and supported by information and action. In 1998, a pilot project "Let the Dolphin Lead" initiated by Against Child Abuse was launched and continued in 1999. Dolphin was chosen as the mammal representing Hong Kong and it symbolises our children and youth who were full of energy, hope, life and strength. The "Let the Dolphin Lead" project was an educational project which aimed at empowering children and youth, through active participation and extensive involvement, in structured activities to formulate their ideal plan for a non-violent society. "Empowerment gives people the opportunity and necessary resources so they can believe, understand and change their world,” noted Joseph F. Lagana, Associate Executive Director, Allegheny Intermediate Unit, Pittsburgh, Pennsylvania. To cultivate a safe environment for children's growth, to educate and empower children and youth to become responsible and sensible individuals become an important area in our work.

The objectives of the project were to provide children and youth with opportunities to express their views, to identify their own as well as those in the society which hinder their optimal growth and development and to draw up a plan with them for the betterment of a caring, non-violent and safe living environment. It was our intention to help them to acquire confidence, positive values of life, knowledge and skills so that they can set proper priorities in life, and to voice their own opinions as well as to join in decision making in areas of their concern.

The project was designed and implemented in three phases:

Phase I: Dolphin Volunteers Training

Around 50 volunteers aged 18 to 25 were recruited, trained and empowered to become leaders to lead younger youths and children. The training includes understanding of child abuse, child protection services and children's rights, knowledge about children's needs and development, self understanding, leadership training, communication skills, team building, creative art work training and program planning for children in the Dolphin Workshop of Phase II. Channels were offered for these Dolphin volunteers to learn and grow, their potentials and creativities were explored and contributed in the process of planning and preparation.

In the last year, one of the volunteers felt that the Dolphin Project had provided ample opportunity for him to plan, design and decide. It was a great satisfaction and encouragement that his abilities and potentials were appreciated and affirmed. He wished that more similar projects be arranged for youths, so that their creativity and productive parts would benefit others in the society.
Phase II: Children Workshop

A number of around 200 students from P.3 to F.3 were invited to participate in the workshop. They were facilitated to express their feelings and thoughts through dance, drama and art work, etc. to the Government, family, school and mass media.

In the last year, some children initially felt that they did not have power to change the Government, but they made a sculpture of the Chief Executive who has a big head which symbolized that they expected him to have a comprehensive plan for a safe, stable and non-violent society. A pair of big ears were also sculptured symbolizing the Chief Executive should always be open and willing to listen to their needs and views.

For the family, they expressed that they wanted to be listened to, to be loved and cared for. One of the pictures drawn showing their wish of not being left unattended at home, and another picture shown that they did not want to be punished physically. They expected parents could spend more quality time with them. Due to the recent economic recession, some children expressed their worries of parents being laid off and some showed concerns about conflicts caused by working in Mainland China.

In school, the children wanted their teacher would be more understanding and would communicate with them. Less examination and homework, but spend more time on creative learning and activities. Some children voiced that they had seen the "ugly", emotional and exhausted faces of their teachers and they did not like it. They did not enjoy school life because all the time was spent in writing, dictation, test and examination. One group of children presented that they would like to set up a cemetery in school to threaten and punish those "naughty" pupils. A lot more has to be explored on this idea of setting up a cemetery in school. What did it represent? How would they feel about threat and punishment? And how to cultivate a positive life value for our children? There are so much to be further explored in the children's inner world and there are so much to be done to help them to develop a positive life value and attitude.

Children were used to violence and pornographic pictures and scenes on daily newspaper, magazines and some television programs. Children in the workshop presented that they had little choices, and they were not aware of any channel which they could express their views about mass media. They expected more quality programs would be produced so that they could have more choices.

Phase III: Declaration

Voices of these children were collected and consolidated in a form of "Dolphin Declaration". A ceremony and an exhibition were held in order to raise public awareness. The declaration was also disseminated to the related parties. The followings were some of their voices:

We want our Government to
- be democratic
- against crime and violence
- have a comprehensive housing policy
- increase resources to social welfare
- concern about environmental protection
- revive the economic situation
- provide opportunity for children and youth to participate
- protect children from being abused

We want our family to be a place where
- you feel secure
- there is respect for privacy
- there are no beating and scolding
- there is no comparison
- there are more compliments
- there is more freedom
- there are no worries
- dad and mom have time for children
- dad and mom listen to and trust children
- dad and mom keep their promise
- dad and mom have stable jobs
- everyone is healthy and happy

We want our school to be a place where
- headmaster/mistress and teachers care about students
- they talk to students
- they would not throw temper
- students can create and participate
- there is respect and no discrimination against new immigrants
- less students in a classroom
- there is no stress of examination
- there are exciting things to do
- there are smiling faces
- there are lots of choices
- is clean, tidy and well equipped

We want our mass media to
- be ethical
- be creative, fun and educational
- reduce pronography and violence
- be attentive to children's participation
- provide channels for children to express their views
- respect personal privacy
Conclusion

There are so much in children's heart and mind, we need to be willing to listen and know how to listen. They always surprise us with their talents, creativity and humor. They bring us life and hope. Let's allow them to teach us with their wonder and dreams. To conclude, let's listen to

What Your Children Might Say

Treat me as a person of short stature who simply has less experience than you. Let me laugh and play, for all too soon I will be your size.

Spend time in my universe, with all its wonders, for I often have trouble understanding the priorities of your world. I, like you, am bored with idle conversation, so talk about meaningful things to me. Speak with me, not at me, and use clear language. Please don't pretend I'm not there when you're talking. Set examples with significant actions, not shallow words. Provide me with a definite "yes" or "no" and stick to it. Tell me why and I might surprise you by minding you. Be honest for I can spot a phony right away. The truth works a lot better than manipulation or guilt trips. Furnish me with guidelines; then I won't be testing the rules. Let me manage important parts of my life as soon as I am able. Grant me privacy and time to myself, but still hug me often. Teach me living skills and encourage my creative side. Nurture the fantasies that are very real to me.

Honor all my feelings, as they are neither right nor wrong. Show me that grief is normal when I lose something. Love me for who I am, not what you want me to be. Recognize my value to you, because I am a beautiful being, even when I make the errors that are called experience. Let me know that you are not God; that you make mistakes too. Seek my opinion; I have wisdom in many matters. Guide me toward my personal spirituality. The golden rule applies to me too.

Anonymous
(quoted in Martens, 1995)

References


The Child Rearing Approach in an Era of Change

AC Leung
Hong Kong

"We used to obey our parents. But children nowadays talk back to their parents."

"I grew up in whips. I am thankful that they have saved me from going astray. Why do people nowadays condemn the whips and indulge the children?"

The above remarks are often heard to be shared among some local parents. It is difficult for them to accept that children nowadays are different from themselves in the old days. They do not recognize that child rearing practices do change with time and culture. In adopting an approach for child rearing, we have to consider the targets, in terms of the time, space and system they are in. Which approach is appropriate? Why? How does it operate? These questions are addressed in this paper with particular reference to the Hong Kong context.

Who?

Who are the targets of child rearing? They are children and parents. Who are the contemporary children, say in the Hong Kong context? Who are the contemporary local parents? Let us take a look of our children and parents, respectively.

Evolving Children

Children born in this era are no longer like sleeping baby cats, as described in our grandparents' days. From my own personal experience, they are wide awake, anticipating to reunite with their parents, once leaving the mother's body. Gibson (1994) reports that newborns, two to four days of age, can already discriminate between their mother's voice and a stranger's voice. Our babies, have evolved, and are not much different from those studied abroad.

Parent Not the Primary Caring Adult

In many families, both parents are working. Children are left to the care of Filipino maids, grandparents, child-minders, friends or relatives who live separately, or even in another region in Mainland China. For these children, their parents have not functioned as their primary caring adult. The parents' way of living have not provided a framework within which children learn to conduct their lives. Discrepancies in their expectations towards each others' behaving are evident.

Media-culture-kids

Almost every household possesses a television. Through the television, children are exposed to ways of living and perspectives different from their own parents.
For children who grow up with the television as their primary companion, the media culture has become their primary working hypotheses on which they base their judgment as to right and wrong. They are aware of the world outside their home. They can be more resourceful than their parents in certain aspects if the latter just bury themselves in work.

**Diverse Sub-culture**

Who are the parents? Over 90% of the local population are of Chinese ethnic origin. The majority grow up in Hong Kong, some are new arrivals from Mainland China, some are Vietnam refugees, some are overseas-born. Leung and Lee (1996) have pointed out the existence of a diverse range of sub-cultures among Hong Kong Chinese, in terms of age, gender, education, economic activities.

Liew-Mak, Lee and Luk (1984) report problems in training parents to be behavioral therapists, and conclude that child rearing practices in Chinese culture are resistant to changes. Another study documented in the same year presents a different picture. Changes in traditional values are evident in an intergenerational study by Ho and Kang (1984). Contemporary fathers are found to become more involved in child-care than their ancestors, putting less emphasis on respect for elders, and more emphasis on the child’s expression of opinions, independence, self-mastery, creativity, self-respect, and all-round development. Apparently, the two studies represent different sectors of the local population. One represent the lower socio-economic sector; the other the educated parents, having been exposed to western culture and perspectives.

**What? Why? How?**

Bearing in mind the kind of children and parents we encounter, what would be the most appropriate child rearing approach in this era? The constructivist approach, that represents “a family of theories sharing the common assertion that humans actively create and construe their personal realities” (Mahoney & Lyddon, 1988), is the promising one. Why? It emphasizes reciprocal social interchanges and the evolutionary nature of human beings; it is open to alternative perspectives, culturally sensitive, holistic and empowering.

**Reciprocal Sociality**

The constructivist approach advocates a reciprocal social interchange between the parent and the child. According to Kelly, the father of Constructivist psychology, “to the extent that one person construes the construction process of another, he may play a role in a social process involving the other person” (1955/1991). That is to say, the parent construes the construction process of the child, and the child construes that of the parent. They develop a ROLE relationship with each other.

If a parent develops a ROLE relationship with the child since birth, both the parent and the child would find each other’s constructs similar and predictable. They are, thus, more likely to be responsive to each other. Similarity and predictive accuracy among family members have been studied to be highly related to mothers’ and adolescents’ family satisfaction (Harter, Neimeyer & Alexander, 1989). The maintenance and negotiation of common constructions has been emphasized in sustaining family relationships (Proctor, 1981), as the affective component in effective parenting (Dix, 1991). Non-compliance, on the other hand, has been explained as “a situation in which the child has applied constructions at variance with the constructions that the parent would apply” (Mancuso & Handin, 1980). Discrepancies between the constructions of the parent and that of the child can be minimized through parent-child ROLE relating.

ROLE relationship is involved, warm and empathic. Empathic parenting has been endorsed to elicit cooperative, responsive social behavior in children (Maccoby & Martin, 1983; Eisenberg & Mussen, 1989; Feshbach, 1989; Dix, 1991). Cross-cultural studies by Rohner (1986, 1992) show that children worldwide who perceive themselves to be warmly parented are more likely to be psychologically healthy and to make productive social adjustments.

However, in ROLE relationships, our core constructs are put to the test. It entails a conglomerated of emotions (anxiety, fear, threat, aggressiveness, hostility and guilt) which Leitner (1985) calls “the terrors of cognition”. Hence, in developing a ROLE relationship, a parent needs to engage despite the awareness that he may experience terrors (courage), subject his core constructs to the results of experimentations. He should examine his own construct system and its implications for others (responsibility). Allow for the creation of new ways of understanding one another as they evolve (creativity), and validate the child’s process over time (commitment).

Leitner (1985) has warned that “When individuals globally avoid ROLE relationships, the resulting deprivation of meaningful interpersonal understandings is often experienced as meaninglessness, emptiness, and guilt”. From my clinical experience, psychiatric symptoms and psychopathology are witnessed in adolescents whose family relationships were reported to be harmonious, but upon exploration, found to be superficial instead. Research study by Radziszewska, Richardson, Dent and Flay (1996) is consistent with Leitner’s assertion and my clinical observation. Unengaged parenting is found to yield worst outcomes in terms of adolescent depressive symptoms, smoking and academic grades, in comparison with autocratic, authoritative and permissive parenting.
**Constructive Alternatism**

The constructivists respect both the child and the parent as experts in their own rights. The child is assumed to know better his own experience, whether he feels hot or cold, thirsty, hungry, interested or not. The parent is assumed to be more knowledgeable and resourceful in providing for and guiding the child. The parent, however, cannot assume he knows the child's experience better than the child himself.

The philosophical position "constructive alternativism" (Kelly, 1955/1991) implies that "our present interpretations of the universe are subject to revision or replacement". We have the active capacity to represent the environment, and we can construe our experiences creatively.

Take an example of a parent-child interaction, as represented by Proctor's Bowtie (1985). A 3-year-old, on seeing his elder siblings playing ping-pong (table-tennis), would like to play, too. He has not yet developed adequate schema to guide his activity. He cannot catch the ball; he has the ball throwing high up in the air, or outside the ping-pong table. His mother is eager to teach him, to see that he is playing ping-pong the correct way. She then holds his hand to teach him. The child’s construct "I know, I like to play with the ping-pong my way" is invalidated. He resists and protests against his mother’s coercive intervention. The mother experiences invalidation of her good intention to help, and feels frustrated too. Instead of construing the child’s construction, the mother blames the child for not receptive to teaching; and the child blames the mother for obstructing his play. Both end up in frustration and hostility.

The ending would be different if the parent alters his perception, or expectation (construction), alter his own behavior, attitude, skill in managing the child, or emotional manifestation (action). It would also be different if the child alters his own construction or action, or both the parent and the child care to construe, or reconstrue the construction process of another.

**Evolving**

Let us take a second look of the mother-son ping-pong episode. On seeing her son not knowing how to play ping-pong, the mother believes that he needs guidance. As she has guided her elder children in playing ping-pong before, she anticipates that her guidance would be equally well received by the younger son. She is then invested in her anticipation, by going over to hold her son’s hand. However, on encountering her son’s hand, she can tell her guidance is not welcomed. Her anticipation is invalidated. She tries to reconstrue the son’s construction, and to revise her anticipation. She comes to the understanding that her son just wants to have fun. He is not ready to play ping-pong the proper way yet. She sees him as wanting to explore things in his own way. With such understanding, she no longer uses the same old method, which she has employed previously with her elder children, to relate with her younger son. As she reconstrues and reformulates her hypothesis, she is allowing new elements to enter into her construction system. Her construction system becomes more permeable, and has thus evolved and grown.

Our predictions about the people and events around us become more valid and precise, as we verify them, revise them with "successive approximations" and have them further verified, as illustrated by the experience cycle depicted in Figure 2. Learning and growth do not take place just as years pass by. Learning occurs only when our anticipations fail, and when we revise our constructions. Invalidations are opportunities for growth. Hence, parents and children are invited to reflect on themselves, step back and reconstrue when they encounter invalidations.

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**Figure 1** A parent-child Interaction Bowtie

<table>
<thead>
<tr>
<th>CONSTRUCTION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENT</td>
<td>1. You don't know how to play ping-pong. Let me teach you.</td>
</tr>
<tr>
<td>5. You are not receptive to teaching.</td>
<td>6. Frustration. Anger. Blaming. Give up</td>
</tr>
<tr>
<td>CHILD</td>
<td>3. I know. I like to play with the ping-pong my way. Don't stop me from playing.</td>
</tr>
</tbody>
</table>
Holistic

Constructivists view a person as a whole, taking into account the person's constructs and action. Constructs, as a person's representation of reality, include a person's thoughts as well as feelings. They can be abstract concepts, or preverbal and symbolic. Constructivists do not just aim at correcting thoughts or behavior, but meaning making, helping the person make sense of his experience. What works, and what does not work. Why things get stuck and do not turn out as expected. How to get the person going from where he has got stuck. Shifting between dilation and constriction of perceptual fields, loosening and tightening, are the way to think creatively and problem solve logically.

Empowering

A person is empowered with the choice to extend or define his construct system. He may choose to enhance his predictions by broadening his field of vision, tolerating some day-to-day uncertainties, extending the predictive range of his system, and making more and more of his life's experience meaningful. Or, he may choose to constrict his field of vision, turn his attention toward the clear definition of his system of constructs, try to become more and more certain about fewer and fewer things, or become vaguely aware of more and more things on the surface.

An obedient child chooses to constrict himself so that he can be more certain about his behavioral outcome. A secure child ventures to take risks, to test limits and expand his system. An insecure avoidant child has no confidence in his own predictions. He just relies on others' constructions of reality. His exploratory behavior is hindered; his freedom is limited (Sassaroli & Lorenzini, 1992). A defiant child, does not find the adults helpful in facilitating him make sense of his experiences. He persists in his own predictions despite repeated invalidations, thrusting his way through. The freedom of his personal construct system is equally restricted. Children from discordant families, experiencing much stress, are noted to have a tendency to behave and make decisions impulsively. In an anxiety state, they may also choose not to act, by staying in helpness inertia.

An over-protective parent, fostering the child's dependency, chooses to restrict the child's range of behavior so that he can be more predictable. A parent under stress may choose to tighten his constructs by arranging his daily routines according to a set of rules in a rigid manner so as to be in control. He will grumble, nag, or blow up should anything outside his plan happen. His children are kept under rigid control. A stressful parent may also choose to loosen his constructs by tolerating ambiguities, vacillating from constructs to constructs, engaging in incomplete exploratory movements, making diffuse, short-sighted and impulsive efforts, and shifting interpretation of an event or a relationship. Landfield (1980) calls this "chaotic fragmentalism". It makes ROLE relationship difficult, because ROLE relationship involves construing, and construing involves organization (Leitner, 1985). His children, in responding to his equivocations would not find him supportive in their efforts to explore an uncertain world (Mancuso, Jaccard, Amendolia & Radecki, 1994).

Figure 2  The Experience Cycle (Adapted from R.A. Neimeyer, 1985)
The constructivist approach empowers the parent and the child in activating their inquiry process and their awareness of their own choices, instead of encouraging their dependency on authorities for solutions to their problems.

**Culturally Sensitive**

Constructivists understand a person multi-dimensionally and multi-systematically. A problem is understood through its implications in a wide context. For example, a child fails to learn to read. We need to assess the child's intellectual functioning. We need to explore how the child construes his school experience, in relation to teachers and peers. We need to explore how the child construes his parental expectations, how he construes himself, how he construes learning, and the implications of success and failure.

Mancuso and Hunter (1985) has illustrated that each child has developed his own unique system for processing all kinds of input – input regarding authorities, or reprimand, respectively. That is to say, the effectiveness of a reprimand depends very much on the child's construction. Does he find the reprimand helpful, or useless in guiding his anticipations of the world? Does the reprimand affect how he sees himself? Does it affect his relationship with the reprimander? How does he view authorities? A person's individual meaning is crucial. Every person is understood uniquely, not as a stereotype of the culture, or the subculture to which he belongs. It is the individual's "internalized culture" (Ho, 1995), meaning and implications that constructivists aims at construing and understanding.

Imposing one single child rearing practice on all people with different internalized culture requires some parents to adopt "a radical shift of attitude" (Blowers, 1991), and hence brings about resistance in some. Constructivists emphasize a two-way interactive process in meaning making. Resistance on the part of the parent is understood as the educator, or the therapist's failure to construe, or reconstrue the construction process of the parent concerned.

**Conclusion**

To conclude, the constructivist approach is a promising theory of choice in an era of change. "It places all in a position of tolerance for the life style of others" (Epting & Leitner, 1992). It draws human relationships closer. It is sensitive to the individual's internalized culture. It is subject to revision and change. It holds out hope for growth and liberation. It empowers both the parent and the child to assume agency of their own lives.

**References**


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Notes

1 The word construe implies perceiving, experiencing and interpreting.
2 The word ROLE, in Kellian sense, is put in the upper case to differentiate from the ordinary dictionary meaning of role.
3 Courage, openness, responsibility, creativity and commitment, together with discrimination, flexibility, forgiveness and reverence are the common characteristics found in optimally functioning persons and persons who are able to sustain deep ROLE relationship (Leitner & Pfenninger, 1994).
4 A loose construct is one which leads to varying predictions but retains its identity (Kelly, 1955/1991a).
5 A tight construct is one which leads to unvarying predictions (Kelly, 1955/1991a).
Suspected Child Abuse Cases in Public Hospitals: an Interim Analysis of 494 Cases

Medical Coordinators on Child Abuse

Corresponding Author, ACW Lee

Summary

Since the designation of Medical Coordinators on Child Abuse (MCCAs) in the paediatric departments of public hospitals, a system of voluntary reporting on the handling of suspected cases of child abuse has been initiated. Between June 1997 and August 1999, 494 cases have been reported from 12 hospitals. Three hospitals contributed more than 50 patients each, accounting for 60% of the reported cases, and are arbitrarily designated as busy units. The suspected victims included 230 (47%) boys and 264 (53%) girls at a mean age of 7.5 (range 0-17.2) years. Children of suspected sexual abuse were more likely to be girls (94% vs. 48%, p<0.001) and younger in age (5.7 vs. 7.7, p<0.001) when compared with the non-sexual abuse cases. Among the whole group of patients, 288 (58%) were diagnosed as child abuse. The forms of maltreatment included physical abuse (n=211), neglect (n=8), psychological abuse (n=3), sexual abuse (n=22), and multiple abuse (n=44). Physical abuse, alone or in combination with other forms of abuse, accounted for the majority of cases (251/288, 87%). Either or both biological parents constituted 71% of the perpetrators. Concerning disposal, 67% cases were restored home, while the others required special placement. Five (1%) patients died as a result of serious head injury. Of the 452 cases where multi-disciplinary case conference was held, abuse was established in 254 (56%). The following factors are associated with a higher chance of establishing a case of child abuse in the conference: (1) non-sexual abuse case (59% vs. 36%, p=0.004), (2) victim of older age (8.0 vs. 7.2, p=0.05), (3) case previously known to an agency (77% vs. 49%, p<0.001), and (4) case admitted to a busy unit (67% vs. 39%, p<0.001). Thus, almost 500 cases of child abuse were handled in public hospitals in the last two years. The figure is likely an underestimate due to incomplete reporting. The pattern of abuse is different from that reported by the Social Welfare Department: (1) there is a higher proportion of physical abuse, (2) children of sexual abuse are much younger in age, and (3) death is seen. Handling of child abuse by the medical profession requires special expertise that deserves a high priority of attention.

Introduction

Since 1979 when the local government started looking into the matters associated with child abuse, official reports and recommendation on the handling of child victimisation were issued successively. When the Procedures for Handling Child Sexual Abuse Cases was released in 1996, Medical Coordinators on Child Sexual Abuse were designated in the ten paediatric departments of the Hospital Authority hospitals. This was gradually expanded to the paediatric units of all public hospitals under the Hospital Authority and the title was changed to Medical Coordinators on Child Abuse (MCCA) to reflect the full spectrum of work carried out by the designated professionals.

Since January 1997, MCCA started meeting with each other at bimonthly intervals to share and review experience. It soon became apparent that the child abuse cases seen in the public hospitals were different from others quantitatively and qualitatively. A voluntary reporting system was commenced in July 1997 in which representatives from each hospital are encouraged to submit case reports on the cases they encountered. The report follows a pre-defined format without revealing the identity of the victim or suspected perpetrator (Table 1). The following report is an interim summary of the cases collected in the first two years.

Materials and Methods

Case reports submitted by the representatives from each hospital were collected at bimonthly intervals. All cases submitted before the end of August 1999 were included for analysis. Institutions from which more than 50 cases were submitted were designated as "busy" units arbitrarily, and the remaining were designated as "less busy" units. Data were analysed using the statistics package SPSS for Windows 7.0 to see if the pattern of abuse handled by the paediatric units was related to the age and sex of the victims, the initial and final allegation, the previous involvement of child care agency, and the kind of institution handling the case.

Results

A total of 494 completed case reports were received between the captioned period. The date of admission spanned from June 1997 to August 1999. Among the cases, there were 230 (47%) boys and 264 (53%) girls. The median age was 7.5 years (range 0-17.3). 128 (26%) of them had been known to a child care agency before. The cases were contributed by 12 paediatric departments. Three of them were arbitrarily labeled as "busy" units and together they contributed 60.5% of the cases. The types of maltreatment at the initial suspicion and at the time of
Table 1  Child Abuse – Report Form

To include all suspected/confirmed cases of child abuse admitted to hospital

A. The Patient:

1. Case Ref: ___________________________ (e.g. KWH1; No patient identity/hosp. no.)
2. Sex:  □ Male  □ Female
3. Age at admission: _______ year(s) _______ month(s)
4. Date of admission: _____ / ____ / ______(dd/mm/yy)
5. Existing records indicate previous reference to a child care agency?
   □ Yes  □ No
6. If yes, specify the agency: CPSU/other: __________________________

B. The Abuse:

7-8. Form of abuse:  Initial suspicion  Final diagnosis
   Physical abuse  □  □
   Gross neglect  □  □
   Psychological abuse  □  □
   Sexual abuse  □  □
   Not abuse/excessive punishment/inappropriate discipline/others: __________________________  □

9. Significant laboratory/radiological findings:

10. Case conference:  □ Yes  □ No

C. The Outcome:

11. Conclusion at conference:  □ case established  □ case refuted
   □ indeterminate (insufficient evidence to establish/refute)
12. Police involved/informed:  □ Yes  □ No
13. Child Protection Registry:  □ included, abused  □ included, at-risk
   □ not included
14. Placement to:
   □ Home  □ Fostered care  □ Small group home
   □ Relative (specify: ____________)  □ Institution (specify: ____________)
   □ Others, specify: ____________  □ Died
15. Anticipated long-term complications:

16. Follow-up care/services:
   □ CPSU  □ Family Service Ctr  □ Paediatrician
   □ Clinical psychologist  □ Other, specify:

D. The Perpetrator/Suspected perpetrator:

17. Relation(s):  □ Father  □ Mother  □ Unknown
   □ Other, specify: __________________________
18-19. Sex/age:  □ Male  □ Female ________ years
20-21. Sex/age of 2nd abuser (if any):  □ Male  □ Female ________ years

E. The Contact Details:

For details, please contact the following doctor(s)/staff at the hospital concerned.
Name of doctor(s)/staff: __________________________
Hospital: __________________________
Signature of doctor: __________________________
disposal are tabulated in Table 2, respectively. After all, 288 (58.3%) of the cases were diagnosed as child abuse. The forms of maltreatment included physical abuse (n=211), neglect (n=8), psychological abuse (n=3), sexual abuse (n=22), and multiple abuse (n=44). The relationship of the perpetrators to the victim in confirmed cases of child abuse is listed in Table 3. Either parent or both accounted for 71.2% of the cases.

Physical abuse, either alone or in combination with other kinds of maltreatment, accounted for 85.6% of the cases admitted for evaluation and 87.2% (251/288) of the confirmed cases of abuse. Children of suspected sexual abuse were more likely to be girls (94% vs. 48%, p<0.001) and younger in age (5.7 vs. 7.7, p<0.001) when compared with the non-sexual abuse cases. The type of abuse and whether case conference was called were not related to the "business" of the hospitals.

Case conference was held in 452 (91.5%) cases, from which 254 (56.2%) cases were established. 60 cases were classified as indeterminate and the remaining 138 cases were not established. The following factors are associated with a higher chance of establishing a case of child abuse in the conference: (1) non-sexual abuse case (59% vs. 36%, p=0.004), (2) victim of older age (8.0 vs. 7.2, p=0.05), (3) case previously known to an agency (77% vs. 49%, p<0.001), and (4) case admitted to a busy unit (67% vs. 39%, p<0.001). The age of the perpetrator and the sex of the victim were not found to be related factors.

337 (67.2%) cases were entered into the Child Protection Registry. 85 were registered as "at risk" and 252 were registered as "abuse" cases. About two-thirds of the children were discharged home and the outcome of the other cases was listed in Table 4. There were five cases (1%) of death in this series of patients. All of them were remarked to have some kind of serious head injury that was compatible with the diagnosis of shaken baby syndrome.4

**Discussion**

Statistics on the number of child abuse cases is collected by the Social Welfare Department by means of the Child Protection Registry (CPR). The main objective of the registry is to provide easy checking for government departments and non-government organizations to ascertain whether a case under investigation has been known to an organization before.2,5 Children who are victims of abuse, or who are at risk for abuse, are reported by their respective caseworker. Their names will generally stay on the CPR for two years, after which they will be de-registered unless a request for continuation of registration is received. The data from the CPR are published annually in the form of a report,6 which cover the demographic data of the victims and abusers, the characteristics of the abuse, and the distribution of the cases geographically. Such information is invaluable for understanding the overall pattern of abuse in the territory. However, the CPR does not contain any information on the severity of injuries sustained by the victimised children.

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**Table 2** The Types of Maltreatment Reported

<table>
<thead>
<tr>
<th>Type</th>
<th>Initial Suspicion</th>
<th>Final Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>396 (80.2%)</td>
<td>211 (42.7%)</td>
</tr>
<tr>
<td>Neglect</td>
<td>7 (1.4%)</td>
<td>8 (1.6%)</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>2 (0.4%)</td>
<td>3 (0.6%)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>59 (11.9%)</td>
<td>22 (4.5%)</td>
</tr>
<tr>
<td>Physical abuse &amp; neglect</td>
<td>8 (1.6%)</td>
<td>16 (3.2%)</td>
</tr>
<tr>
<td>Physical abuse &amp; psychological abuse</td>
<td>13 (2.6%)</td>
<td>20 (4.0%)</td>
</tr>
<tr>
<td>Physical &amp; sexual abuse</td>
<td>4 (0.8%)</td>
<td>0</td>
</tr>
<tr>
<td>Physical &amp; psychological abuse and neglect</td>
<td>2 (0.4%)</td>
<td>4 (0.8%)</td>
</tr>
<tr>
<td>Other multiple abuse</td>
<td>3 (0.6%)</td>
<td>4 (0.8%)</td>
</tr>
<tr>
<td>Not abuse</td>
<td>0</td>
<td>206 (41.7%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>494</strong></td>
<td><strong>494</strong></td>
</tr>
</tbody>
</table>

**Table 3** The Perpetrators in Confirmed Cases of Child Abuse

<table>
<thead>
<tr>
<th>Related to Victim</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>121</td>
<td>42.0%</td>
</tr>
<tr>
<td>Mother</td>
<td>69</td>
<td>24.0%</td>
</tr>
<tr>
<td>Both parents</td>
<td>15</td>
<td>5.2%</td>
</tr>
<tr>
<td>Stepmothers</td>
<td>6</td>
<td>2.1%</td>
</tr>
<tr>
<td>Mother’s boyfriend ± mother</td>
<td>9</td>
<td>3.1%</td>
</tr>
<tr>
<td>Uncle or aunt</td>
<td>8</td>
<td>2.7%</td>
</tr>
<tr>
<td>Sibling</td>
<td>4</td>
<td>1.4%</td>
</tr>
<tr>
<td>Fostered parent</td>
<td>2</td>
<td>0.7%</td>
</tr>
<tr>
<td>Maid</td>
<td>7</td>
<td>2.4%</td>
</tr>
<tr>
<td>Childminder</td>
<td>5</td>
<td>1.7%</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
<td>0.7%</td>
</tr>
<tr>
<td>Neighbour</td>
<td>2</td>
<td>0.7%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>4.2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>26</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

**Table 4** The Placement of Children Evaluated for Suspected Child Abuse

<table>
<thead>
<tr>
<th>The Placement/Outcome</th>
<th>Number of Cases</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>332</td>
<td>67.2%</td>
</tr>
<tr>
<td>Fostered care</td>
<td>30</td>
<td>6.1%</td>
</tr>
<tr>
<td>Small group home</td>
<td>36</td>
<td>7.3%</td>
</tr>
<tr>
<td>Relatives</td>
<td>38</td>
<td>7.7%</td>
</tr>
<tr>
<td>Institutions</td>
<td>45</td>
<td>9.1%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>1.6%</td>
</tr>
<tr>
<td>Death</td>
<td>5</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
Children who died of abuse would not be included in general because checking would not be needed afterwards.

Children admitted into the hospital for suspected child abuse represent a special subset of cases whose general characteristics may not be reflected by information available from the CPR. For instance, physical abuse and sexual abuse represent 47% and 38% of new cases reported to CPR in 1997, respectively. However, they correspond to 80% and 12% of the caseload handled in public hospital. The predominance of physical abuse is also reflected in the confirmed cases. We believe that this predominance represents a referral bias. Hospitals in Hong Kong are renowned for the management of acute medical conditions, whereas children with subtle or non-physical injuries may not be deemed necessary for admission.

The referral bias can be viewed from another perspective. Children admitted for suspected sexual abuse have a mean age of 5.7 years. However, over 71% of sexual abuse cases reported to the CPR are over the age of 9. Thus, public hospitals are more likely to encounter the immature and dependent cases of suspected sexual abuse — a subgroup where interrogation is unlikely to be straightforward and spontaneous disclosure is uncommon.

The present study also identifies other features in the management of child abuse that may not be apparent from the CPR reports. While the definition of child abuse does not seem to be dependent on age (other than ages beyond childhood) and the organization that the child may have come across, the outcome of case conference appears to be determined by a number of factors. For instance, there is a lower chance of establishing a case if it involves sexual abuse. The finding is perhaps not surprising in view of the prohibitive nature of this kind of maltreatment. However, the current arrangement of interrogation that places heavy emphasis on a single video-recorded interview and a single case conference does not accommodate for the piecemeal nature of disclosure in young victim of sexual abuse.

It is also interesting to note that cases in which the victims are previously known to an agency are most likely to be established. This feature probably identifies a vulnerable group of children by virtue of their social deficiency.

While inter-disciplinary disagreement on the interpretation of child abuse issues is common during case conference, discrepancy arising within the same profession has not been examined. The fact that "busy" hospitals are more ready to establish a case compared with "less busy" units is intriguing. On the one hand, the degree of "business" may well reflect another kind of referral bias, with readily identifiable cases flooding to the "busy" department. On the other hand, the "busy" hospitals may be working on an operational basis that promotes the positive identification of cases. We speculate that the "busy" paediatric departments are more likely to have trained and experienced staff in the area of child protection, and are more likely to have established a close working relationship with the regional child protection workers.

Because of the voluntary nature of reporting, under-reporting of cases certainly occurs. Because of the anonymity of the reported cases, it is hard to ascertain the missing cases. The Clinical Management System, which captures the disease coding of each patient under the care of the Hospital Authority, may provide an interface for ascertainment. However, it is unclear whether the disease coding was properly done at the first instance. The MCCA are currently looking into ways to improve the rate of reporting from each institution.

Despite the shortcomings, the current report gives an approximate idea of the amount of cases and the extent of injuries in relation to child abuse handled in the public hospitals. With close to 250 cases per annum, child abuse outnumber childhood cancer by 67%. Yet, the societal morbidity associated with childhood victimization may be much more persistent and significant. While paediatric oncology is a well established medical subspecialty in Hong Kong, the same cannot be said of child abuse. Like treating cancer, the handling of child abuse by the medical profession requires special expertise in recognition, treatment and advocacy. All deserves a high priority of attention.

Appendix

The Medical Coordinators on Child Abuse include A Tsang, E Kwan (Queen Mary Hospital), CM Yu, SM Tai (Pamela Youde Nethersole Eastern Hospital), P Ip, P Cheung (United Christian Hospital), PW Ko (Our Lady of Maryknoll Hospital), W Tse, S Ho, B But, WH Lee (Queen Elizabeth Hospital), SWW Cherk, LCK Leung, CS Ho (Kwong Wah Hospital), PWT Tse, JYC Chan (Caritas Medical Centre), PS Cheng, HL Wong (Prince of Wales Hospital), FT Yau, KP Lee, KL Yam (Alice Ho Miu Ling Nethersole Hospital), LP Lee, A Cheng, CB Chow (Princess Margaret Hospital), KF Huen, WC Mak (Yan Chai Hospital), KC Chan, KW Tsui, TW Wong (North District Hospital), ACW Lee, Y Ou, KT So (Tuen Mun Hospital), CC Lee (Kwai Chung Hospital).
References


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