Child Abuse in Kuwait: Problems in Management

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Key Words

Child abuse · Munchausen syndrome by proxy

Abstract

Objectives: To explore the extent of child abuse in Kuwait and examine the difficulties associated with its management. **Subjects and Methods:** A retrospective analysis of the 60,640 medical records of children admitted to Al-Amiri and Mubarak Al-Kabeer Hospitals, Kuwait, between 1991 and 1998 was done. **Results:** Of the 60,640 records, 16 children showed evidence of abuse. Of these, the perpetrator was a parent in 75% of the cases, which involved the following abuses: physical, 13; sexual, 2; and Munchausen syndrome by proxy in 1. Children with physical abuse had more than one type that included bruises (77%), burns (38%), intracranial haemorrhage (38%), fractures (23%) and cut wounds (15%). Seven of the children were returned to their biological parents, 7 were lost to follow-up and 2 died. **Conclusion:** Child abuse exists in Kuwait and is probably underreported. Management proceedings are not ideal and guidelines as well as legislation are needed.

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Introduction

Child abuse has been documented in the medical literature for over 130 years [1]. It was, however, the well-recognized publication by Kempe et al. [2] that raised professional and public interest in the problem, extending physicians' responsibilities beyond the treatment of injuries to include early recognition, reporting and prevention. The incidence of child abuse has been on the rise over the last three decades, due to both an increased awareness as well as an actual increase of cases [3]. Furthermore, it is believed that the number of reported cases represents a minority of actual cases, as the problem is frequently underreported [3].

The first report on child abuse in an Arab Gulf Council Country was in 1987 from Kuwait [4]. It stimulated active discussions both at professional and public levels. Several reports followed from the neighbouring country of Saudi Arabia [5–7], a country with a similar cultural and religious background. It soon became obvious that since guidelines and legislation do not exist, work needs to be done to establish such that conform with the culture and Islamic religion [8]. Although such guidelines and legislation are established in many Western countries, it is believed that they still fall short of providing the necessary protection for abused children [9, 10].

We herein report our experience with child abuse in Kuwait, an Arab and predominantly Muslim country, and highlight the difficulties facing paediatricians throughout various stages of the management process.

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Table 1. Findings in 16 children with child abuse

Case	Date of admission	Sex	Age	Findings	Abuser	Outcome
1	13/11/1996	M	2.5 years	bruises, burns, fractures	mother	successful
2	14/9/1994	F	3 years	bruises, burns, cut wounds	mother	successful
3	6/7/1997	M	2 months	bruises, torn frenulum	mother	successful
4	9/6/1997	M	1.5 years	bruises, burns, fracture	father	lost to follow-up
5	12/6/1991	F	6 years	bruises, cut wounds, intracranial haemorrhage	father	died
6	26/3/1996	M	9 years	bruises	father	lost to follow-up
7	29/5/1998	F	3 years	bruises	mother	lost to follow-up
8	28/10/1998	M	4 months	bruises, burns	babysitter	successful
9	12/8/1998	M	9 years	bruises, burns	mother	lost to follow-up
10	27/9/1998	M	9 months	intracranial haemorrhage, fractures, seizures, neurologic sequelae	unspecified	lost to follow-up
11	7/11/1992	F	1.5 months	convulsions, apnoeic episodes, intracranial haemorrhage	mother	successful
12	27/4/1998	M	9 months	bruises, retinal haemorrhage, prolonged repeated seizures, intracranial haemorrhage	babysitter	lost to follow-up
13	13/6/1995	M	3 months	encephalitis-like picture, intracranial haemorrhage	father	successful
14	1/10/1998	F	2.5 years	recurrent vaginal discharge, sexually transmitted disease (gonorrhoea)	unspecified	successful
15	11/7/1994	M	3.5 years	rectal bleeding, perianal lacerations, patulous anus	household member	emigrated
16	1/7/1996	M	1.5 years	repeated administration of a corrosive, recurrent mouth ulcerations and pneumonias (MSBP)	mother	died

M = Male; F = female; MSBP = Munchausen syndrome by proxy.

Subjects and Methods

This is a retrospective analysis of 60,640 medical records of two regional hospitals in Kuwait (Al-Amiri and Mubarak Al-Kabeer) between 1991 and 1998. Three paediatricians verified the diagnoses and studied the patients' demographic data, clinical details, interventional methods and outcome. Abuse was suspected when the nature of the injury could not be explained as having been caused by an accident. An underlying haematological disorder was ruled out in all cases. Seven children with physical abuse had a skeletal survey and 6 of them had a computerized axial tomography of the brain. In all cases, the diagnosis of physical abuse was confirmed by a parent or attendant admitting abuse after being confronted with the diagnosis.

Interventional methods involved the paediatrician, the social worker and in some cases, psychiatrists and the police department. The outcome was defined as successful if, after intervention, the child was returned to the biological parents or an alternative home, with cessation of abuse on follow-up.

Results

Of the 60,640 medical records reviewed only 16 children with unequivocal evidence of abuse were identified: 5 were Kuwaiti nationals (38%) and 11 were expatriates

(62%). The population drained by the two regional hospitals in 1995 was around 650,000, of whom 35% were Kuwaiti nationals and 65% were expatriates, reflecting the percentages of child abuse found in these two groups.

Among the 16 patients, 11 were males and 5 females. All children were developmentally normal prior to abuse with the exception of 1 female (case 5), who was mentally and physically normal, but had serious adjustment problems with her father. Three of the children were 6–9 years of age, 7 were between 1 and 5 years, and 6 were less than 1 year.

Thirteen of the children were subjected to various forms of physical abuse (table 1; cases 1–13); 2 to sexual abuse (table 1; cases 14 and 15) and 1 Munchausen syndrome by proxy (case 16). The perpetrators were a mother in 7 cases, a father in 4, a babysitter in 2, a household member in 1 case. In 2 cases, the perpetrators could not be identified.

Bruises at unusual sites considered mild abuse were the most common clinical finding (table 2). The most serious finding, however, involved intracranial haemorrhage (38%). In 4 of the 5 patients, all of whom were 9 months old or younger, the injury probably resulted from shaking.

Table 2. Summary of findings in 13 children with physical abuse

Finding	n	%
Bruises at unusual sites	10	77
Burns	5	38
Intracranial haemorrhage	5	38
Fractures	3	23
Deep cut wounds	2	15

In the 5th child (case 5) the cause was a direct hit against the wall. Fractures were detected in 3 children, involving the humerus in 2 and the ribs in 1.

All children had a disadvantageous home situation as depicted in table 3. In only 1 case (case 5) there was evidence that the child's behavioural problems, which started at the age of 4 years, could have contributed to her abuse: she was defiant and aggressive. In addition, she reportedly showed no positive emotions to her parents, perhaps because this girl was immediately separated from her parents after birth to be raised by her grandmother for the first 3 years.

In the 2 cases of sexual abuse (cases 14 and 15), a non-family caretaker was involved. In case 14, where both parents worked outside of the home, the girl was cared for by a family friend. Once abuse was suspected, the family changed residence and refused intervention in any form to avoid disgrace. As a result, the perpetrator was never definitively identified. In case 15, the parents were divorced and had emigrated back to their respective countries, leaving the 3.5-year-old boy with a friend, who probably subsequently abused the child.

An 18-month-old boy (case 16) was admitted several times to different hospitals with recurrent mouth ulcerations and pneumonias. Extensive immunologic and other investigations were unrevealing. The mother was described as 'nice', co-operative and constructive as well as compassionate. The boy, who needed intensive care on several occasions, had 'lesions' that would improve in the hospital, but recur after discharge. He eventually died with severe oesophageal burns and massive pneumonia. Only then the possibility of Munchausen syndrome by proxy was suspected and a can of Flash (caustic chemical detergent) was found in the room.

In all cases interventional options were quite limited, as the paediatrician who was the main advocate could not enforce keeping children in the hospital. Two children were discharged to their parents by the afternoon of the same day on which they were admitted. Three more chil-

Table 3. Home characteristics of the abused children

Characteristic	n	%
Divorce	4	25
Parental psychiatric illness	4	25
Serious marital problems	3	18
Other disadvantageous home situations	5	32
Total	16	100

Table 4. Outcome in 16 children with child abuse

Outcome	n	%
Successful intervention	7	44
Lost to follow-up (further abuse probable)	6	38
Emigrated	1	6
Died	2	12
Total	16	100

dren were lost to follow-up. The family of 1 child with sexual abuse decided to take no further action to avoid disgrace. There is no legislation to allow obtaining a court order for the exclusion of these children from the abusive environment, and a child protection agency does not exist. Reporting the case to the police department requires changing the status to that of a criminal case. This was done in cases of disadvantageous home situations (cases 4, 5 and 13); for cases 4 and 13 the mother herself was abused and had filed for divorce. Table 4 summarizes the outcome in these children. Success was achieved in only 7 cases (44%) through the work of the paediatrician and the social worker. The case fatality rate was 12%.

Discussion

Corporal punishment of children has always been a subject of controversy [11]. It has been defined as the use of physical force to inflict pain but not injury for the purpose of correction or control of the child's behaviour [12]. While the 'smacking' advocates justify the use of a spank or two administered to the buttocks [13], others believe that this practice should be banned as it can quickly escalate into abuse [11, 14].

In the sacred law of Islam all forms of frank abuse are unacceptable [15], yet disciplinary physical punishment

is, on a limited number of occasions, permissible [15, 16]. It should not exceed a minimal force; the head and face should be avoided and there should be no bruising [16]. According to these criteria, all of the 16 children reported in this series suffered unacceptable child abuse.

It is conceivable that the number of child abuse cases reported in this study is a gross underestimate of the actual size of the problem because we reviewed 60,640 medical records. In the USA, the actual incidence of child abuse is at least 10 times more than that actually reported [3]. In Kuwait, parents, the perpetrators in 75% of our cases, have the full authority to refuse admission and to discharge their children before the diagnosis is verified and management proceedings started. Furthermore, sexual abuse is rarely if ever voluntarily reported, and when accidentally discovered, as in our 2 cases, families tend to refuse any further action to avoid stigmatization, shame and disgrace. In addition, childhood injuries are treated in adult surgical emergency departments, where the number of abuse cases missed may be substantial.

The principal findings in this study (tables 1–4) are essentially similar to those reported in developed countries [2, 3], the inclusion of ‘mild cases’ reflects an increased awareness after the initial report from Kuwait [4] and Saudi Arabia [5–8]. We continue, however, to see serious brain injuries (38%) and bone fractures (23%), and a fatality rate of 12%. The diagnosis of Munchausen syndrome by proxy was made only after the child died, reflecting the inherent difficulties in making such a diagnosis [17]. This type of diagnosis was also made in 6 of 30 cases of child abuse reported from Saudi Arabia [5–7]. The outcome of this study was successful in 7 cases (table 4). This was primarily through supportive family intervention by the paediatrician and the social worker. Further abuse is considered probable in 6 more cases, as there is currently no legislation to enforce preventive proceedings. As reporting to the police is mandated by law, the paediatrician is torn between protecting himself, or acting as the primary advocate for child protection [9].

The paediatrician working in a developed country is helped by guidelines and legislations; he can report to a child protection agency and follow juvenile court proceedings for temporary or final placement [9, 10]. This is particularly mandatory with severe abusive behaviour that is less amenable to supportive family interventions [18]. The outcome, however, is not as bright as thought by some [19], as it is believed that legislation and proceedings still fall short of offering full protection for severely abused children [9, 10, 18]. However, the virtual absence of these guidelines and legislation in Kuwait calls for a

greater role on the part of the paediatrician working in such circumstances and highlights the importance of the suggestion made by Jellinek et al. [9] that ‘reporting should be followed by advocacy’.

Temporary or permanent exclusion of a child from an abusive environment is the central issue in procedures aimed at child protection [10]. In the West, the problem is sometimes solved by adoption. However, adoption, as practiced in these countries, is not acceptable under Islamic law; rather fostering is preferred because the child will continue to carry the name of his biological father [20] and can be arranged with an extended family as a temporary measure. However, as a final measure, children may be placed in special children’s homes already established in Kuwait.

We suggest the establishment of a National Child Protection Committee to deal with child abuse in all hospitals. This organization should include paediatricians, social workers and representatives from the police and judicial system as well as from the Ministries of Islamic and Social Affairs. Supportive facilities already in place include Al-Zakat house and the Patient Helping Trust. In cases where supportive family intervention proves unsuccessful, the police representative should call for a court proceeding. The presiding judge would provide alternatives for family treatment rather than a punitive verdict. Meanwhile, a placement order could be taken and enforced. Supportive family intervention at different levels would aim at ‘healing’ the circumstances that led to child abuse before any attempt at returning the child to his biological parents would be undertaken. These arrangements may be suitable for other Muslim countries and in other countries where Muslims are a minority.

Conclusion

Child abuse exists in Kuwait and is probably underreported. Management proceedings are far from satisfactory, lacking urgently needed guidelines and legislation.

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