

Editorial

Getting away with it: the extent of violence against children

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Spring 2009 saw the publication of the long-awaited report of the Commission to Inquire into Child Abuse (CICA), relating to child abuse in homes run by the Roman Catholic Church in Ireland from around the mid-1930s to the present day, but particularly between 1936 and the 1970s (Commission to Inquire into Child Abuse, 2009). During that period, children who were orphaned, abandoned, unwanted or deemed to be in need of care and protection were placed in residential schools run by priests or members of religious orders, either nuns or monks. The schools were known as 'industrial schools', and were intended to provide an education that would enable the children to find employment. However, once at the schools, these children were physically, emotionally and sexually abused until they reached the age of 14 years, when they were able to leave and find work. Survivors who gave evidence to the Commission reported that the slightest misdemeanour was punished by violent beatings that were out of all proportion to the offences that had been committed. Sometimes beatings took place for no reason at all. In the Artane Industrial School, which was run by the Congregation of Christian Brothers, every Brother had the right to beat a child with whatever came to hand (boots, fists, or the leg of a chair), and it was not unusual for several Brothers to participate in administering such beatings (BBC, 2009a). Moreover, beatings often took place in front of or 'within earshot of other children ... as a means of engendering fear and ensuring control' (Commission to Inquire into Child Abuse, 2009). This violent culture extended to the children themselves, leaving younger and weaker ones exposed to unchecked bullying and abuse by older residents. This scenario was replicated in many other schools investigated by the Commission.

Other forms of abuse also took place. For example, Beechpark Industrial School, run by the Daughters of Liege, had a policy of preventing deaf children from

using signs, and forcing them to learn to speak. The Commission noted that the methods of enforcing this 'were at times too severe' (Commission to Inquire into Child Abuse, 2009). Sexual abuse was also common, particularly in boys' schools. At Lota, for example, which was run by the Brothers of Charity for boys with special needs, a Brother who was known to have committed sexual offences in England was assigned a teaching post at the school. This was not unusual. Individuals who were known to be sexual abusers were moved around from one school to another. One member of the Congregation of Christian Brothers was allowed to teach in six different schools, and any attempt to challenge his behaviour simply resulted in another move (Commission to Inquire into Child Abuse, 2009).

How could this have happened? To begin to answer this question requires some understanding of Ireland between the mid-1930s and the mid-1970s. It was a very poor country in which the majority of children grew up knowing that they would have to leave Ireland and go abroad in order to earn a living. Ireland, a fairly new republic, functioned as an authoritarian and theocratic state in which the Church held power over daily life at all levels, over and above that of the elected government (McCluskey, 2000; Kearns, 2004). The two institutions worked together to create and uphold what they regarded as a pure Irish society: 'the dominant philosophy at the time, constructed by the state, articulated by the Church and upheld by the people was that outside [Ireland] was bad, inside was pure' (McWilliams, 2006, p. 31). Thus Ireland was a closed society in which many things were neither questioned nor discussed. To protest about the treatment of children would have been to challenge the twin pillars of Irish society, and to invite social, political and, above all, religious condemnation that could make the protester an outcast both in this world and in the next. Nevertheless, people did complain. Not everyone in

Ireland was a violent child abuser, and some children themselves complained after they had left the schools. Some of the religious orders even kept records. The Congregation of Christian Brothers maintained records known as the Rome Files, but 'complaints were not handled properly and the steps taken by the Congregation to avoid scandal and publicity protected perpetrators of abuse. The safety of children was not a priority at any time during the relevant period' (Commission to Inquire into Child Abuse, 2009). Some religious orders, such as the Rosminian Order, were more inclined to accept that abuse had taken place, whereas others, such as the Sisters of Mercy, maintained no records and could deny any involvement (Commission to Inquire into Child Abuse, 2009).

The Church, rather than the state, was the main provider of social care through religious orders of monks, nuns and priests who enjoyed high social status that was reflected on their families. Thus a son or daughter who joined an order brought prestige to their family, especially their parents. Therefore it is probable that at least some young people found themselves entering convents and monasteries for a way of life for which they were deeply ill suited, but from which they were unable to escape. Children became the victims of their anger and frustration especially as, at that time, children were regarded as intrinsically evil and in need of discipline from parents, teachers and anyone else responsible for their care (McCluskey, 2000). Families were often large, which meant that the bonds between parents and children were not always as close as might be expected among those more familiar with life in nuclear families (McWilliams, 2006). What would now be considered violent and cruel by many was a normal part of everyday life, even for those children who were brought up by their parents.

However, these explanations do not answer the question of how and why children in industrial schools were abused. The simple answer is, of course, that adults abused children because they could, and they continue to do so in all parts of the world 'because there is no authority to say no, there is no calling to account of those in power, there is no independent scrutiny, and there is no recourse to independent protection' (Black, 2009). As a species, humans have an appalling record of ill treatment of their young. Reports from countries as far apart as Peru, Haiti and the Philippines show that child domestic workers are subjected regularly to beatings, rape, harassment, and denial of food (UNICEF, 2006). Perpetrators of abuse share the same characteristics, regardless of the country in which they operate. They hold positions of power, and use settings in which the child is isolated from other adults who might intervene or object. They find children an attractive target because they have limited ability to physically resist abuse, and have no power when it comes to complaining (UNICEF, 2006). Adults,

it would seem, abuse because they can and because they believe that they can get away with it, and get away with it they did in Ireland. To date no one has been prosecuted in connection with abuse in industrial schools, and the religious orders have issued no apology, although the Irish government has done so (BBC, 2009a). However, a number of priests have been convicted, and more prosecutions are likely in the wake of the most recent report on child abuse in the Archdiocese of Dublin (Sharrock, 2009). A redress committee was set up to enable survivors of child sexual abuse to tell their stories and receive compensation, but this has proved nerve-racking for many extremely damaged people. Only 10% of the fund for compensation has been provided by religious orders; the Irish taxpayer has had to provide the rest. Very few survivors have had the stamina and determination to pursue what they really want, namely justice and an apology from the Church and the state.

Ireland features again in our first editorial about abortion in both the Republic of Ireland and Northern Ireland. In both countries, terminations are extremely difficult to obtain, possibly, as Ann Rossiter suggests, because of the influence of the Catholic and Protestant churches and the traditional value placed on children in large poor agricultural families. However, in both countries, religious and social systems have a history of inflicting cruelty on women, particularly with regard to sexual matters. Sexual, physical and emotional abuse meant that, in the past, many women had more children than they could provide for and grew old before their time (Kearns, 1994, 2004). Injustices continue as both countries sidestep the issue of what to do about unwanted pregnancies, preferring to export the problem to other European states and leave the women to be looked after by strangers.

Justice for all is an important theme in this issue of *Diversity in Health and Care*. Patrick Vernon presents a manifesto from Afiya Trust, an association that campaigns for health equality on behalf of black and minority ethnic people, and which has played a significant role in developing and managing the National Black Carers and Carers Workers Network. This organisation developed the first BME Carers' Manifesto, and has gone on to develop this approach. Caring for someone means doing with or for them all those tasks that they would perform for themselves if they had the ability, strength or knowledge (Henderson, 1966). It is one of the standard conceptualisations of professional nursing and requires huge amounts of patience, compassion, technical knowledge and skill. Unfortunately, it seems to be widely believed by health and social care service planners that caring is something that anyone can do. It isn't, but to their credit many carers, who have no professional expertise, cope 24 hours a day, 7 days a week, 52 weeks of the year with no prospect of an end in sight. Some do so willingly, others because

they feel they have no choice; no one else will take on their role and they cannot simply abandon the person for whom they care. Carers perform valuable work in enabling so many people to avoid hospital or residential care; they deserve respect, recognition and support for their efforts.

The pain and suffering we have drawn attention to here requires some redress and in this context we are pleased to welcome our first editorial from Saudi Arabia, in which Sawsan Majali presents a thoughtful appraisal of the pain and suffering people inflict on one another, destroying each other's humanity and reducing each other to nothing. She calls on health and care professionals to use their skills compassionately to alleviate suffering and promote healing, something that the world badly needs.

Our first two papers concern another type of justice, namely equitable access to services. First, Karl Atkin and his colleagues present the results of their qualitative research about the difficulties experienced by South Asian women in the UK when they try to find out whether they have a genetic susceptibility to breast cancer. As in other health and social care settings, poor communication emerged as a key factor. Time and again we learn that professionals dominate consultation sessions, using the time to gather the information that they require, rather than to really listen to what the patient has to say. Professionals seem to be adept at selectively engaging with patients when what is really needed is *presencing*, whereby they give patients their full attention (Benner, 1984). This is particularly needed in situations in which the patient and the professional do not share a common language. Once again it is made obvious that interpreting is a skilled professional role and not something that can easily be undertaken by relatives or friends.

Alexander Bischoff and his colleagues researched access to cancer screening services by Swiss nationals and members of minority ethnic groups (Portuguese, former Yugoslavian, Spanish, French, Italian and German) in Switzerland. This was a secondary analysis of data collected in the Swiss Health Survey, a telephone survey of 19 706 people residing in Switzerland. A total of 10 046 women were asked if they had ever undergone cervical screening. The findings showed that Swiss nationals and German women were far more likely to have had cervical screening than women in any of the other groups. The discovery that the majority of women from ethnic minorities are less likely than nationals to undergo screening is not new, but this paper adds to the body of discourse on this subject in that, to our knowledge, the subject has not previously been examined in the Swiss context.

Our third paper addresses justice from a different perspective, namely that of disfigurement. The qualitative study by Andrew Thompson and Lucy Broom shows that people who are visibly different encounter

prejudice and discrimination in every aspect of daily life. Adults who should know better stare at and pass remarks about the appearance of individuals with disfigurement, without any apparent thought for the consequences of their behaviour. In our professional experience the effects of such remarks can be devastating. One of us used to be in charge of a rehabilitation unit in which it was normal practice to take residents shopping or out for a walk. Complete strangers would think nothing of saying 'Does that mean you've got VD?' to a young woman with facial disfigurement. Frequently, the member of staff accompanying a resident would be told that the disfigured person should be 'locked up for looking like that.' Indeed, in our last editorial we had occasion to comment on the public response to a BBC CBeebies presenter who was born with one hand (Johnson and McGee, 2009). As a result of such behaviour, participants in the study reported here had to develop coping strategies that could range from covering up the affected area with clothing or make-up, to ignoring the perpetrator, or engaging in aggressive behaviour. Although some of these coping strategies may not be entirely appropriate, they are understandable and forgivable when considered in the context of the daily distress engendered by a thoughtless and cruel public.

In our fourth research paper, Michael Clark and his colleagues present their research findings about the UK's transplant allocation policy to prioritise younger adults and those who have been waiting a long time for a transplant. Theoretically this policy benefited members of minority ethnic groups in which there are few people registered as kidney donors. This study set out to examine whether this change was in fact what people wanted. The findings strongly suggest that it was not. Ethnicity appears to have been a crucial factor. Black ($n = 69$) and South Asian participants ($n = 50$) did not favour the new priority given to young people or those with moderate disease, nor did they tend to give greater priority to good tissue matching. This paper shows that there are conflicting views about what constitutes social justice for those who require a kidney transplant, and it presents some thought-provoking information for service planners whose job it is to provide an equitable service with the limited number of kidneys available.

Our final paper concerns groups of people for whom social justice has long been an issue, namely those who are gay, lesbian or bisexual. In many countries simply being who they are is illegal and thus punishable in a variety of ways, which include execution. In liberal societies such as the UK it is easy to assume that most of the battles have been won but, as recent events in California have reminded us, what is given by one administration can easily be revoked by the next (BBC, 2009b). Consequently, gay people who thought that they had won the right to civil partnerships now find

that right withdrawn, and approximately 18 000 couples are in legal limbo. Mary Pennant's systematic review shows that, in the UK, people who are gay, lesbian or bisexual still do not receive the same standard of healthcare as the heterosexual population. Many do not come out at all to health professionals, but those who do so run the risk of experiencing homophobia and discrimination. In fairness, some health professionals do recognise their lack of expertise, so perhaps they will now make the effort to learn more in order to provide safe, meaningful and effective healthcare. In this they may be aided by the recent creation of 'In the Pink', a training resource (available from Leicester PCT or the Leicester LGB Centre at www.llgbc.com).

In our regular 'Did you see?' section, Amilton Santos challenges the prevailing orthodoxies in teaching about cultural competence in medical education. This paper is all the more welcome because it brings a Brazilian perspective to the journal. We have so far received very few papers from the Central or South American countries, and we hope that this will be the first of many about health and care in those regions. Readers who would like to contribute to the 'Did you see?' section should contact Dr Nisha Dogra (ndl13@le.ac.uk). Finally, in our regular 'Knowledgeshare' section, Professor Lorraine Culley presents a range of resources and information that will, we are sure, be of interest to our readers. Readers who wish to contribute to the 'Knowledgeshare' section should contact Lorraine directly (lac@dmu.ac.uk).

In closing, we are pleased to announce that in 2010 we shall produce a special supplement on black African men in the UK and HIV/AIDS. Dr Martha Chinouya from the London School of Tropical Medicine and Hygiene has agreed to act as guest editor. Martha has an established portfolio of research about black African people, particularly Zimbabweans, and HIV/AIDS. She will, we are sure, bring considerable expertise to this special supplement. A call for papers for both the

supplement and Volume 7 of *Diversity in Health and Care* will be published shortly.

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