Dicle Tıp Dergisi / Dicle Medical Journal 2011; 38 (1): 121-127

REVIEW ARTICLE / DERLEME

Child maltreatment: Abuse and neglect

Çocuklara kötü muamele: İstismar ve ihmal

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Geliş Tarihi / Received: 04.103.2010, Kabul Tarihi / Accepted: 28.12.2010

ABSTRACT

Each year, millions of children around the world are the victims and witnesses of physical, sexual and emotional violence. Child maltreatment is a major global problem with a serious impact on the victims' physical and mental health, well-being and development throughout their lives and, by extension, on society in general. Family physicians who are involved in the care of children are likely to encounter child abuse and should be able to recognize its common presentations. There is sufficient evidence that child maltreatment can be prevented. The ultimate goal is to stop child maltreatment before it starts.

In this paper, the characteristics of the perpetrators and victims of child maltreatment, maltreatment types, risk factors, differential diagnosis and discuss about strategies for preventing were summarized.

Key words: Child maltreatment, child abuse, neglect

ÖZET

Dünyada her yıl milyonlarca çocuk fiziksel, cinsel ve duygusal zorbalığa hedef veya şahit olarak maruz kalmaktadır. Çocuklara kötü muamele kurbanların fizik ve mental sağlığı, iyilik durumu ve gelişimi üzerinde hayat boyu süren ve sonuçta genel olarak topluma da ciddi etki eden büyük yaygın bir sorundur. Çocukların bakımı ile ilgilenen aile hekimleri olasılıkla çocuk istismarı ile karşılaşacaklardır ve çocuk istismarının genel belirtilerini tanımaları gerekir. Çocuk istismarının önlenebileceğine dair yeterli kanıt mevcuttur. Esas amaç çocuk istismarını başlamadan durdurmaktır. Bu yazıda, çocuk istismarı yapan ve istismara maruz kalanların tipik özellikleri, istismar tipleri, ayırıcı tanı ve önlem için uygulanacak stratejiler özetlenmiştir.

Anahtar kelimeler: Çocuklara kötü muamele, çocuk istismarı, ihmal

INTRODUCTION

Every child, anyone who has not yet reached their 18th birthday, has the right to live a healthy life free from violence. Each year, millions of children around the world are being the victims or witnesses of physical, sexual or emotional violence.[1]

Family physicians who are involved in the care of children are likely to encounter child abuse and should be able to recognize its common presentations. A multidisciplinary approach is recommended to adequately evaluate and treat victims of child abuse; however, family physicians have the responsibility to recognize and treat these cases at first presentation as to prevent significant morbidity and mortality.[2]

DEFINITIONS

Child maltreatment

Child maltreatment is defined as, all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[3]

The perpetrators of child maltreatment may be parents and other family members; caregivers; friends; acquaintances; strangers; others in authority – such as teachers, soldiers, police officers and clergy; employers; health care workers or other children.[1]

As already stated, the World report on violence and health and the 1999 WHO Consultation

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on Child Abuse Prevention distinguish four types of child maltreatment: physical abuse, sexual abuse, emotional and psychological abuse, neglect.

Physical abuse

Physical abuse of a child is defined as the intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating. Much physical violence against children in the home is inflicted with the object of punishing.[1],[4] Table 1 shows the clues in the evaluation of inflicted trauma in children[2]:

Table 1. Clues in the evaluation of inflicted trauma in children

Suspect inflicted trauma if the answer is yes to any of the following questions:
Is there an unusual distribution or location of lesions?
Is there a pattern of bruises or marks?
Can a bleeding disorder or collagen disease be ruled out as a cause of lesions?
If there is a bite or handprint bruise, is it adult size?
If there is a burn, are the margins clearly demarcated with uniform depth of burn?
If there is a burn, is there a stocking and glove distribution?
Are there lesions of various healing stages or ages?
Is the reported mechanism of injury inconsistent with the extent of trauma?

Sexual abuse

Sexual abuse is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society.

Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim.[1]

Emotional and psychological abuse

Emotional and psychological abuse involves both isolated incidents, as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. Acts in this category may have a high probability of damaging the child's physical or mental health, or its physical, mental, spiritual, moral or social development. Abuse of this type includes: the restriction of movement; patterns of belittling, blaming, threatening, frightening, discriminating against or ridiculing; and other non-physical forms of rejection or hostile treatment.[1]

Neglect

Neglect includes both isolated incidents, as well as a pattern of failure over time on the part of a parent or other family member to provide for the development and well-being of the child – where the parent is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions.[1]

The scale of the problem

According to WHO, in the year 2002 an estimated 31 000 deaths were attributed to homicide among children less than 15 years of age.[1] In the United States, 905,000 children were victims of maltreatment in 2006 and 1,530 of them died from abuse and neglect.[5]

It is possible for child deaths due to maltreatment to be missed for this reason these estimates underestimate the true number of deaths from child maltreatment.[1]

Data from various reporting sources, however, indicate that improved reporting could lead to a significant increase in the number of cases of child abuse substantiated by child protection agencies.[6]

Table 2 shows the incidence of reported cases of child abuse in 2008:

Table 2. Victims of each type of abuse during 2008[(7)]

Type of abuse	Percent of total
Neglect	71,1
Physical abuse	16,1
Sexual abuse	9,1
Psychological maltreatment	7,3
Medical neglect	2,2
Other	9,0

Note: These percentages total more than 100% because if a child fell into more than one category each maltreatment type was counted accordingly.

VICTIMS

Global estimates of child homicide suggest that infants and very young children are at greatest risk, with rates for the 0–4 year age group more than double those for 5–14-year-olds.[1] Furthermore; infants and pre-school children are at the greatest risk of fatal maltreatment as a result of their dependency, vulnerability and relative social invisibility.[8]

Homicide is the fourth leading cause of death in children from one to four years of age and the third leading cause of death in children from five to 14 years of age. Neonaticide (i.e., the murder of a baby during the first 24 hours of life) accounts for 45 percent of children killed during the first year of life.[9]

It is generally accepted that deaths from maltreatment are underreported and that some deaths classified as the result of accident and sudden infant death syndrome might be reclassified as the result of child abuse if comprehensive investigations were more routinely conducted.[9]

Figure 1 shows the number of deaths from maltreatment (including 'undetermined') over five years per 100,000 children throughout the OECD countries as a whole.[10]

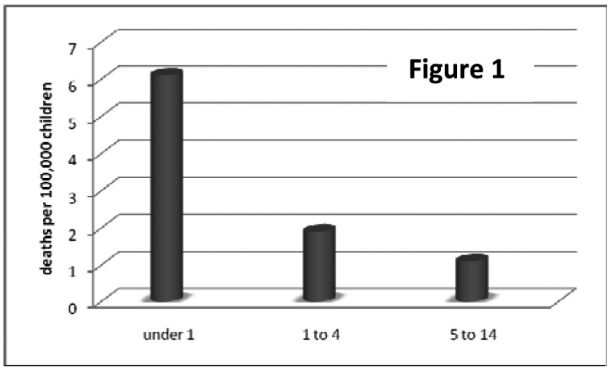

Figure 1. Deaths from child maltreatment over five years in OECD countries

CLUES TO DIAGNOSE CHILD MALTREATMENT

The most important information leading to a diagnosis of physical abuse is obtained through the medical history. Certain "red flags" in the medical history should raise the possibility of a diagnosis of child abuse.[11,12] For example; if the history provided by the caregiver does not explain the child's injuries, the history changes over time, the history of self-inflicted trauma does not correlate with development, or if there is an inappropriate delay in seeking care; the physician should be alert for the possibility of abuse.[2]

The diagnosis of abuse should be pursued if there are injuries to multiple areas, injuries in various stages of healing, or suspicious injury patterns. Bruises, bites, burns, fractures, abdominal trauma, and head trauma are the most common physical findings. Injuries considered suspicious for inflicted injury include posterior rib fractures; retinal hemorrhages; metaphyseal or complex skull fractures in infants; long bone fractures in children younger than two years; scapular, spinous process, and sternal fractures; and cigarette burns. Subdural hemorrhages in infants are highly suggestive of inflicted trauma. The American Academy of Orthopaedic Surgeons states that there is no pathognomonic fracture pattern in abuse. Transverse fractures are the most common type of fracture, regardless of etiology, and femoral spiral fractures are no more common in inflicted injuries than in noninflicted ones.[2]

PERPERATORS

Nearly 80 percent of perpetrators were parents.[10] Figure 2 shows the perpetrators of physical abuse of children. The data show the percentage of perpetrators and are for substantiated cases of physical abuse in Canada in 1998. Only cases where the perpetrator was a relative are included.[10]

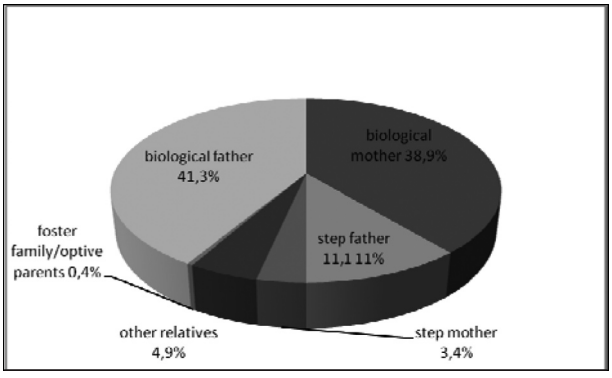

Figure 2. The perpetrators of physical abuse of children[10]

Causes of chills abuse

Authors produced the "ecologic" model which views child abuse within a system of risk and pro-

tective factors interacting across four levels: [1] the individual, [2] the family, [3] the community and [4] the society.[1] We discussed about the factors that contribute to the child abuse and neglect below.

RISK FACTORS FOR CHILD MALTREATMENT: [11,12,13]

Risk factors in parents and caregivers

These include the parent or caregiver who:

• has difficulty bonding with a newborn child-as a result, for example, of a difficult pregnancy, birth complications or disappointment with the baby;

• does not show nurturing characteristics towards the child;

• was maltreated as a child;

• displays a lack of awareness of child development or has unrealistic expectations that prevent understanding the child's needs and behaviours - for instance, interpreting the child's perceived misbehaviour as intentional, rather than as a stage in its development;

• responds to perceived misbehaviour with inappropriate, excessive or violent punishment or actions;

• approves of physical punishment as a means of disciplining children, or believes in its effectiveness;

• uses physical punishment to discipline children;

• suffers from physical or mental health problems or cognitive impairment that interfere with the ability to parent;

• shows a lack of self-control when upset or angry;

• misuses alcohol or drugs, including during pregnancy, so that the ability to care for the child is affected;

• is involved in criminal activity that adversely affects the relationship between parent and child;

• is socially isolated;

• is depressed or exhibits feelings of low self-esteem or inadequacy – feelings that may be reinforced by being unable to fully meet the needs of the child or family;

• exhibits poor parenting skills as a result of young age or lack of education;

• experiences financial difficulties.

Risk factors in the child

Saying that certain risk factors are related to the child does not mean that the child is responsible for the maltreatment she/he suffers, but rather that it may be more difficult to parent because she/he:

• was an unwanted baby or failed to fulfill the parent's expectations or wishes – in terms, for instance, of its sex, appearance, temperament or congenital anomalies;

• is an infant with high needs – one, for instance, who was born prematurely, cries constantly, is mentally or physically disabled, or has a chronic illness;

• cries persistently and cannot be easily soothed or comforted;

• has physical features, such as facial abnormalities, that the parent has an aversion to and reacts to by withdrawing from the child;

• shows symptoms of mental ill-health;

• demonstrates personality or temperament traits that are perceived by the parent as problematic – such as hyperactivity or impulsivity;

• is one child out of a multiple birth, which has taxed the parent's ability to support the child;

• has a sibling or siblings – possibly close in age – who are demanding of parental attention;

• is a child that either exhibits or is exposed to dangerous behaviour problems – such as intimate partner violence, criminal behaviour, self-abusive behaviour, abuse towards animals, or persistent aggression with peers.

Community risk factors

Characteristics of community environments that are associated with an increased risk of child maltreatment include: tolerance of violence, gender and social inequality in the community, lack of or inadequate housing, lack of services to support families and institutions and to meet specialized needs, high levels of unemployment, poverty, harmful levels of lead or other toxins in the environment, transient neighbourhood, the easy availability of alcohol, a local drug trade, inadequate policies and programs within institutions that make the occurrence of child maltreatment more likely.

DIFFERENTIAL DIAGNOSIS AND LABORATORY EVALUATION

Evaluating suspected child abuse is a challenging task, and an incorrect diagnosis of child abuse can be as devastating to a family as the impact of missing a diagnosis of abuse can be to a child. A brief list of the many medical conditions that may mimic child abuse is given in the Table 3.[12]

Because organic and medical causes should be considered in the differential diagnosis of suspected physical abuse, ancillary studies that assist in a full medical evaluation should be performed (Table 4).[2]

Table 3. Differential diagnosis of child abuse[12]

Hematologic
Hemophilia, Idiopathic thrombocytopenic purpura,
Von Willebrand's disease, Henoch-Schönlein purpura
Dermatologic
Phytophotodermatitis, Mongolian spots
Vascular malformations, Subcutaneous fat necrosis
Infectious
Bullous impetigo, Staphylococcal scalded skin syndrome
Petechia or purpura from systemic bacterial or viral infections
Metabolic congenital
Osteogenesis imperfecta, Ehlers-Danlos syndrome, Rickets
Insensitivity to pain disorders
Accidental trauma
Toddler's fracture, Stress fracture

Table 4. Recommended and Optional Studies for Physical Abuse Evaluation

Study	Indication
Recommended for most patients	
Dilated, indirect ophthalmoscopy performed by an ophthalmologist	To detect retinal hemorrhages in children younger than two years
Head CT	To detect subarachnoid, subdural, or intraparenchymal injury
Laboratory evaluation: amylase, complete blood count, hepatic transaminases, lipase, partial thromboplastin time, prothrombin time, fecal occult blood test, urinalysis, and urine toxicology	To detect genitourinary or abdominal trauma and to ensure no underlying blood disorder
Skeletal survey radiography (e.g., of the spine, extremities, skull)	Suspected old or new fracture
Optional	
Abdominal CT	If history, examination, or laboratory results suggest abdominal trauma
Bone scan	To find occult fractures up to two weeks after injury
Dental consultation	If there is a bite present, dentists can determine the source
Magnetic resonance imaging of the head	If CT of the head is inconclusive

CT = computed tomography.

THE CONSEQUENCES OF CHILD ABUSE

Health burden

Ill health caused by child abuse forms a significant portion of the global burden of disease. While some of the health consequences have been researched, others have only recently been given attention, including psychiatric disorders and suicidal behavior. Importantly, there is now evidence that major adult forms of illness – including ischaemic heart disease, cancer, chronic lung disease, irritable bowel syndrome and fibromyalgia – are related to experiences of abuse during childhood.[11] Table 5 shows the health consequences of child abuse.[11]

Table 5. Health consequences of child abuse

Physical
Abdominal/thoracic injuries Brain injuries Bruises and welts Burns and scalds
Central nervous system injuries Disability Fractures Lacerations and abrasions
Ocular damage
Sexual and reproductive
Reproductive health problems, Sexual dysfunction, Sexually transmitted diseases, including HIV/AIDS
Unwanted pregnancy
Psychological and behavioural
Alcohol and drug abuse, Cognitive impairment
Delinquent, violent and other risk-taking behaviours
Depression and anxiety, Developmental delays, Eating and sleep disorders
Feelings of shame and guilt, Hyperactivity, Poor relationships
Poor school performance, Poor self-esteem, Post-traumatic stress disorder
Psychosomatic disorders, Suicidal behaviour and self-harm
Other longer-term health consequences
Cancer, Chronic lung disease, Fibromyalgia, Irritable bowel syndrome
Ischaemic heart disease, Liver disease
Reproductive health problems such as infertility

THE PREVENTION OF CHILD MALTREATMENT

There is sufficient evidence, including in the scientific literature, to state with full confidence that child maltreatment can be prevented. Despite this, little attention in terms of research and policy has been given to prevention.[1]

The ultimate goal is to stop child maltreatment before it starts. Primary prevention is defined as both the prevention of disease before it occurs and the reduction of its incidence. Strategies that support parents and teach positive parenting skills are very important. Positive parenting skills include good communication, appropriate discipline, and responding to children's physical and emotional needs. Programs to prevent child maltreatment also improve parent-child relationships and provide parents with social support.[14]

Programs for parents can take many different forms. They may occur in parents' homes, in schools, in medical or mental health clinics, or in other community settings. Programs may involve one-on-one or group sessions.[14] Table 6 shows the strategies for preventing child abuse.[14]

Conclusions and recommendations

Child maltreatment is not a simple problem with easy solutions. Significant improvements in prevention, child protection and treatment, though, are not beyond reach.

Although child abuse is a pervasive and complex problem with many causes, we should not take a defeatist attitude toward its prevention. Despite the absence of strong evidence to guide our preventive efforts, physicians can do many things to try to prevent abuse. At the very least, showing increased concern for the parents or caregivers and increasing our attempts to enhance their skills as parents or caregivers may help save our most vulnerable patients from the nightmare of abuse and neglect. [9]

Family physicians who suspect physical abuse are mandated to make a report to the state child protective services agency and to assure the ongoing safety of the child. Documentation in the medical record should be done with great care, because the record may become evidence in a criminal prosecution.[12]

Physicians' awareness, knowledge and motivation is so important to diagnose child abuse.[15] Family physicians should be aware of the risk factors for child abuse and possible interventions that could prevent it.

Table 6. Strategies for preventing child abuse

Office strategies
• Diagnose pregnancy in unmarried mothers and explore its impact with them.
• Assess the number of stressors on new parents, including: --Social support --Financial situation
--Marital status --Level of education --Number of children
• Identify families with problems of:
--Substance abuse --Domestic violence --Mental health
• Offer new parents:
--Services of a social worker --Long-term home visitation
--Parenting classes
• Educate new parents regarding:
--Developmental tasks of childhood --Age-appropriate anticipatory guidance
--Nutrition and feeding problems --Safety --Discipline
• Discourage corporal punishment
• Provide:
--Evening and weekend office hours for single or working parents
--Payment schedules for the working poor and the working underinsured that make it easier for them to pay for the care they receive
--Care for some Medicaid and indigent patients
--A readily available list of social service agencies and their telephone numbers
• Survey parents to identify health issues that are of interest to them.
Community, state and federal strategies
• Support universal health care for children.
• Advocate for quality, affordable and universally available child care.
• Advocate for community respite care for parents.
• Advocate for community alcohol and drug treatment, mental health, and spouse and child abuse centers.

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