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How important is it?

Child maltreatment is comprised of all abusive or neglectful actions committed by adults against minors. Maltreatment can be classified into the five following types.

1. Physical abuse represents any deliberate use of physical force against a child that constitutes a threat to the child’s health, development, and self-respect. The range varies from milder forms of violence (e.g., pushing and shoving) to more severe forms (e.g., strangling and hitting).

2. Child sexual abuse (CSA) encompasses any completed or attempted sexual act, including both contact and non-contact interactions, committed against a child by a caregiver.

3. Neglect involves failure to meet a child’s basic needs, including physical, emotional, medical/dental, or educational needs; failure to provide adequate nutrition, hygiene, shelter; or failure to ensure a child’s safety.

4. Emotional maltreatment includes caregiver actions that result in, or has the potential to result in adverse effects on the child’s emotional health and development. Caregiver behaviour can take various forms on the part of the caregiver including: rejection, isolation, ignoring, terrorizing, corruption or exploitation.

5. Exposure to intimate partner violence (IPV) has also been considered a form of maltreatment because children who are exposed to IPV (also referred to as domestic violence) display similar problems as children who are the direct target of physical abuse.

Worldwide estimates reveal that approximately 40 million children are currently the victims of maltreatment, with neglect being the most commonly reported form. Recent increases in the reported rates of neglect and IPV exposure have been attributed to new powers and a wider scope of activity of professionals working with children, as well as their improved ability to detect maltreatment. In contrast, the reported rates of child sexual abuse (CSA) have been on the decline, but the reason is unclear; this may reflect an actual reduction, perhaps due to the success of prevention programs, but could also be attributed to an increasing reluctance of victims to report the abuse, or more restrictive criteria to identify CSA. In fact, a recent meta-analysis measuring the prevalence of CSA around the world, estimated nearly 13% of adults self-report as having been the victims of CSA, a rate which is 30 times higher than the one of official disclosures.

Child maltreatment in any form causes long-lasting harm to children’s health and development, and in the United States alone carries a yearly estimated direct and indirect cost of over $100 billion in services to recognize the abuse, intervene, and address its detrimental effects.

What do we know?

Maltreated children are at risk for a multitude of health problems such as growth, development and chronic
physical and mental health conditions that extend into adulthood. Substance abuse and criminality in adolescence and adulthood are also frequently observed in these individuals. The effects of maltreatment and associated risk factors vary as a function of the type of child maltreatment.

Physical abuse

The most direct consequences of physical abuse are injuries, serious ones involving head trauma and damage to internal organs; injuries such as bruises visible on the skin are the most common ones. Poverty, single-parent family, early pregnancy, domestic violence, and mental health problems are all considered environmental risks for this form of abuse. Although physical abuse is most frequent in older children, deaths caused by physical abuse are much higher in infancy and toddlerhood. The rate of death increases when the child lives with an unrelated adult, but overall has been consistently dropping over the past three decades.

Child sexual abuse (CSA)

Although clinical symptoms of CSA are not apparent in 1/3 of victims at the time the abuse is reported, CSA victims are at risk of experiencing mental health problems, including post-traumatic stress disorder, depression, substance abuse and dissociative symptoms (feeling that one’s conscious experience is disconnected from one’s environment, body, or emotions). Risky unprotected sex is also common among victims. In adulthood, CSA victims often continue to deal with mental health problems, are prone to involvement in violent relationships, and women are 2 to 3 times more likely to be sexually assaulted. Girls experience a twofold risk of CSA compared with boys, but this may be because boys are reticent to disclose the abuse. CSA occurs more frequently among adolescents between 12 and 17 years of age, though girls tend to be molested at a younger age and for longer than boys. Support from the parent who is not the perpetrator and no prior history of abuse have been identified as protective factors that can help children cope with the abuse.

Neglect

Unlike abuse, neglect is typically not committed intentionally, and often results from problems that impair a parent’s ability to meet a child’s needs. However, the negative consequences of neglect can be as damaging as those of abuse, especially when it is severe, chronic, and when it occurs early in life. Neglected children are at-risk for experiencing physical and mental health problems. In preschool and school-age children, social withdrawal, negative peer relations, academic difficulties, and depression are more common among neglected children relative to abused victims. As adults, they show similar risk of involvement in violence relationships compared with those who were physically abused.

Emotional maltreatment

This form of maltreatment is difficult to determine and document as it is less visible in its impact. Children exposed to emotional maltreatment can experience chronic stress that leads to physical and/or emotional impairment, such as risk behaviours (e.g., alcohol abuse) and early and persistent psychiatric disorders.

Exposure to intimate partner violence (IPV)

Even when exposure to IPV does not lead to clinical maladjustment, it may cause small distortions (ex.
favorable attitudes toward violence) that predispose children to experience more severe problems later on (e.g. believing that one is the cause of domestic violence, becoming violent themselves). Compared to children in non-violent households, those exposed to IPV are more aggressive and anxious, and they experience more problems with peers and at school. Children under 5 years of age are the most likely to be exposed to IPV because domestic violence is more common among couples with children in this age group. Unfortunately, these children are particularly vulnerable to the damaging effects of IPV because of their restricted coping skills and understanding of conflict.

What can be done?

Prevention and intervention

The key to reduce child maltreatment is a strong focus on prevention. Strategies used to prevent the occurrence of maltreatment have been grouped into three major categories.

1. Prevention before occurrence; these include universal and targeted programs. The best evidence is for the Nurse Family Partnership, an intensive program of nurse home visitation provided to first-time socially disadvantaged mothers. Another home visiting program – Early Start – and a parenting program – Triple P – are promising, but need further evaluation to determine their effectiveness. Hospital-based educational programs to prevent abusive head trauma are also promising, but need further study. Enhanced pediatric care for families of children at risk of physical abuse and neglect is also promising, but requires further assessment.

2. Prevention of recurrence is much more challenging; one program - Parent-Child Interaction Therapy, has shown benefits in reducing the recurrence of physical abuse, but not neglect. It is considered promising and needs further study.

3. Prevention of impairment programs, especially cognitive-behavioural therapy that focuses on reducing deficits in victims, can improve the well-being of sexually abused children who present with post-traumatic stress disorder symptoms. Interventions that target cognitive-emotional components have shown to yield better cognitive outcomes (e.g., memory) in children exposed to emotional maltreatment.

Transferring children to foster care can also enhance children’s mental and physical health, and provide better outcomes in the behavioural, social and academic realms. Transition from the home (e.g., quality preschool experiences, school entry) provides emotionally-abused children with opportunities to realign their emotions.

Given that financial difficulties put children at risk for maltreatment, fighting poverty can go a long way in promoting children’s safety. In addition, policies on employment flexibility can help parents establish a healthy balance between their home and job responsibilities. Strategies should also be implemented to encourage children and family members to disclose and report child maltreatment. Promoting coping and resilience in contexts of adversity is important.

Professionals working with children can contribute to making reduction of child maltreatment a priority. Abuse should always be considered in the assessment of children presenting with injuries or mental health problems. Trained workers should also become familiar with the cultural context in which children grow up to ensure that
children’s needs for safety, nurturance and protection are met no matter what the cultural practices. Interventions to help maltreated children and neglectful families should also be guided by a common set of standards:

- Identify who and what contributes to the problems;
- Build a therapeutic alliance with the family;
- Set reasonable and concrete goals in collaboration with the family;
- Supervise the situation with care, and modify the plan as needed;
- Ensure that the needs of children are met;
- Collaborate with other professionals involved.
Child Physical Abuse: An Overview

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February 2012

Introduction

The social environment in which children live has a profound effect on their health and well-being. For children around the globe, few social problems cause greater harm to their health than child abuse and neglect. Regardless of the type of maltreatment perpetrated against a child, the potential for lifelong physical and emotional consequences is significant. Although seemingly straightforward, the definition of physical abuse is variable. Child physical abuse has been defined by the World Health Organization as the intentional use of physical force against a child that results or has a high likelihood of resulting in harm for the child’s health, survival, development or dignity. Legal definitions of physical abuse typically require physical harm to have occurred; governmental definitions of abuse and neglect are not uniform. Some definitions of physical abuse do not include perpetrator intent; others reflect motive rather than injury type. Additionally, definitions of physical abuse are culturally determined, and what is considered abusive in one society may not be in another.

There are no reliable global estimates for the prevalence of child physical abuse. In addition to the definitional challenges, in many countries, epidemiologic data are not collected, and in those countries that monitor child maltreatment, official reports do not reflect the true prevalence. Measuring physical abuse is methodologically challenging, and incidence and prevalence will vary by the surveillance methods used to define and detect the problem. Many maltreated children are not brought to the attention of public agencies, and are not counted in official statistics. Even when abused children are brought to the attention of health or child welfare professionals, the abuse may be unrecognized or ignored by those in a position to protect the child. It is estimated that approximately 40 million children around the world suffer from maltreatment, and recent population based research suggests that approximately 125/1,000 American children are victims of maltreatment.

Child abuse results from a complex interaction of individual, family and societal risk factors. A number of variables are traditionally thought to increase the risk for child physical abuse. These include poverty, substance abuse, single parenthood, household composition, young maternal age, parental depression or other mental illness, and domestic violence. Risk factors for specific types of physical abuse have been documented. For example, men more commonly perpetrate abusive head trauma, and rates of fatal child abuse are exceptionally high for young children who live in households with an unrelated adult in the home. Although the association of some of these risk factors and child maltreatment is clear, risk factors should be considered broadly defined markers, rather than strong individual determinants, of abuse. Understanding the epidemiology of child abuse is important for developing governmental policies and intervention and prevention.
strategies. However, the individual professional cannot rely on population-based risk factors in determining whether a child before him or her is a victim of physical abuse.

**Consequences of Child Physical Abuse**

Victims of abuse are at high risk for poor health, related not only to the physical trauma they have endured, but also to high rates of other social risk factors associated with poor health. Abused children have high rates of growth problems, untreated vision and dental problems, infectious diseases, developmental delay, mental health and behavioural problems, early and risky sexual behaviours, and other chronic illnesses, but child welfare and health care systems historically have not addressed the health needs of dependent children. Compared to children in foster care, maltreated children who remain at home exhibit similarly high rates of physical, developmental and mental health needs.

Child physical abuse takes many forms, and patterns and severity of injury vary by age of the child. Although physical abuse is more common among older children, the youngest victims—infants and toddlers—have the highest rates of mortality from physical abuse. They are the most vulnerable because of their physical and developmental immaturity, and relative social invisibility. Morbidity from physical abuse is great in young victims of physical abuse, reflecting both the physical consequences of trauma to the small child, and the developmental and emotional effects of early childhood trauma on the developing brain.

The public health consequences of child physical abuse are sizeable, and extend into adulthood. Recent retrospective and prospective studies have identified strong associations between cumulative traumatic childhood events, such as child maltreatment and family dysfunction, and adult physical disease, such as adult heart disease, liver disease, autoimmune diseases and sexually transmitted infections. Mental health disease and the use of psychotropic medications are also greater in adults who had been maltreated as children.

Emerging scientific investigation is improving our understanding of the causal biological pathways for these robust associations. Early childhood trauma, including physical abuse, leads to the production of stress hormones, such as cortisol and adrenaline that are normally protective, but with severe or persistent trauma can become toxic. These stress hormones regulate neural circuits that are important in modulating an individual’s response to stress, and over time, are associated with structural and functional changes in the brain and other organs. Influenced further by epigenomes, these changes are linked with impairment in the child’s ability to respond to future biological and environmental stress, and increase the risk for physical and mental health disease later in life. This emerging research underscores the need to develop and test prevention and early, aggressive intervention strategies for children who have been victims of serious physical abuse.

**Recognition of Physical Abuse**

Injuries that result from abuse are not always obvious or diagnostic, and identifying child physical abuse can be challenging. The history provided by the parent or other responsible adult is often inaccurate, either because the adult is unaware of the actual history, or is the perpetrator of the abuse, and is unwilling to provide a truthful history of events. Victims of serious physical abuse are often too young or too ill to provide a history of their assault, and if older, may be too frightened to do so. Perpetrators of abuse may provide a false history of
trauma to an unsuspecting physician. In order to identify and protect abused children, a small dose of skepticism is needed. Injuries to non-ambulatory infants, those that are not explained by the reported history, multiple or patterned injuries, and injuries to multiple organ systems should always raise the possibility of abuse. Abusive injuries to children are most commonly found on the skin, but the most serious injuries occur to the brain, abdomen and other internal organs.\textsuperscript{53,54} No single injury is diagnostic of abuse, but certain patterns of trauma can be highly specific for maltreatment. It is important, however, to recognize that there is a differential diagnosis for every potential injury, and objective and thorough evaluation is required in order to diagnose abuse with reasonable confidence.\textsuperscript{55}

**Implications for Policy**

Child physical abuse is a pervasive social problem that affects large segments of the pediatric population around the world. Despite the documented direct effects of physical abuse on the health of children, the recognition that early childhood trauma is a leading predictor of adult morbidity and early mortality, and the enormous indirect costs of funding the social and legal systems required to investigate abuse, protect children, hold perpetrators accountable and treat affected families, available public resources have not adequately addressed the problem. Child welfare agencies in the U.S. continue to receive more than three million reports of suspected abuse annually, but only investigate approximately two-thirds of the reports made.\textsuperscript{56} After investigation, a minority of reports result in confirmation of abuse\textsuperscript{10} and effective treatments for the child and family have been limited. At any given time, more than half a million American children reside in foster care, and more than 800,000 children pass through the foster care system annually.\textsuperscript{57} Almost 30,000 young adults annually leave foster care without achieving permanency in familial relationships.\textsuperscript{58} Despite spending billions of dollars annually on in home child protection services for abusive and neglectful families and foster care,\textsuperscript{59} the effectiveness of standard child welfare services is largely unproven.

The evidence for prevention and early identification and treatment is compelling, but children have no political capital, and solutions require comprehensive programs with real collaboration between child welfare, law enforcement, courts, health and education. Few prevention programs have been rigorously evaluated, and only a few have proven effective.\textsuperscript{60,61} Health-care based prevention programs, including parent education programs to reduce rates of abusive head trauma, and improving physician ambulatory care practices to help families decrease risk factors for child maltreatment have shown good initial results, but require further evaluation.\textsuperscript{62,63} Specific intensive home visitation programs such as nurse home visiting programs for first-time mothers have proven to be both clinically and cost effective in preventing maltreatment.\textsuperscript{64,65} However, a program of nurse home visitation has been found ineffective as a treatment model for abusive and neglectful families, highlighting the importance of primary prevention, as well as the need to rigorously evaluate potential treatments for abusive families.\textsuperscript{66} Child welfare services are historically structured as short-term interventions that monitor families for recidivism, provide parenting education and assist with referrals to community-based services. The focus is on prevention of abuse recurrence, with less emphasis on prevention of child and family impairment, all of which are important measures of outcome. Little research has addressed treatment to improve children’s impairment after physical abuse, but a few programs, such as parent-child interactive therapy, have shown promise in preventing the recurrence of child physical abuse.\textsuperscript{67,68}

Future strategies to prevent the physical abuse of children and protect them from further harm require a public health approach. Reducing rates of maltreatment, supporting struggling families and improving pediatric and
adult outcomes for victims requires community-wide strategies, with true collaboration between child welfare, judicial, education, health and mental health colleagues to advocate for programs that are adequately tested and shown to be effective. Finally, reducing the toll of child abuse will only come when policy-makers embrace the belief that an ounce of prevention is truly better than a pound of cure.

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Child Neglect: An Overview

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Introduction

Neglect is by far the most common form of child maltreatment reported to the U.S. child welfare system; 78% of reports in 2009 were for neglect. The short- and long-term outcomes associated with neglect are often serious, including fatalities, physiological changes in the brain, academic difficulties, criminal behaviour and mental health problems. In 2009, almost 75% of deaths attributed to child maltreatment involved neglect. Furthermore, child neglect places an enormous economic burden on society. A recent conservative estimate regarding the costs associated with child maltreatment exceeded 100 billion dollars a year; much of this was for neglect.

Subject

In general, the child welfare system considers neglect when there are parental omissions in care that result in actual or potential harm. An alternative approach focuses on children’s unmet needs, acknowledging the many possible contributors (e.g., lack of access to health care), as well as parental behaviour. The latter approach fits with the developmental ecological perspective which posits that no one factor alone contributes to neglect; there are multiple and interacting contributors at the level of the child, parents, family, community and society.

Neglect often does not involve one discrete act. Rather, it is a pattern of care that falls on a continuum ranging from optimal, where a child’s needs are fully met, to extremely harmful, where a child’s needs are not met at all. In addition, given that neglect naturally varies in type, severity and chronicity, it is clearly a very heterogeneous phenomenon.

A child-focused definition of neglect offers several advantages. First, rather than blaming parents, a child-focused definition draws attention to children’s basic needs (e.g., getting enough food). Second, given that most neglected children remain with their caregivers, a child-focused approach allows for a more collaborative relationship between professionals and caregivers. Lastly, this approach reflects ecological theory which recognizes that there are multiple interacting factors that contribute to neglect; it is not simply about parents who don’t care about their children.

Intentionality. When children are neglected, it is not usually the case that their parents intend to do so. Rather, a variety of problems may impede their ability to adequately care for their child. As a practical matter, intentionality is difficult to assess and is therefore not useful in addressing neglect. Indeed, it may be harmful if this leads professionals and others to be angry toward neglectful parents.

Culture. Research suggests that there is a remarkable level of agreement regarding what members of different communities define as neglect. For example, few differences have been found when examining the views of...
African Americans and Whites, rural and urban adults, and low- and middle-income people as to what constitutes minimally adequate care for children.\textsuperscript{4,5} Similarly, the United Nations Convention on the Rights of the Child offers remarkable testimony to what diverse countries and societies consider to be the basic needs or rights of children. Only two countries, the United States and Somalia, have not ratified the Convention. Nonetheless, myriad parenting practices across cultures do exist. These need to be understood and carefully assessed before conclusions regarding neglect are drawn.\textsuperscript{5}

**Problems: Effects of Neglect on Children**

Child neglect can have severe detrimental effects on children’s physical health, psychological well-being, cognitive and academic abilities, and social development. The severity, timing and chronicity of neglect influence the extent to which children are negatively impacted. Children’s development is cumulative in nature, such that children’s ability to accomplish new developmental tasks builds upon achievement of previous developmental milestones. Children who are neglected early in life may suffer impairment and thus struggle with subsequent developmental tasks.\textsuperscript{7}

Research also suggests that the consequences of neglect are as detrimental as those of physical abuse. For example, in one study, neglected children had a smaller corpus callosum relative to control and comparison groups.\textsuperscript{8} Compared to their non-maltreated peers, children in another study who experienced emotional neglect early in life performed significantly worse on achievement testing during the first six years of schooling.\textsuperscript{9} Furthermore, although both abused and neglected children performed poorly academically, neglected children experienced greater academic deficits relative to abused children.\textsuperscript{10} These cognitive deficiencies also appear to be long lasting. In a longitudinal follow-up study, adults abused or neglected in childhood performed poorly on tests of intelligence and reading ability compared to adults without a history of abuse or neglect.\textsuperscript{11}

Neglected children often also struggle socially. In preschool and during middle childhood, neglected children are more likely to be socially withdrawn and experience negative interactions with their peers.\textsuperscript{9,12} Additionally, neglected children may have significant internalizing problems such as withdrawal, somatic complaints, anxiety and depression when compared to physically-abused and sexually-abused children.\textsuperscript{7} Similar to adults with a history of physical abuse, adults with a history of neglect are at increased risk for violent criminal behaviour.\textsuperscript{13}

**Contributors to Child Neglect**

Multiple and interacting factors contribute to the occurrence of child neglect. Belsky’s\textsuperscript{14} developmental-ecological framework highlights three contexts in which child maltreatment is embedded: 1) the developmental-psychological context, which includes parent and child characteristics, parental developmental history, and intergenerational transmission of child maltreatment; 2) the immediate interactional context, which includes parenting behaviours and patterns of parent-child interactions; and 3) the broader context, which includes community and social support, socio-economic status, neighbourhood context, social norms and cultural influences. Importantly, these factors often interact and no one pathway to child neglect exists.

**Identification of Neglect**

Identifying neglect should be guided by specific state laws and 1) whether the child’s basic needs are unmet
and 2) whether potential or actual harm have occurred. Examples of unmet basic needs include inadequate or delayed health care, inadequate nutrition, inadequate physical care (e.g. poor personal hygiene, inappropriate clothing), unsafe or unstable living conditions, inadequate supervision and inadequate emotional care. A comprehensive assessment is needed to understand the nature and context of neglect, which are crucial in determining the most appropriate intervention.

Cultural practices are an important consideration when assessing possible neglect. Terao and colleagues offer a six-step decision-making model useful in differentiating child maltreatment from culturally-based parenting practices. Understanding the cultural context of families will inform clinicians on how to best respond.

Prevention and Intervention

A variety of approaches appear promising in helping to prevent neglect. Specific home visitation programs, especially with nurses supporting parents prenatally and then after the baby is born, have been carefully evaluated. Parenting programs also offer valuable guidance and can be effective, such as the Triple P intervention. Another example is the Safe Environment for Every Kid (SEEK) model of pediatric primary care. Building on the relationship between pediatrician and family, SEEK identifies and helps address prevalent risk factors such as parental depression. All these interventions aim to strengthen families, support parents and improve children’s health, development and safety.

For families where neglect has already occurred, interventions aim to prevent recurrences as well as the harmful outcomes that may follow. SafeCare is an example of an intervention that may reduce recidivism, but further research is necessary to determine its effectiveness. The specific intervention needs to be tailored to the needs and strengths of the individual child and family. The circumstances naturally vary greatly, but some core principles include: 1) address the contributors to the problem, 2) forge a helping alliance with the family, 3) establish clear achievable goals and strategies for reaching them, with the family, 4) carefully monitor the situation and adjust the plan if necessary, 5) address the specific needs of neglected children and those of other children in the home, and 6) ensure that interventions are coordinated with good collaboration among the professionals involved.

Advocacy

Advocacy regarding neglect may be at several levels as outlined in the following examples: 1) at the child’s level, for example, explaining to a parent that responding to a crying infant does not risk spoiling him/her is a form of advocacy on behalf of a preverbal child; 2) at the parental level, helping a depressed mother access mental health care or encouraging a father to be more involved in his child’s life; 3) at the community level, supporting efforts to develop community family resources; and 4) at the societal level, supporting government policies and programs such as those that reduce access to health care, food benefits, and subsidized child care.

Implications for Policy

There are many governmental policies that can help prevent neglect; reducing poverty and its many associated burdens is paramount. It is the biggest risk factor for compromising children’s health, development and safety. Other policies are needed to ensure adequate resources for addressing the main risk factors for neglect.
Flexible employment policies that enable mothers and fathers to better balance work with the demands of parenting are much needed. A final example is the need for disseminating evidence-based parenting programs. These are sorely needed to help prepare and guide many parents who struggle to meet their children’s basic needs.

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Child Sexual Abuse: An Overview

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February 2012

Introduction

Child sexual abuse (CSA) is a form of maltreatment that is recognized globally as a serious human rights violation. This paper will provide an overview of the state of knowledge on CSA.

Subject

It is now recognized that the definition of CSA includes both contact and non-contact abuse. CSA comprises any sexual activity perpetrated against a minor by threat, force, intimidation or manipulation. The array of sexual activities includes fondling, inviting a child to touch or be touched sexually, intercourse, rape, incest, sodomy, exhibitionism, or involving a child in prostitution or pornography.

Problem

The full extent of CSA is difficult to determine given differences in data collection systems. Recent U.S. data has suggested a decline in investigated CSA cases, which is interpreted by some as a true decline in the number of U.S. children exposed to sexual abuse. These U.S. results, however, do not necessarily apply to other countries in view of potential differences across cultures and social contexts. For instance, although a decline was also observed in Canada, where incidence rates of reported CSA have dropped from .93 per 1000 children in 1998 to .43 per 1000 in 2008, this trend has not been fully explained. Other statistics, such as rates of CSA and sexual assaults reported to the police, have not followed as consistent a pattern as in the U.S. There are several possible explanations that can account for the drop in CSA cases substantiated by child protection services. For example, the victims may be less likely to report their abuse to authorities than at previous times or the criteria to screen a case in for investigation or to substantiate may be more restrictive than before.

Research Context

Most studies emphasize that the full extent of CSA victimization remains unknown. In a review by Finkelhor, only about half of victims across all studies had disclosed the abuse to anyone. Clearly official reports of to authorities underestimate the extent of CSA, when compared with high self-report rates by youth and adults. A recent meta-analysis showed CSA rates to be more than 30 times higher in self-report than official-report studies (127/1000 or 12.7%) versus 4/1000 or 0.4%).
Key Research Questions

For the past few decades, several questions have been central in guiding CSA research. These include: What are the risk factors for CSA? What are the mental health outcomes of CSA? What are the protective factors that make some children less likely to experience impairment following CSA exposure? What are the most effective prevention, assessment and treatment strategies?

Recent Research Results

Female children are about two times more likely to be victims of CSA than males. There is a strong likelihood, however, that boys are more frequently abused than the ratio of reported cases would suggest given their probable reluctance to report the abuse. Risk for CSA rises with age, with the highest number of victims in the 12 to 17 year age range. Girls are considered to be at high risk for CSA starting at an earlier age and of longer duration, while risk for boys peaks later and for a briefer period of time.

CSA is a major risk factor for developing a host of negative consequences in both childhood and adulthood. Victims have been shown to experience more post-traumatic stress and dissociation symptoms than non-abused children, as well as more depression and conduct problems. They engage more often in at-risk sexual behaviours. Victims are also more prone to abusing substances and to suicide attempts. These mental health problems are likely to continue into adulthood. CSA victims are also more at risk than non-CSA youth to experience violence in their early romantic relationships; women exposed to CSA have a two to three-fold risk of being sexually revictimized in adulthood compared with women without a history of CSA exposure.

However, about one third of victims may not manifest any clinical symptoms at the time the abuse is disclosed. This can be explained, in part, by the extremely diverse characteristics of CSA which lead to a wide range of potential outcomes. Also, several factors influence the resilience of CSA victims; for example, children who receive support from their non-offending parents and those who have not experienced prior abuse seem to fare better. In all cases, however, early assessment and where indicated, intervention to address the negative outcomes, are important.

In the area of assessment, two forensic protocols have undergone considerable evaluation. These include the National Institute of Child Health and Human Development (NICHD) Structured Interview Protocol and the Sexual Assault Nurse Examiner (SANE) Model.

• The use of a structured investigative protocol, such as the NICHD model, specifies that police officers receive extensive training to elicit detailed information from CSA victims in a non-suggestive manner. This protocol clearly enhances the quality of interviews and facilitates the assessment of credibility by child investigators.

• The SANE nurses provide, usually in the context of a hospital emergency unit, a first response that addresses victims’ emotional and physical needs while gathering the forensic evidence that could potentially lead to prosecution of the person responsible for the abuse. The effectiveness of SANE in regards to forensic evidence collection and prosecution rates in CSA cases involving children has been demonstrated.

In terms of treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the most established treatment for children who have experienced CSA and present with post-traumatic stress disorder (PTSD)
Randomized controlled trials have shown this treatment to be effective in improving participant symptomatology as well as parenting skills and children’s personal safety skills, even when the duration of the program was as short as eight weeks. Sustained improvement following TF-CBT has been shown for anxiety, depression, sexual problems and dissociation at the 6-month follow-up and in PTSD and dissociation at the 12-month follow-up.

Although school-based educational programs are widely disseminated and promoted as a primary prevention strategy, little evidence exists that they are effective in preventing actual exposure to CSA.

**Research Gaps**

Two main gaps are worth highlighting: since most CSA victims remain unidentified, current knowledge is likely biased in its focus on information from victims where CSA has been detected; further investigation is needed to understand the variable ways in which children exposed to CSA present and to identify additional evidence-based approaches to assessment, treatment and prevention.

**Conclusions**

While there is now a general consensus regarding the definition of CSA, the magnitude of the problem remains difficult to estimate given the differences in data collection systems. The most recent meta-analysis on CSA prevalence showed that 12.7% of adults were sexually abused in their childhood or teenage years, with females and older children showing an increased risk. CSA is a major risk factor in the development of short- and long-term negative consequences, such as depression, PTSD, and substance abuse, although not all victims experience impairment. Two forensic protocols – the NICHD Structured Interview Protocol and the SANE Model – are well established in the field. The most effective treatment of children exposed to CSA and presenting with PTSD symptoms is TF-CBT. Future research should focus on developing strategies to facilitate the disclosure and reporting processes of CSA, to better identify the needs of CSA victims, and to develop prevention strategies.

**Implications for Parents, Services and Policy**

In an effort to provide effective services to all victims, we should prioritize the development of strategies to address the barriers to disclosure and reporting. Although the taboo of CSA might not be as prominent as a few decades ago, stigma as well as difficulty accessing services may still prevent victims from receiving necessary resources.

**References**


Emotional Maltreatment

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February 2012

Introduction

Emotional maltreatment reflects a caregiver’s failure to provide a developmentally-appropriate and supportive environment, including persistent, pervasive or patterned acts such as frequent name-calling (emotional abuse; act of commission) and lack of affection (emotional neglect; act of omission). Six types of emotional maltreatment are recognized: (1) rejecting (e.g., constant criticism, belittling); (2) isolating (e.g., keeping family and friends from child); (3) ignoring (e.g., non-responding to child attentional bids, achievements etc.); (4) terrorizing (e.g., threatening abandonment or harm), (5) corrupting (e.g., child involvement in criminal activities); (6) exploiting (e.g., assigning caregiver role to child for parent or other children, expecting child to maintain family finances). Further, other forms of maltreatment – sexual and physical abuse, and physical neglect – are considered to have emotional maltreatment components. Thus, emotional maltreatment may be a stand-alone form of abuse or neglect, as well as a frequently co-occurring form.

Some consider exposure to adult intimate partner violence (IPV) as a form of emotional maltreatment (i.e., exposure to violence against a parent), while others view it as a separate category. For example, the 2008 Canadian Incidence Study documented 34% of substantiated cases as exposure to IPV, and an additional 9% of substantiated cases as emotional abuse (with verbal aggression being the most common form). A review of foster care children found a wide range in the proportion of cases reported for emotional maltreatment (8% to 77%). One U.S. study of child welfare-involved cases, in coding maltreatment experiences with a standard framework, found that over 50% of youth had emotional abuse (chiefly terrorizing), and that the majority of these also experienced physical abuse and neglect.

Subject

In order to develop into persons who can function well on a day-to-day basis, it is important to grow in an emotionally- and physically-safe and nurturing environment. When determining exposure to emotional maltreatment, it is important to assess the interactional patterns in the home (parent-to-parent; parent-to-child; among siblings). Emotional abuse may occur as acute events (e.g., emotionally-abusive tirade), or as chronic patterns (e.g., failures to acknowledge child in school accomplishments, chronic school lateness or absences; uncelebrated birthdays etc., also known as an “invalidating environment”). Parents who direct intense negative emotions towards the child (rage, fear, disgust) risk further disabling, overwhelming the child’s cognitive capacities with parental “emergency” emotions (panic, rage etc.). Research has shown that, in such interactions, parents who perceive themselves as powerless, have higher emotional reactivity, and hostile views about the child and child behaviour, tend to select power assertive and controlling actions towards the child (hostility, rejection, attack). If social isolation is part of the family interactional style, the child has few
opportunities to understand what is “normal” behavioural sequences and “normal” behaviour responding.

Beyond the “fight or flight” response to acute stress, children exposed to emotional maltreatment can experience chronic stress that leads to physical and/or emotional impairment. Furthermore, good stress management is not modeled in the home. Impairment can include many elements of risk behaviours (i.e., cigarette smoking, overweight, alcohol abuse, among others) in addition to early and persistent psychiatric disorders. Beyond a stand-alone form, emotional maltreatment co-occurs with sexual abuse, physical abuse and neglect, given the harmful aspects of these other types (e.g., feeling betrayed by the caregiver).

Problems

1. As with all types of abuse and neglect, the prevalence of emotional maltreatment is unknown and likely substantially underestimated, as it is a frequent co-occurring form.

2. About one third to one half of reported cases has an indicator of emotional harm.2,11,12

3. While there is emerging consensus on (a) patterned caregiver behaviour and (b) including acts of omission and commission, there is no agreement as to how to operationalize emotional maltreatment for practical use by child protection systems; protection needs to be provided when caregiver acts fall below community standards for reasonable parenting, and not the reaction of the child.13,14

4. Existing parenting programs have some content relevant to emotionally maltreating caregiving (e.g., planned attention, positive time or time-in); prevention of emotional maltreatment has not yet been a focus in child welfare or public health. The prevention of IPV and children’s exposure to violence remains a global priority.7

5. With other forms of maltreatment established, child welfare authorities may not fully assess emotional maltreatment, since the former can be sufficient for case-opening and service provision; however, as disclosure is a process, full assessment for all maltreatment types is needed and assessment may need to be revisited.

6. Males may be more negatively impacted by emotional maltreatment than females among those in the child welfare system, in the areas of mood, delinquency and attachment to parents and peers.15

Research Context

Most information on emotional maltreatment, as it relates to youths receiving services from child welfare authorities, comes from countries with formal child protection systems. This research does not look at the experience of the parents’ expressed emotion in range, appropriateness and intensity of negative affect (rage, fear, hostility, helplessness). When a case of emotional maltreatment is substantiated, it means the child welfare authorities investigated the allegation and deemed it to be of sufficient seriousness. The services provided could range from investigation only to child counseling to out-of-home placement for alternate caregiving.

When emotional maltreatment research is conducted with community samples, it is reliant on the use of self-report questionnaires. Finally, most research does not isolate the unique impact of emotional maltreatment, recognizing that, especially for child welfare populations,4 and other public service sectors, more than one type
of maltreatment is common.

Key Research Questions

1. What unique type of impairment is associated with exposure to emotional maltreatment?
2. How does emotional maltreatment combine or interact with the other forms of maltreatment in leading to impairment or resilient outcomes?
3. Are there emotional maltreatment indicators, or red flags, that signal greater impairment potential? Are there certain parental psychiatric disorders that show a strong association with a child’s exposure to emotional maltreatment and impairment in their health and development?
4. Do programs designed to prevent child injuries and physical and/or sexual abuse substantiations, also yield secondary gains in reducing emotional maltreatment levels?

Recent Research Results

The most recent focus of attention has been the cognitive functioning and development of maltreated children and its association with problems (impairment) and positives (resilience) in functioning, despite the experience of adversity (maltreatment). For example, among foster children (out-of-home care), a history of neglect or emotional abuse was negatively correlated with height-for-age, visual-spatial processing, memory, language and executive function. Early intervention that targets the cognitive-emotional components that underlie emotional maltreatment shows promise in yielding better child cognitive outcomes (e.g., memory) that seem to be mediated by the child’s stress response hormones. The ultimate goal is to consider the contexts for mind-body impairments, as well as those for resilient functioning, integrating streams of biological, clinical and epidemiological research.

Research Gaps

Emotional maltreatment is difficult to document by the child protective services (CPS), as it may not be identifiable as an event, or have clearly identifiable, causal links to the victim’s impaired functioning. Legal and medical definitions to guide CPS thresholds for intervention vary across states and regions. Presently, there is no “gold standard” approach to determine exposure to emotional maltreatment. Better prevalence estimates of emotional maltreatment are needed that utilize a common definition in population studies of child welfare-involved youths, community surveys of adolescents, as well as studies of groups known to have higher rates of maltreatment backgrounds, such as those in public care sectors (i.e., juvenile detention, substance abuse treatment, special needs in education, mental health services).

More research is needed to understand the processes whereby “critical events” impact development and health. For example, positive emotion dominance (i.e., much more positivity shown in interactions) is advanced as a key aspect of resilience in that it may translate into maintaining an “approach” (versus “avoidance”) stance with others, and a positive attributional style towards the behaviour of others.

Conclusions and Implications for Parents, Practice and Policy
Emotional maltreatment, being less visible in its impact, can be underestimated in its impact. The implications for parents, practice and policy is: (1) a consideration of the home emotional climate, emotional literacy and the provision of experiences where there is a dominance of positive over negative emotions; (2) to prevent the occurrence of both child maltreatment and exposure to adult IPV; (3) to adequately address perpetration to promote the safety, well-being and rights of children and vulnerable caregivers; (4) to prevent or dampen maltreatment-related impairment; and (5) to promote coping and resilience in unknown or unavoidable contexts of adversity. Evidence-based prevention programs exist, and it is severely costly to not implement these from a public health perspective.7,18,20,21

A chaotic, violent home life may be psychologically maltreating in a persistent way for children. Transition from the home, such as quality preschool experiences, formal school entry, and increasing autonomy in adolescence provide opportunities to realign the expected emotional encounters and the learned (or over-learned) emotion-based coping towards greater health, financial and quality-of-life expectations for the future. Better life outcomes occur when the personal and home environment ceases. A predominance of enjoyment, discovery and positive engagement would seem to be a fundamental birthright.

References


Prevention of Child Maltreatment and Associated Impairment

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February 2012

Introduction

Child maltreatment encompasses four main types of abuse – physical, sexual, emotional abuse and neglect. More recently, exposure to intimate partner violence has also been identified as a form of child abuse. Child maltreatment is a significant public health and social welfare problem, particularly in high-income countries and effective methods of prevention have begun to be identified during the past two decades.

Subject

Significant numbers of children experience abuse. A recent review of prevalence studies concluded that around 4-16% of children are physically abused; 10% are neglected or psychologically abused; 5-10% of girls and 5% of boys are exposed to penetrative sexual abuse, and 3 times more exposed to non-penetrative sexual abuse. The consequences of such abuse are wide-ranging with a significant impact on morbidity and mortality. In the U.S. for example, over 2000 children die due to abuse and neglect every year, with 86% of all maltreatment deaths being under the age of 6 years and 43% being infants less than one year of age. The long-term consequences for survivors include wide-ranging mental health problems including drug and alcohol misuse, risky sexual behaviour, and criminal behaviour, all of which continue into adulthood. The societal consequences of abuse are also high in terms of the costs, both direct (e.g., services to identify and respond to child abuse) and indirect (e.g., services to deal with associated problems such as mental health problems; substance misuse; criminality, etc.).

The high prevalence and serious consequences of child maltreatment point to the importance of effective prevention and treatment programs. Preventive strategies focus on a) primary prevention, which is aimed at intervening before abuse has been identified and utilizes two types of approach – population and targeted; b) prevention of recurrence of abuse after it has been identified; and c) prevention aimed at reducing associated impairment.

Problems
One of the main difficulties associated with identifying ‘what works’ to prevent child maltreatment is an absence of rigorous research designs being applied to the field of assessing program effectiveness. There is also wide variation in the measurement of outcomes and an over-reliance on the use of parental self-reports and reports of child behaviour.

**Research Context**

Although child maltreatment is a significant public health problem both in terms of the individual and societal consequences, there is a limited body of research that explicitly addresses prevention, and much of the available research focuses on secondary/tertiary (i.e., intervening once abuse has occurred) rather than primary prevention. Similarly, much of the available research within primary prevention focuses on approaches that target high-risk groups as opposed to universal or population-based approaches.

**Key Research Questions**

The key research questions focus on both the effectiveness and cost-effectiveness of preventive approaches to child maltreatment, and address the four main types of maltreatment highlighted above in terms of the different levels of prevention. Other questions focus on the specific approaches that are best suited to the different population groups that pose a risk in terms of child maltreatment (e.g., parents abusing drugs; and parents for whom intimate partner violence is the main issue).

**Key Research Results**

**Primary prevention**

The research suggests that a range of preventive strategies have considerable potential.

Although home-visiting is not uniformly effective, the Nurse Family Partnership⁴ and Early Start⁵ have been shown effective. Standardized parenting programs such as Triple P⁶ have also shown benefits, but further evaluation is needed specifically with high-risk populations. Hospital-based educational programs to prevent abusive head trauma⁷ show promise, alongside enhanced paediatric care⁸ for families of children at risk of physical abuse and neglect. Although school-based educational programs appear to be effective in improving children’s knowledge and protective behaviours,⁹ it is not currently known how effective they are in preventing sexual abuse.

**Prevention of recurrence**

There is very limited evidence available concerning what works to prevent the recurrence of abuse. Parent-Child Interaction Therapy (PCIT)¹⁰ has shown benefits in preventing recurrence of child physical abuse, but there is no randomized controlled trial evidence available addressing what works to prevent recidivism of the other types of abuse.

**Prevention of impairment**

The research suggests that the prevention of impairment requires a thorough assessment of the child and
family. The best evidence for reduction in mental-health conditions among maltreated children is for cognitive-behavioural therapy (CBT) for sexually abused children with post-traumatic stress symptoms. Several interventions show promise: some child-focused types of therapy for neglected children including resilient peer treatment, an imaginative play program, multisystemic therapy and a day treatment intervention. There is also some evidence of the benefits of post-shelter counseling intervention for women exposed to intimate-partner violence, child-parent psychotherapy, and trauma-focused CBT for children with intimate partner violence-related post-traumatic stress disorder (PTSD) symptoms.

For maltreated children

The research shows that foster care can lead to benefits across a range of domains including antisocial behaviour, sexual activity, school attendance and academic achievement, social behaviour and quality of life compared with children who remain at home or who reunify following foster care, and that enhanced foster care can produce even better outcomes in terms of fewer mental and physical health problems.

Research Gaps

More research is needed to identify approaches and strategies that can be used as part of both a primary population-based approach (e.g., available to everyone), and also targeted-approaches (e.g., with high-risk groups) to the prevention of child abuse. Population-based strategies include wide-ranging changes to the legal systems that protect children better from the use of aversive parenting methods (e.g., physical punishment), and the application of population-based strategies to the delivery of evidence-based parenting programs (e.g., population-level Triple-P). Further evaluation is needed of the value of targeted approaches such as video-interaction guidance, attachment- and mentalisation-based interventions, and parent-infant psychotherapy, all of which are early interventions aimed at improving parent-infant/toddler interaction in high-risk families. There is a need for further long-term follow-up particularly of interventions that are delivered during the first three years, and for the use of multimethod and multisource approaches to the assessment of maltreatment. There is also a need for further research into potentially beneficial approaches to the prevention of recurrence and impairment, where once again, the evidence is limited. Such research should build on what is already known about what works.

Conclusions

Given the high prevalence of child maltreatment and the serious consequences in terms of its impact on the lives of the individuals concerned, their families, and society more generally, it is important that we identify effective methods of prevention and intervention, and there are some suggestions that a public health approach is now needed. Although there is limited research available in terms of what works to prevent child maltreatment, there have been significant gains over the past 20 years in terms of the development of new approaches. The strongest evidence available supports the use of specific home visiting and parenting programs as part of targeted and population-based approaches to primary prevention. Much less is currently known, however in terms of approaches for preventing sexual abuse, psychological abuse and children’s exposure to intimate partner violence. Similarly, although there are a broad range of programs being used to prevent recurrence, there is little evidence currently about their effectiveness, and existing evidence-based programs such as PCIT have shown benefits for physical abuse but not neglect. The strongest evidence in
relation to impairment is for improving the psychological functioning of children who have experienced sexual abuse where CBT appears to improve outcomes for children showing signs of PTSD, and for a small number of child-focused therapies for children who have experienced neglect. Finally, although out-of-home care is one of the most widely used interventions for maltreated children, there is limited evidence available, which is mostly focused on the benefits of foster care and adaptations of this model.

**Implications for Parents, Services and Policy**

The research suggests that strategies to prevent maltreatment should begin during pregnancy and encompass both population-wide approaches that aim to provide pregnant women/parents and new babies with access to wide-ranging universal support (such as Population level Triple-P), alongside the provision of targeted approaches (i.e., intensive home visiting such as Nurse Family Partnership) to families who face additional risks that increase the vulnerability of the baby. Prevention of recurrence and impairment should include the provision of interventions that target parents (post-shelter counseling), the dyad (e.g., parent-infant psychotherapy and parent-child interaction therapy), and child-focused interventions (e.g., school-based educational programs, trauma-based CBT and CBT on its own, play therapy, multisystematic therapy, resilient peer programs and (enhanced) foster care.

**Acknowledgements:**

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Child Maltreatment and its Impact on Psychosocial Child Development: Epidemiology

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Introduction

Child maltreatment is a significant threat to the healthy development of children. Understanding the scope and severity of maltreatment is critical in developing clinical interventions and social policies to protect children at risk and to treat children who have already been victimized. The following article describes the incidence, prevalence and severity of child maltreatment and discusses the importance of inter-disciplinary and community-based strategies for addressing this major social problem.

Definitions

Child maltreatment is the broad term used to describe abusive and neglectful acts perpetrated by adults or older youth against children. These fall into four broad categories: physical abuse, sexual abuse, neglect and emotional maltreatment. Physical abuse ranges from severe assaults against children that can permanently injure or kill children to abusive physical punishment to shaking infants. Sexual abuse includes intercourse, fondling, acts of exposure, sexual soliciting and sexual harassment. Neglect refers to a caregiver’s failure to supervise or protect a child or failure to meet a child’s physical needs. The distinction between physical neglect and family poverty is difficult to draw since most of these families live in poverty, although very few poor families are considered neglectful. Emotional maltreatment includes extreme or habitual verbal abuse (threatening, belittling, etc.), and systematic lack of nurturance or attention required for a child’s healthy development. Children’s exposure to intimate partner violence (IPV) is increasingly being recognized as either a form of emotional maltreatment or a separate category of exposure.

Annual Incidence

Child maltreatment incidence statistics are tracked in Canada through the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), a periodical survey of cases investigated by provincial and territorial child-protection authorities.¹ The 2008 cycle of the study found that an estimated 235,497 maltreatment related investigations involving children under 16 years of age were conducted in Canada in 2008, and that child maltreatment had been substantiated for 85,440 of these children, a rate of 14.19 victims per 1,000 children.²

Over a third of these children, 31,506, were under six years of age.¹ Rates of victimization were highest for
younger children (17.10 per 1,000 children under 1 compared to 14.57 for 5 year olds), but there was no clear pattern by sex (see bar charts).

It is difficult to make direct comparisons between incidence rates in Canada and in other countries because of differences in reporting and investigation procedures. The rate of victimization reported in the United States in 2008 was 10.3 per 1000 children, whereas in Australia, the rate of victimization for fiscal year 2008-09 was 6.9 per 1000 children.

**Childhood Prevalence**

Prevalence studies have typically measured rates of victimization during childhood, as opposed to incidence statistics that measure rates of victimization during a specific year. The most extensive child maltreatment prevalence data available in Canada is from a population health survey of residents 15 years of age and older conducted in Ontario in 1990. Thirty-one percent of males and 21.1% of females reported that they had been physically abused during their childhood, while 12.8% of females and 4.3% of males reported a history of sexual abuse. The study did not identify at what point during childhood respondents had been abused. The rates of sexual victimization reported in the Ontario Health Supplement are somewhat lower than rates reported in other countries, which cluster around 20% for females and 3 to 11% for males, but this may be because the Supplement restricted questions about child sexual abuse to adults and did not include adolescent perpetrators.

**Injury and Death**

Most cases of maltreatment reported to child welfare services involve situations where children have already suffered from some sort of emotional harm, or are at significant risk of being injured or suffering some type of emotional harm. Physical injuries due to maltreatment, however, are relatively rare. The 2008 CIS found that physical injuries were noted in 8% of the 26,339 cases of substantiated maltreatment involving newborns to five-year-olds. In most instances these were bruises and scrapes that did not require medical attention. Injuries requiring medical attention were noted in 4% of cases involving children one to five years old. Injuries were generally more serious for children under one year of age: 8% required medical attention and head trauma was noted in 3% of cases.

Severe abuse leading to injuries is of particular concern in situations involving young children because of the elevated risk of permanent harm or death during the first three years of life. Children under five are at highest risk of being killed by a parent: two-thirds of children from birth to 17 who are killed by a family member are five or under, and 29% are infants under one year of age. Children under three are most often killed by shaking (24%) or beating (28%), whereas older children and youth are more likely to be killed by firearms. Rates of child and youth homicides perpetrated by family members have been declining over the past 30 years, down to a historic low of 3 per million in 2005 and again in 2007.

**Trends**

Child maltreatment is becoming a health problem of growing concern. The rate of maltreatment has increased by over 50% from 9.21 substantiated investigations per 1,000 documented in 1998, to 14.19 in 2008. This
increase appears to be primarily driven by broadening mandates and greater recognition of child maltreatment amongst professionals working with children, in particular with respect to the rate of neglect which has almost doubled, and the rate of exposure to IPV which has more than tripled. In contrast, the rate of substantiated sexual abuse has decreased by over 50% between 1998 and 2008. The increase in cases of exposure to IPV has primarily been driven by a dramatic shift in the response of the police, health professionals and schools, who account for nearly 90% of all domestic violence reports. The decrease in reports of child sexual abuse is more difficult to interpret. Some argue that this reflects an actual decrease in rates of sexual victimization, attributable to extensive prevention, detection and prosecution efforts. Others are concerned that children and non-offending parents are increasingly hesitant to report victimization.

**Implications for Policy and Practice**

Child maltreatment is a major health problem, affecting over 85,000 children a year across Canada. Abused and neglected children are at very high risk of developing long-term social, emotional and cognitive problems. The response to these children has, however, been fragmented. Beyond the universal introduction of mandatory reporting laws across Canada, few treatment and prevention programs have been systematically developed to meet the needs of these children. An examination of rates of victimization reveals a diverse population, ranging from cases of severe physical abuse requiring urgent response to complex cases of neglect and exposure to domestic violence, where the role of child protection authorities may need to be reconceptualized. Under the continued pressure of increasing caseloads, child welfare service-providers are seeking more effective models for collaborating with other service-providers.

**Note:**

In another 17,918 cases maltreatment could not be substantiated, but remained suspected, in 71,053 cases maltreatment was unsubstantiated and 61,431 investigations were investigations of future risk of maltreatment where no specific allegations of past incidents of maltreatment had been made.

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Domestic Violence and Its Impact on the Social and Emotional Development of Young Children

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Introduction

Population statistics from the U.S. indicate that 29.4% of children in dual-parent homes live in a family in which partner violence has occurred within the last year. Even when children in violent homes are not the target of abuse by parents, they are frequently involved in their parents' violence in other ways that put them at risk. Children are at physical risk when they intervene in their parents' fights or accidentally get caught in the "crossfire." Children may also experience psychological distress, especially when they are in the position of having to report the violence to authorities and even testify in legal proceedings related to charges against a parent. This distress may be compounded by parents' attempts to blame the child for the parents' conflict and aggression.

Subject

It is important to pay attention to child witnesses because domestic violence is more likely in families with children, especially children from birth to age five. Physical violence is highest early in the domestic relationship, when children are likely to be young. Children in violent homes commonly see, hear and intervene in episodes of domestic violence.

There is increasing evidence that children who witness domestic violence are at risk for a range of psychosocial problems. Indeed, problems seen in child witnesses to domestic violence are quite similar to those seen in children who are the direct victims of physical abuse. Because witnessing domestic violence can terrorize children and significantly disrupt child socialization, some experts have begun to consider exposure to domestic violence a form of psychological maltreatment.

Problems

Children show a wide range of reactions to witnessing domestic violence, including intervening, withdrawing or becoming aggressive. These behaviours may be adaptive in the context of family violence, but are maladaptive in other settings. Children who witness domestic violence are at risk for a wide range of psychological, emotional, behavioural, social and academic problems.
Not all children exposed to domestic violence show clinically significant levels of maladjustment. However, these children may still experience mild problems that put them at risk for subsequent psychological or interpersonal problems. For example, these children may show inappropriate attitudes about violence as a means of resolving conflict, greater willingness to use violence themselves and stronger beliefs about being responsible for their parents’ conflicts.

Research Context

Child outcomes: The first case studies of child witnesses appeared in the 1970s, and the first empirical studies in the 1980s. Few studies have focused specifically on effects seen in very young children. Empirical research includes correlational studies (examining correlations between extent of exposure to domestic violence and child outcomes) and group-comparison studies (comparing groups of children who were exposed to domestic violence with those who were not). Child outcomes are typically defined in terms of parent reports or child self-reports of children's internalizing and externalizing problems. A smaller line of research has examined children's responses to simulated or hypothetical incidents of inter-adult conflict in laboratory settings.

Treatment: Treatment programs such as the Boston City Hospital’s Child Witness to Violence Project have been developed to address the special needs of child witnesses to inter-adult violence. However, there are very few published reports of control-group studies evaluating the effectiveness of these programs. Promising results come from a 10-week program designed to help eight- to 13-year-old witnesses develop more effective ways of coping with and responding to domestic violence. Compared to the control group, children in the program showed improved attitudes about inter-parental anger and a reduced sense of responsibility for parents' violence. Another program, Project SUPPORT, was also evaluated in a randomized study. Participating children between the ages of four and nine showed a significantly lower rate of conduct problems two years after treatment compared to children receiving existing services.

Key Research Questions

Should mild/moderate aggression be distinguished from more severe aggression? In many studies, more extreme forms of violence (choking, beating) are not distinguished from milder forms of aggression (pushing, shoving). This distinction may be useful, both in terms of documenting the effects of violence and in terms of understanding the mechanisms of these effects.

What are the mechanisms by which witnessing domestic violence disrupts development? Exposure to less severe forms of aggression may affect children through the same processes identified in research on general family conflict, including direct effects due to children's behavioural and emotional dysregulation and indirect effects due to disruptions in parenting. More severe aggression is more likely to be traumatic for children, and as such its processes of effect may be more similar to those identified in research on child abuse and neglect than those identified in research on family conflict.

How should child outcomes be measured? It is important to document not only clinical levels of distress, but also children's sub-clinical distress, as well as resilience in the face of family violence. Resilience would be defined not just as the absence of pathology, but also as the presence of competence in the face of stressors associated with inter-parental aggression. Thus, it will be important in future research to assess children's stage-
Recent Research Results

Kitzmann and colleagues conducted a meta-analysis of 118 empirical studies examining the psychosocial adjustment of child witnesses to domestic violence. Results showed that 63% of child witnesses were faring more poorly than the average child who had not been exposed to inter-parental violence. Problems included aggression, anxiety, difficulties with peers and academic problems, all to similar degrees. Limited evidence from a small number of studies suggested a greater risk for preschoolers. For children of all ages, similar levels of adjustment problems were seen in children who witnessed domestic violence, children who were physically abused and children who both witnessed and experienced physical aggression.

Conclusions

Children exposed to domestic violence are at risk for a range of psychosocial problems, even when they themselves are not the target of physical aggression. These problems are similar to those seen in physically abused children, suggesting that violence anywhere in the family may disrupt child development. Although very young children are disproportionately exposed to domestic violence, little research has focused on the adjustment of children in this age group. There is some evidence to suggest that younger children are more at risk, presumably because of their limited understanding of conflict and limited coping strategies. Few treatment programs have been tested in randomized trials. Research needs to include more precise measures of violence (e.g. distinguishing mild from severe aggression), multiple risk factors (e.g., controlling for the presence of parental alcohol abuse) and outcomes (e.g., identifying sub-clinical distress that may put the child at risk for later problems).

Implications

Policy

Discussions concerning consensus definitions of child abuse and the distinction between child abuse and child maltreatment may need to be expanded to include consideration of children who witness violence in the home but are not themselves the target of violence. This question has direct implications for decisions about arrest, child placement and social-services interventions in cases of domestic violence. In 2001, U.S. federal legislators proposed but did not enact the Children Who Witness Domestic Violence Protection Act. Scaled-back versions of this legislation were included in the No Child Left Behind Act of 2002 and the Keeping Children and Families Safe Act of 2003, both of which provide funding for programs to address the needs of children who witness domestic violence. Similar provisions have been enacted by several Canadian provinces.

Treatment

Interventions should target both the direct effects of exposure to domestic violence (e.g. helping children learn to cope with the stressors associated with family violence) and the indirect effects via disruptions in parenting (e.g. helping parents provide consistent nurturance and discipline, despite disruptions caused by violence). A multi-systemic approach to treatment may be important to address the multiple social influences that increase
or decrease risk among children exposed to domestic violence.\textsuperscript{31}

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