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Maltreatment (child)

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Harriet MacMillan, MD, McMaster University, Canada

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Synthesis

How important is it?

Child maltreatment is a major public health problem, affecting at least one in three Canadian children before the age of 16. Recent increases in the reported rates of neglect and intimate partner violence (IPV) exposure have been attributed to widening definitions of child maltreatment, as well as professionals' 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 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 more than 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 Canada, the lifetime economic costs of CSA alone have been estimated to be $9.3 billion. 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. There is also growing evidence of the neurobiological effects of all types of maltreatment, including neglect and emotional abuse. 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 (e.g., 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. School-based educational programs appear to improve children’s knowledge and protective behaviour and may increase the likelihood of disclosure.
2. Prevention of recurrence is much more challenging; one program - Parent-Child Interaction Therapy, has shown benefits in reducing the recurrence of physical abuse. Home-based training such as SafeCare can also slightly reduce the recurrence of child maltreatment for preschool children.

3. Prevention of impairment programs, especially cognitive-behavioural therapy (CBT) and interpersonal psychotherapy that focus on reducing mental health problems for maltreated children have been shown to improve their well-being. Trauma-focused CBT for sexually abused children are effective in reducing post-traumatic stress disorder symptoms as well as externalizing and internalizing problems. Resilience-oriented programming may be an innovative approach to dampening the impact of emotional maltreatment. Group-based interventions for mothers and children and parenting skills training along with practical support for parents may offer promise for children exposed to IPV.

Children at risk of maltreatment can benefit from structured, enrichment activities with caring, consistent adults outside of the home (e.g., school, quality preschool). In a small minority of cases investigated by child protective services, children need to be removed from the home for maltreatment and ongoing safety concerns. In these cases, foster care can enhance children's mental and physical health and provide better outcomes in the behavioural, social and academic realms.

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. 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 and neglect 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.

Preventing and Responding to Children's Exposure to Intimate Partner Violence

Emma Howarth, PhD

The University of East London, United Kingdom

April 2021

Introduction

In every country across the world, millions of children and young people (CYP) are being exposed to intimate partner violence (IPV) involving one or more of their caregivers or parents. IPV is a form of family violence, that refers to any behaviour by an intimate partner or ex-partner that results in physical, sexual or psychological harm, and includes physical aggression, psychological abuse and controlling, coercive behaviours. It can occur in any relationship regardless of gender or sexual orientation, although women, transgender and gender non-binary persons are at increased risk of experiencing IPV.[1]

Children's exposure to IPV has high human and economic costs. Children living in abusive households are at increased risk of negative physical and emotional health and educational outcomes across their lifespan.[2-4] The pain and suffering experienced by Canadian children as a result of IPV committed in one year (2009) was estimated to be associated with an economic cost of $235.2 million,[5] although the costs of the impact on children are likely to be much higher when the financial impact of responding to children and families is taken into consideration. More recent data from the US estimates the lifetime costs associated with children's exposure to IPV in any given year as $55 billion, related to increased costs due to higher use of healthcare, increased crime and lost productivity.[6]

The scale and impact of this issue necessitates an effective response for children and their families. A comprehensive response includes prevention of IPV from occurring in the first place, detection of and early response to children's exposure to IPV to prevent recurrence, and support to limit or prevent ill effects once a child has experienced it.[7] Below is a summary of what is known in relation to each part of the response to children, as well as gaps in knowledge, evidence, and practice.

Subject

Awareness of a child that the caregiver on whom they rely for protection and comfort is experiencing IPV, can be extremely stressful for a child. Such exposure, even if not observed directly, is increasingly considered as a form of maltreatment, either as a form of emotional abuse or as a separate type of exposure.[7,8] It is important to understand that children can be exposed to IPV in many ways (e.g., seeing the aftermath of IPV, being told about IPV by a sibling, experiencing diminished parenting as a result of IPV); they do not need to directly see or overhear IPV to be impacted by its presence in their lives.[9-11]

Children exposed to one incident of IPV are more at risk of repeated exposure to the same type of violence,[12] and are at greater risk of experiencing multiple different types of victimisation. This is known as poly-victimisation.[13] One study found that of the children and young people who had witnessed IPV in the past year, 33.9% had experienced other types of maltreatment; among those who had been exposed to IPV sometime during their childhood, more than half (56.8%) had experienced other child maltreatment types. Children exposed to multiple types of victimization are more likely to experience negative outcomes than children experiencing none or one form of maltreatment.[14]

Problems

Children exposed to IPV are two to four times more likely to exhibit clinically significant mental health (MH) problems.[3] These include internalizing symptoms (e.g., anxiety, depression), externalizing behaviours (e.g., aggression) and trauma symptoms. While problems may not be severe enough to meet diagnostic criteria for a mental health disorder, they can cause significant distress and functional impairment for CYP and their families.[3,15] It is well established that exposure to IPV in childhood and adolescence is associated with negative outcomes in adulthood, [16] which is mediated in part by early adjustment difficulties, particularly behaviour problems.[17]

Importantly, a number of studies have found that around 30% of children demonstrate resilient outcomes in the short to medium term, meaning they showed successful adaption in the face of significant adversity.[3] Differences in children’s adaptation may in part be explained by the presence or absence of other adversities in children’s lives, as well as children’s, parents’ and family strengths and resources.[18]

Research Context and Recent Findings

To avoid or reduce the distress and difficulties associated with exposure to IPV among caregivers, it is imperative that there are a range of effective strategies to prevent and respond to it.

Prevention of IPV and children's exposure to it

The most direct way of preventing the negative consequences of IPV for children is to prevent or end the violence itself.[19] To date there is insufficient evidence about how to prevent IPV from happening (and in turn children's exposure to it), for example by targeting societal- and community-level risk factors such as gender inequality and poverty.[19] There is also little evidence about the effectiveness of public awareness campaigns.[20] There is some evidence to suggest that educational and skills-based programs to prevent adolescent victimization (commonly referred to as dating violence), may be effective, in particular, programs that are delivered in multiple settings (e.g., community and school), which are longer in duration and involve key adults in adolescents' lives (e.g., teachers, community leaders).[21] However the evidence is equivocal with other reviews concluding that these interventions have little effect on the occurrence of relationship violence, or on attitudes, knowledge or skills that may be associated with relationship violence.[22]

Interventions targeting families experiencing or at risk of child maltreatment (e.g., home visitation and parenting programs), which include, but may not explicitly target families experiencing IPV, are effective in improving child outcomes,[7,23] although the benefit of these broader interventions may be attenuated for families experiencing IPV.[24,25] Advocacy interventions aimed at adult victims (mostly women) to prevent the recurrence of IPV (and therefore children's continued exposure) can be effective,[26] but evidence is lacking about the impact of these interventions on children in the family.[7,27,28]

Identifying children exposed to IPV

Children may need specific interventions to help them recover from their exposure to caregiver IPV but must first be identified as needing support. Existing evidence on how best to identify children is generally weak and there is a lack of evidence to show whether identification of children is linked with better outcomes such as access to care and improved wellbeing.[29] In the absence of good evidence, it is suggested that professionals use a case-finding approach (rather than screening), which means being alert to the signs and symptoms that a child may be exposed to IPV and providing a tailored initial response based on the child's presentation and safety

considerations.[29]

We have some knowledge about the barriers that parents and professionals face when identifying children who have experienced IPV. Caregivers who have experienced IPV may not recognize the impact on their children or they may think that their child was unaware of the violence. They may also be reluctant to seek help for themselves or their children due to fear of involvement with child protections services, and the fear that their children will be removed from their care.[28] Professionals working directly with children and families are generally uncertain about how to respond when they suspect exposure to IPV and are particularly unclear when the violence involves emotional, but not physical harm.[30-33] Evidence suggests that training programs aimed at improving the response of professionals to children who have experienced IPV may improve participants' knowledge, attitudes and clinical competence up to a year after the intervention,[34] and it is recommended that they should be made widely available.[35]

Assessment and referral

If children's exposure to IPV is suspected or confirmed, a qualified professional's assessment is required, followed by a referral to evidence-based interventions and subsequent follow up.[29] Given significant variation in children's adjustment following exposure to IPV, comprehensive assessment is important to guide decisions about whether intervention is appropriate and if so, what type would best meet a child's needs. Although a number of instruments exist to measure children's exposure to IPV, their utility in clinical contexts is largely unknown and there is no single measure that is appropriate across all settings, presenting symptoms or age groups.[29] When children's exposure to IPV is suspected, there is some evidence to suggest that reports from multiple informants (e.g., child and parent) regarding exposure should be obtained when possible.[29] There are many well validated measures to assess children's physical and mental health and wellbeing,[36-38] and these can be used to identify current levels of functioning and appropriate referral pathways.

Targeted intervention after IPV has occurred

Reviews indicate that a wide range of interventions have been developed to improve mental health outcomes among children exposed to IPV and these vary in terms of their therapeutic model, focus, format and mode of delivery.[39-42] Program developers and researchers have focused primarily on the needs of IPV-exposed children by offering services to children directly, to

caregivers who are mothers, or to both mothers and children.[40]

There is limited rigorous evidence to show whether any of these interventions are effective and if they address what children and caregivers find helpful.[39,42] Overall, there are relatively few studies that evaluate the outcomes associated with accessing an intervention following experience of IPV; the available evidence is limited by some important methodological limitations.[39,40,42] The practical implication of this is that interventions are currently delivered without strong evidence showing that they make a difference to children and families or do more good than harm.

Since it will take some years for evidence to catch up with practice, what options should practitioners offer in the meantime? Looking across reviews of interventions, there is some preliminary evidence that psychotherapy for young children, trauma-focused cognitive behavioural therapy, group-based interventions for mothers and children, and parenting skills training along with practical support for parents may offer some benefits.[29,39,41] However it is important to note that reviews, often using the same data, draw different conclusions, and replication studies are needed before stronger conclusions can be drawn.

Research Gaps

- To date, most interventions that aim to enhance child outcomes, focus on working with individuals and families. There has been little emphasis on the impact of strategies which aim to improve those conditions at community and societal levels (e.g., poverty) that are associated with increased risk of IPV. This work is urgently needed.
- Most interventions that aim to improve outcomes for children are offered to the non-abusing caregiver (often mothers) only, children only, or mother and children together. There is limited evidence about the effectiveness of interventions for caregivers who commit IPV in terms of their impact on child outcomes.
- Most interventions have been developed to respond to children who have experienced IPV between cis-gender parents, and where the violence has been perpetrated by a male caregiver against a female caregiver. There is an absence of interventions that explore how to effectively support children experiencing violence occurring between gender-diverse caregivers or where the male caregiver has been victimized.
- Evidence is lacking about to how to effectively support children living with ongoing IPV between caregivers. Often these children are excluded from interventions and ongoing

violence is not measured during interventions delivered in research settings, leaving a gap in our understanding.

- As with adult victims, little is known about how the outcomes of evidence-based mental health treatments are affected when therapy is delivered in the context of exposure to current or past IPV.

Key Research Questions

- Which interventions are effective in preventing IPV and children's exposure to it?
- What are the most effective strategies for identifying children who have experienced IPV?
- Which evidence-based interventions are cost-effective and acceptable for preventing or reducing harm once a child has experienced IPV?
- What type of support is appropriate and effective for groups of children who are underserved by current approaches to intervention?

Conclusions

Children's exposure to IPV is a significant public health problem that requires a comprehensive evidence-based response. Current evidence about the effectiveness for each part of the IPV response in improving child outcomes is limited. There is an urgent need for evidence-based approaches to know what works, for whom and under what circumstances.

Implications for Parents, Services and Policy

Children who live with IPV are victims in their own right, who may experience the consequences of such exposure throughout their lifetime. However, it is important to remember that poor outcomes are not inevitable. The strengths of parents, families and wider communities can protect children from negative outcomes.

Preventing children's exposure to IPV before they experience negative outcomes should be a priority; when interventions focus on reducing the impairment associated with IPV this should be coupled with ongoing efforts to prevent recurrence of children's exposure to violence. Providers should work to increase support for parent survivors in their efforts to keep their children safe, while recognizing that many parents are fearful of information being reported to child protection agencies.

Frontline healthcare and social service professionals need training and support to help them identify children who may be exposed to IPV in their families or who have sequelae from past exposure (See: https://vegaproject.mcmaster.ca/). Programs for children affected by IPV should be a priority among mental health services; it is essential to ensure that services supporting children and families experiencing IPV are available, accessible and evaluated to determine their effectiveness.[43,44]

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Recognizing and Responding to Child Maltreatment: An Overview

Jill McTavish, PhD, Harriet MacMillan, CM, MD, MSc, FRCPC

Offord Centre for Child Studies, McMaster University, Hamilton, Canada

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Introduction

Child maltreatment is a significant public health problem with many potential deleterious consequences. Authors in this series provide concise overviews of key concerns and policy implications related to child physical abuse,[1] child neglect,[2] child sexual abuse,[3] child emotional abuse[4] and children's exposure to intimate partner violence (IPV).[5] Also offered is an overview of what is known about the prevention of child maltreatment and associated impairment,[6] as well as a summary of the epidemiology of child maltreatment,[7] including information about prevalence and incidence rates in Canada. Each author draws attention to the complexity of maltreatment, the importance of understanding risk and protective factors that must be addressed in order to effectively prevent or respond to maltreatment and key policy implications regarding specific types of maltreatment. In addition to these important overviews, we draw attention to educational resources for healthcare and social service providers seeking to recognize and safely respond to children exposed to maltreatment.

Recognition of maltreatment

Across each overview, authors note the challenges of identifying children who have experienced maltreatment. Trocmé[7] notes that physical injuries due to maltreatment are relatively rare, with the 2008 Canadian Incidence Study finding physical injuries in 8% of the 26,339 cases of substantiated maltreatment involving newborns to five-year-olds. However, Chaiyachati and Christian[1] discuss the complexities of receiving an accurate account of injuries when physical abuse is a consideration. The authors note that many children are too young or too ill to provide details about their experiences of abuse and if older, may be too frightened to give an account of what happened. In addition, caregivers may not know about the physical abuse experiences. Caregivers may also be unwilling to provide accurate information if they themselves have caused an injury, if they are worried about the consequences of disclosing what occurred, or if they are

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fearful of another adult who is using violence in the home. Dubowitz and Poole[2] note the difficulty in identifying child neglect and suggest identification should be based on jurisdiction-specific laws regarding children's basic unmet needs and any potential or actual harm resultant from unmet needs. Wekerle and Smith[4] note the challenges in identifying emotional abuse given that there are no physical indicators as there are for other forms of maltreatment. They also draw attention to the high co-occurrence rates of emotional abuse with other forms of maltreatment, as well as the serious impairment that can result from emotional maltreatment. In spite of the difficultly of identifying emotional maltreatment, Trocmé[7] notes that most cases of abuse and neglect reported to child protection services involve current experiences or significant risk of emotional harm. Collin-Vézina and Milne[3] note the complexity of identifying children who have experienced sexual abuse, given that most children delay disclosures or never tell.

The signs and symptoms of maltreatment can be, for these reasons (and others), difficult to recognize; they often overlap with manifestations of other potential environmental concerns in the child's life, such as poverty or parental substance abuse. Howarth[5] notes that evidence regarding different strategies to identify children exposed to IPV is generally weak and that in the absence of good evidence, it is recommended that professionals use a case-finding approach (versus universal screening). Case-finding involves being alert to signs and symptoms of maltreatment, as well as providing a tailored response based on the child's presenting concerns and any safety considerations.

Prevention and interventions

A clear message across the child maltreatment overviews is the need for a public health approach to child maltreatment, involving primary prevention (preventing maltreatment from occurring), preventing the recurrence of maltreatment after identification, and preventing impairment associated with maltreatment. As noted by the authors of each overview, prevention efforts involve mitigating risk factors and enhancing protective factors at each socioecological level, such as individual risk factors (e.g., child or parent characteristics, such as social isolation or parental history of maltreatment), family risk factors (e.g., lack of parent-child attachment), community risk factors (e.g., high levels of unemployment), and societal risk factors (e.g., policies that lead to poor living standards). For example, Dubowitz and Poole[2] note that prevention of child neglect requires addressing neglect-related risk factors of poverty and unemployment, whereas flexible employment opportunities can be a protective factor for families. Wekerle and Smith[4] note that policies are required that promote the safety, wellbeing, and rights of children to live free of all

forms of violence. The also suggest that resilience-oriented programming may help dampen the effects of emotional maltreatment. Collin-Vézina and Milne[3] note that girls are at higher risk of experiencing child sexual abuse, but this may partially be due to boys' reluctance to disclose. In addition, risk for sexual abuse rises with age, with the highest number of victims being between 12 and 17 years of age. Howarth[5] notes that exposure to IPV can occur in any relationship, but women, transgender and gender non-binary persons are at increased risk of experiencing IPV.

Prevention efforts also involve attention to the coordination of services across sectors and political will. Chaiyachati and Christian[1] note that while the argument for primary prevention is compelling, children have little power to advocate for effective prevention programs and "solutions require comprehensive programs with collaboration between child welfare, law enforcement, courts, health and education." The authors therefore argue that reducing the impact of maltreatment requires political will to focus attention and policies on prevention of maltreatment efforts.

Barlow[6] describes many limitations in the current evidence base regarding interventions seeking to prevent maltreatment and associated impairments, such as the paucity of rigorous research designs that can be useful for assessing program effectiveness, the wide variation in measurement outcomes used within and across studies, the over-reliance on parental self-report and proxy measures of an outcome, and the lack of research overall in low- and middle-income countries. In spite of these research limitations, Barlow[6] does draw attention to some promising programs, such as Triple P or Nurse Family Partnership for primary prevention of maltreatment; Parent-Child Interaction Therapy and SafeCare for prevention of recurrence; and trauma-focused cognitive behavioral therapy for children who have experienced sexual abuse and have post-traumatic stress symptoms.

In spite of these limitations in the current evidence, some authors in this series discuss good practice skills that providers can use to assist children and families when maltreatment is suspected or confirmed. For example, Dubowitz and Poole[2] discuss the following six principles that can guide providers in tailoring services to children and families' unique needs: "1) address the contributors to the problem, 2) forge a helping alliance with the family, 3) establish clear achievable goals and strategies for reaching these goals, 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. These types of skills are helpful for providers to consider while we await advances in research about effective evidence-based programs for

preventing maltreatment and associated impairments.

Training for healthcare and social service providers

While the authors of each overview emphasize that the best way to help children is to prevent maltreatment from ever happening (primary prevention), healthcare and social service providers need support to care for and protect children who are currently experiencing maltreatment. Thanks to funding from the Public Health Agency of Canada, the VEGA (Violence, Evidence, Guidance, Action) Project[8] (see https://vegaproject.mcmaster.ca/whyvegavideo) has created pan-Canadian guidance and educational resources to assist healthcare and social service providers with recognizing and responding safely to those experiencing family violence, including child maltreatment. VEGA[8] includes a platform for evidence-based guidance and an accreditable curriculum comprised of learning modules (e.g., care pathways, scripts, how-to videos), interactive educational scenarios, and a handbook to better equip providers (including students) across a range of settings to provide safe and effective care to those who may have experienced family violence. Modules address 1) epidemiology of maltreatment (rates of maltreatment, definitions, health and social impacts, and risk and protective factors), 2) strategies to create safe interactions and environments through trauma- and violence-informed care, including patient/client physical, emotional, and cultural safety and 3) strategies for identifying children experiencing maltreatment and safely responding. VEGA educational resources were developed based on results from extensive systematic reviews, which were conducted in coordination with the World Health Organization (WHO) officials and parallel WHO child maltreatment guidance development. In addition to evidence-based information, like the principles detailed by Dubowitz and Poole,[2] VEGA contains many guiding principles of good practice when responding to children experiencing maltreatment. For example, VEGA suggests that before asking children questions that might result in them disclosing exposure to child maltreatment, certain conditions of safety must be achieved, such as a private space to speak with the child separately from the caregiver. Additional good practice information is available regarding strategies for identification, ways to inquire safely about maltreatment, ways children disclose about maltreatment, safe responses to disclosures of maltreatment, strategies to fulfill reporting duties, principles of comprehensive assessment, considerations for documentation, and more.

Conclusion

Child maltreatment has major human and economic costs, given the potential physical and mental health consequences of these exposures. Policy efforts should address prevention of maltreatment, as well as mitigation of risk factors associated with maltreatment (e.g., poverty, employment). Research on effective interventions for prevention of maltreatment and associated impairment is limited, but a few promising programs are available. While prioritizing prevention is a key concern, the VEGA Project offers helpful educational resources for healthcare and social service providers so that they may effectively recognize when children may be experiencing maltreatment and safely respond to these children.

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Child Physical Abuse: An Overview

Barbara H. Chaiyachati, MD, PhD, Cindy W. Christian, MD

University of Pennsylvania, USA

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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.[1] 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.[2] 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.[3] Additionally, definitions of physical abuse are culturally determined, and what is considered abusive in one society may not be in another.[4,5] In many societies, physical violence against children as a method of punishment is endorsed by parents, sanctioned by societal institutions (such as schools) and allowed by law.

Quantifying the burden of child physical abuse is difficult. 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.[6-8] Measuring physical abuse is methodologically challenging, and incidence and prevalence will vary by the surveillance methods used to define and detect the problem.[9] 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.[10,11] Review of the best available research estimates that global prevalence of maltreatment by self-report is 226/1,000 children and approximately 125/1,000 for American children.[12,13] Lifetime risk of confirmed maltreatment for American children is estimated to be greater than 1 in 10.[14]

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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 exposure to intimate partner violence.[15-20] A risk factor may impact families independently or risk factors may accumulate toward a threshold increased risk for physical abuse.[21] Risk factors for specific types of physical abuse have also 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.[22,23] 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.[24] 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 chronic illnesses, but child welfare and health care systems historically have not addressed the health needs of dependent children.[25-30] Compared to children in foster care, maltreated children who remain at home exhibit similarly high rates of physical, developmental and mental health needs.[31]

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.[32] They are the most vulnerable because of their physical and developmental immaturity, and relative social invisibility.[2] Morbidity from physical abuse is high 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. 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 heart disease, liver disease, autoimmune diseases, sexually transmitted infections, and early death.[33-37] Mental health disease and the use of psychotropic medications are also greater in adults who had been maltreated as children.[38-40]

Scientific investigation is improving our understanding of the causal biological pathways for these robust associations.[41] 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.[42,43] 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.[44,45] This research underscores the need to develop and test prevention and early 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 may be inaccurate, either because the adult is unaware of the actual history, or is unwilling to provide a truthful history. There are many potential barriers to providing a truthful history that may include circumstances when the caregiver is the perpetrator of intentional abuse, the caregiver is fearful of consequences related to a plausible accident, or the caregiver is fearful for their own safety with regard to disclosing abuse by another adult. 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. 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.[46,47] No single injury is diagnostic of abuse, but certain patterns of trauma can be highly specific for maltreatment. It is important to recognize that there is a differential diagnosis for every potential injury, and objective and thorough evaluation is required in order to identify abuse with reasonable confidence.[48,49]

Implications for Policy

Child physical abuse is a pervasive social problem. Child welfare agencies in the U.S. receive more than four million reports of suspected maltreatment annually and investigate approximately two-thirds of the reports made.[32,50] At any given time, more than 400,000 American children reside in foster care.[51] 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 struggle to adequately address the problem.[52]

Child welfare services are historically structured as short-term interventions that monitor families for recidivism, provide targeted 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 Interaction Therapy, have shown promise in preventing the recurrence of child physical abuse.[53,54]

The argument for primary prevention and early identification and treatment is compelling, but children have no political capital, and solutions require comprehensive programs with collaboration between child welfare, law enforcement, courts, health and education. The evidence-base for child abuse prevention is growing yet there are still limited rigorous studies that show significant impact.[55-57] Programs that show promise are discussed in the Child Maltreatment Prevention paper by Professor Jane Barlow.[58]

Preventing the physical abuse of children and protecting them from further harm continues to 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 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

Howard Dubowitz, MD, MS, Gina Poole, PhD

University of Maryland, School of Medicine, USA

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Introduction

Neglect is by far the most common form of child maltreatment reported to the U.S. child welfare system; 75% of reports in 2017 were for neglect.[1] 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 2017, 75% of deaths attributed to child maltreatment involved neglect.[1] Furthermore, child neglect places an enormous economic burden on society. A conservative estimate regarding the costs associated with child maltreatment exceeded 100 billion dollars a year; much of this was for neglect.[2]

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.[3] 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.[3] 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 considering neglect to be intentional 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.[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 one country, the United States, has 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.[6]

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.[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 a comparison group.[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.[9] Furthermore, although both abused and neglected children performed poorly academically, neglected children experienced greater academic deficits relative to abused children.[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.[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.[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.[7] Similar to adults with a history of physical abuse, adults with a history of neglect are at increased risk for violent criminal behaviour.[13]

Contributors to Child Neglect

Multiple and interacting factors contribute to the occurrence of child neglect. Belsky's[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, whether the child's basic needs are unmet, and whether potential or actual harm are involved.[15] 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 and the contributing factors. This understanding helps guide the most appropriate intervention.

Cultural practices are an important consideration when assessing possible neglect. Terao and colleagues[16] offer a six-step decision-making model useful in differentiating child maltreatment from culturally-based parenting practices. Understanding the cultural context of families will also help 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.[17-19] Parenting programs also offer valuable guidance and can be effective, such as the Triple P intervention.[20] Another example is the Safe Environment for Every Kid (SEEK) model of pediatric primary care.[21] Building on the relationship between pediatrician and family, SEEK identifies and helps address prevalent risk factors such as parental depression and intimate partner violence. All these interventions aim to strengthen families, support parents and parenting and promote 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.[22] 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 these goals, 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 improve 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

[1]Delphine Collin-Vézina, PhD, [2]Lise Milne, PhD

[1]McGill University, Canada, [2]University of Regina, Canada

May 2019, Éd. rév.

Introduction

Child sexual abuse (CSA) is a form of maltreatment that is recognized globally as a serious human rights violation and a major public health concern. 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.[1] There is a general consensus that CSA is a complex phenomenon occurring for multiple reasons, in various ways, and in different relationships within families, peer groups, institutions, and communities.[2] Two important overlapping unresolved issues include the lack of a conceptual model of CSA and the absence of a shared definition or understanding of what constitutes CSA worldwide.

Scope of the Problem

Most studies emphasize that the full extent of CSA perpetration remains unknown.[1,3] It is difficult to determine given differences in the way data is collected,[4] as well as the reticence of most children to disclose the abuse.[5]

Disclosure of traumatic events such as CSA can often be a very complex, iterative life-long process.[6] Victims of CSA often delay reporting, or never tell.[5] For example, in a review by Finkelhor [7] only about half of survivors across all studies had disclosed the abuse to anyone. In another study, the vast majority of survivors (93%) did not report the abuse to authorities prior to the age of 15.[8]

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In a 2013 systematic review and meta-analysis of recent studies worldwide, CSA prevalence rates were found to be 8 to 31% for girls and 3 to 17% for boys. Forced intercourse was self-reported by 9% of girls and 3% of boys.[9] In contrast, incidents of CSA reported annually to formal, official bodies such as child protection services is drastically lower (e.g., .43% in Canadian child protection systems;[10] 2.4% in U.S. child protection and community agencies).[11] Clearly, official reports to authorities underestimate the extent of CSA; in another worldwide CSA prevalence meta-analysis, rates were more than 30 times higher in self-report than official-report studies (12.7% versus 0.4%).[12]

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.[12] 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.[13] 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.[1]

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 dissociative symptoms than non-abused children,[14] as well as more depression and conduct problems.[15] They engage more often in at-risk sexual behaviours.[16] Victims are also more prone to abusing substances,[17] and to suicide attempts.[18] These mental health problems are likely to continue into adulthood.[19] CSA victims are also more at risk than non-CSA youth to experience violence in their early romantic relationships;[20] 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.[21]

However, about one third of victims may not manifest any clinical symptoms at the time the abuse is disclosed.[22] 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[23] and those who have not experienced prior abuse[24] 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.[25]
- 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 regard to forensic evidence collection and prosecution rates in CSA cases involving children has been demonstrated.[26]

In terms of interventions for reducing impairment associated with CSA, a recent meta-analysis found that treatment is effective in reducing PTSD symptoms as well as externalizing and internalizing problems.[27] Of the handful of evidence-based treatments, 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) symptoms.[28] 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.[29] 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.[30,31]

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; they appear to improve children's knowledge and protective behaviours and may increase the likelihood of disclosure, but it is unknown whether they prevent the occurrence of CSA.[32]

Research Gaps

Two main gaps are worth highlighting: First, 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. Second, there is a need to identify additional evidence-based approaches for assessment, treatment and prevention of CSA.

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. A 2011 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

Beyond the broad range of deleterious health and social impacts of CSA, the lifetime economic costs have been estimated to be $9.3 billion.[33] To address this major public health problem, we should prioritize the development of strategies to prevent sexual abuse from happening in the first place and 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.

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Emotional Maltreatment: An Overview

Christine Wekerle, PhD, Savanah Smith, BA

McMaster University, Canada

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Introduction

Emotional or psychological maltreatment is a highly prevalent and damaging form of child abuse. It reflects a caregiver's failure to provide a developmentally-appropriate and supportive environment, including persistent, pervasive or patterned dehumanizing acts such as frequent name-calling (emotional abuse; acts of commission) and failures in providing nurturance, affection, and approval (i.e., emotional neglect; acts of omission). Six types 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 or exposure to criminal activities); and (6) exploiting (e.g., assigning caregiver role to child for parental care or childcare).[1] Some jurisdictions also categorize exposure to adult intimate partner violence (IPV) as a form of child emotional abuse. In this series, children's exposure to IPV is considered as a separate category of child maltreatment. Experiencing emotional maltreatment is strongly associated with the experience of other forms of childhood maltreatment and household dysfunction.[2] Unlike other forms of maltreatment, which may have physical indicators, emotional maltreatment has none. In sum, emotional maltreatment may be a stand-alone form of abuse or neglect, as well as a frequently co-occurring form.[1]

Prevalence and Under-Reporting

Different estimates of emotional maltreatment prevalence arise from research with different populations. A review of meta-analyses estimates the global prevalence of emotional abuse as 36.3% of people affected, and emotional neglect as 18.4% of people affected.[3] Studies of youth involved with Child Protective Services (CPS) have found that emotional maltreatment tends to occur much more frequently than what is recorded by CPS workers. In one study of CPS-involved cases that involved coding maltreatment experiences with a standard framework, over 50% of youth had experienced emotional abuse (chiefly terrorizing); the majority had also experienced

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physical abuse and neglect.[4] The Ontario Incidence Study of Reported Child Abuse and Neglect placed the 2013 CPS substantiation rate for emotional maltreatment rate at 13%, and the exposure to IPV at 48%.[5] Researchers found that 30% of cases where emotional maltreatment was the primary form had more than three prior case openings for some form of maltreatment.[6] The U.S. CPS-involved youth longitudinal study (LONGSCAN) found that 98% of youth who reported emotional maltreatment, reported re-experiencing it.[7] Exposure to early emotional maltreatment, number of CPS reports, and having a caregiver with depression were factors shown to predict entry into the foster care system.[8]

Subject

Recent longitudinal research found that maternal negative expressiveness mediated the relationship between mother's own emotional maltreatment experiences and their infant's emotional dysregulation and behavioral problems, in children as young as 14 months.[9] Parents who direct intense negative emotions towards the child (disgust, anger) or create highly negatively charged environments (yelling, being over-controlling) risk overwhelming their child's cognitive capacities and creating disorganized behavioural responses. This dynamic of parental ignore/attack and child destabilization creates a trajectory of impairment in managing emotions related to self and others. Research has shown that parents who perceive themselves as powerless, have both higher emotional reactivity and hostility towards their child's behaviour. In response to perceived child personal attack or personalization of disobedience, the parent responds with power assertive actions (rejection, attack).[10] Not surprisingly then, emotional maltreatment has been linked to significant impairment in emotion regulation, including difficulties with both emotional clarity (i.e., being able to identify one's emotions) and emotional expressiveness.[11-14] Emotional maltreatment-related impairment spans a wide range of mental health areas, including personality problems, mood disorders, substance abuse problems, and relationship violence.[2,15,16] A systematic review showed increased risks impacting school achievement (impulsivity, inability to pay attention, reduced literacy, and numerical skills difficulties).[16] Emotional maltreatment is associated with social anxiety and anxiety disorders[17-20] and depression.[21-24] Emotional neglect has been associated with drug-use and smoking,23 as well as binge drinking, alcohol abuse, and other alcohol-related problems.[25] There is some evidence of greater mental health impact of emotional maltreatment in adolescence on male victims.[26] Experiencing emotional abuse is predictive of aggression symptoms, however, there may be gender differences in the pathway from maltreatment to aggression. For example, one study

found that this relationship was mediated by psychoticism in males, and neuroticism in females.[27] In a study of male youth offenders, maternal warmth mediated the relationship between emotional neglect and youth presenting with callous unemotional traits.[28]

Longitudinal research has identified the experience of emotional maltreatment over the course of a three-year period as a significant predictor of youth suicide ideation.[29] A nationally representative U.S. study found that adolescents who reported child emotional abuse were 2.6 times more likely to report suicidal ideation, and 2.4 times more likely to report a suicide attempt in the past year than those who had not experienced emotional abuse.[30] A core insult may be to the victim's sense of mattering (i.e., to one's self, to others, and to the environment), with emotional maltreatment linked with low levels of mattering.[31]

Another potential area of impairment for victims of emotional maltreatment is in building and maintaining positive relationships. A systematic review of the literature on adolescent victims of emotional maltreatment identified associations to both perpetration and victimization of IPV in males.[32] For CPS-involved youth, emotional maltreatment predicted dating violence perpetration in adolescent males and victimization in females, both of which were explained in part by the level of trauma symptomatology.[15] Similarly, emotional maltreatment predicted risky sexual behaviour at age 18, mediated in part by trauma symptoms.[33] The link between childhood emotional maltreatment and later decreased life satisfaction was mediated by rejection sensitivity in romantic partnerships in males.[34] For females, emotional maltreatment has been shown to significantly predict low relationship satisfaction.[35] Similarly, results from the U.S. Longitudinal Study of Adolescent to Adult Health found that experiencing emotional abuse was significantly related to adult perpetration and victimization of IPV in males, and perpetration and mutually-perpetrated violence in females.[36] Emotional maltreatment in childhood appears to be a robust disruptor of functioning in close relationships.

Finally, there is some evidence that children who have been victims of emotional maltreatment may be at risk of disordered eating behaviour and relationships in adolescence and adulthood. Kimber and colleagues conducted a systematic review finding the prevalence of emotional maltreatment, including IPV exposure, as it relates to eating disorders ranging from 21% to 66%.[37] A study of obese adults found that those with binge eating disorder reported significantly higher levels of emotional abuse and neglect.[38] In a large non-clinical study, emotional abuse was a significant positive predictor for hoarding of material possessions.[39]

Problems

1. Prevalence of emotional maltreatment is high.
2. While there is emerging consensus on (a) patterned caregiver behaviour defining emotional maltreatment, and (b) parental risk factors (depression, substance abuse, psychiatric illness in general, and a history of maltreatment), there is no agreement as to how to operationalize emotional maltreatment for practical use in terms of community standards for reasonable parenting.[40,41]
3. 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, although IPV has in both systems.[42,43]
4. Sex may be a factor in understanding the emotional maltreatment–impairment link. Impact across the gender spectrum remains to be considered further.
5. A 2011 review determined further research was needed to develop a reliable and valid instrument to measure childhood emotional maltreatment.[44] Clinicians are encouraged to ask children about their family relationships, feelings of self-worth, being loved and safety.

Research Context

Most information on emotional maltreatment, as it relates to youths receiving CPS services comes from countries with formal child protection systems. 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.

Key Research Questions

1. How does emotional maltreatment reflect a cycle of violence?
2. Are there emotional maltreatment indicators that signal greater risk for impairment or factors promoting resilience?
3. How does emotional maltreatment relate to gender diverse youth experiences?

Recent Research Results

A recent meta-analysis of studies involving parents committing emotional abuse found that emotionally abusive parents typically reported negative affect, depression, verbal aggression, emotion dysregulation and anger, as well as low levels of emotional control and positive coping strategies.[45] These results draw attention to the issue of intergenerational transmission of risk, as well as the need to emphasize intervention to bolster positive coping or parenting resilience.

A recent focus of attention has been the cognitive functioning and development of maltreated children.[46] For example, among foster children (in out-of-home care), a history of emotional abuse was negatively correlated with height-for-age, visual-spatial processing, memory, language and executive function.[47] Early intervention that targets environmental enrichment shows promise in yielding better child cognitive outcomes (e.g., memory) that seem to be mediated by the child's stress response hormones.[48] The ultimate goal is to consider the contexts for resilient functioning, integrating streams of biological, clinical and epidemiological research, with prevention.[49]

To date, it appears that there have been no studies looking at how concepts of heteronormative discrimination and social stigma may relate to emotional maltreatment among LGBTQ2SI+ youth. One recent study found that gay, lesbian, and bi-sexual adults who had experienced childhood emotional maltreatment had significantly higher levels of depression and anxiety symptoms as compared to those not experiencing familial emotional maltreatment.[50]

Research Gaps

Legal and medical definitions to guide CPS thresholds for intervention vary across regions, despite the clear need for CPS to accord more attention to emotional maltreatment impacts.[49] Presently, there is no "gold standard" approach to determine exposure to emotional maltreatment. In 2012, the American Academy of Pediatrics published a clinical report emphasizing the need for clinicians to be alert for this form of maltreatment, and consider interventions that promote positive parenting and child development, emphasizing the priority of child safety includes both physical and psychological safety.[51] A gap area relates to the rise of e-communications and the issue that emotional maltreatment may be perpetrated over the internet or via social media by family and others.

It is also important to examine how the effects of emotional maltreatment occur beyond caregiver/family dynamics. Recent research has examined the effects of emotional maltreatment on students by their teachers.[52] One study of Korean youth reporting that 18.2% had experienced

emotional maltreatment committed by their teacher,[53] and another study from the Republic of Cyprus reporting that 33.1% of students surveyed had been emotionally abused by a teacher in primary school.[54] As complex as it may be to define and identify familial emotional maltreatment, it becomes increasingly complicated to detect emotional maltreatment occurring outside of the home.

Conclusions and Implications for Parents, Practice and Policy

Emotional maltreatment is a prevalent, but less visible form of childhood maltreatment. 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 child maltreatment including exposure to adult IPV; (3) to adequately promote the safety, well-being and rights of children and youth to live free of all forms of violence; and (4) to prevent or dampen maltreatment-related impairment via an increased focus on resilience. Evidence-based parenting programs exist and, given the broad range of impairment, it is severely costly to not implement these from a public health perspective.[55-58]

A chaotic, violent, antagonistic home life is maltreating in a persistent way for children and represents a toxicity to child and adolescent development. Transition from the home, such as quality preschool experiences, formal school entry, and increasing autonomy in adolescence provide opportunities to realign emotion-focused learning and orient towards positivity and healthy coping. Resilience-oriented programming may be an innovation approach to dampening the impact of emotional maltreatment. Emotional maltreatment has been linked to lower optimism; however, the experience of positive life events may buffer this effect and increase dispositional optimism.[59] Research has demonstrated the effectiveness of positive schemas (i.e., the ability to focus on positive stimuli and ignore negative, or emotionally taxing stimuli) in promoting resilience and interrupting the trajectory from childhood emotional maltreatment to poor mental health (e.g., depression).[60,61] These findings underscore an opportunity to emphasize safe, social relationship-building and to embrace service systems as partners in promoting wellbeing and resilience. Better life outcomes occur when violence in the personal and home environment ceases and positive experiences and opportunities increase. Emotional maltreatment is a preventable form of child maltreatment, and may yield sizeable dividends, given its prevalence.

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Prevention of Child Maltreatment and Associated Impairment

Jane Barlow, DPhil; FFPH (Hon)

Warwick Infant and Family Well-being Unit, University of Warwick, United Kingdom

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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, in both high- and low-income countries and effective methods of prevention have begun to be identified during the past two decades.

Subject

Significant numbers of children experience abuse with prevalence levels varying by maltreatment type, gender and setting. The most recent review of prevalence studies concluded as follows: (n.b. the median or 50th percentile in addition to the 25th to 75th centile are presented, which means that 50%, 25% and 75% respectively of the values are below these centiles:

"Sexual abuse is the most commonly studied form of maltreatment across the world with median (25th to 75th centile) prevalence of 20.4% (13.2% to 33.6%) and 28.8% (17.0% to 40.2%) in North American and Australian girls respectively, with lower rates generally for boys. Rates of physical abuse were more similar across genders apart from in Europe, which were 12.0% (6.9% to 23.0%) and 27.0% (7.0% to 43.0%) for girls and boys respectively, and often very high in some continents, for example, 50.8% (36.0% to 73.8%) and 60.2% (43.0% to 84.9%) for girls and boys respectively in Africa. Median rates of emotional abuse were nearly double for girls than boys in North America (28.4% vs 13.8% respectively) and Europe (12.9% vs 6.2% respectively), but more similar across genders groups elsewhere. Median rates of neglect were highest in Africa (girls: 41.8%, boys: 39.1%) and South America (girls: 54.8%, boys: 56.7%) but were based on few studies in total, whereas in the two continents with the highest number of studies, median rates differed between girls (40.5%) and boys (16.6%) in North America but were similar in Asia (girls: 26.3%, boys: 23.8%).[1]"

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The consequences of such maltreatment 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.[2] The long-term consequences for survivors include wide-ranging mental health problems such as depression, drug and alcohol misuse, risky sexual behaviour, and criminal behaviour, all of which continue into adulthood.[3] The societal consequences of abuse are also high in terms of both direct (e.g., services to identify and respond to child abuse) and indirect costs (e.g., services to deal with associated problems such as mental health problems; substance misuse; criminality, etc.).[3]

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 is effective in preventing child maltreatment is a paucity of rigorous research designs that can be applied to the field of assessing program effectiveness. There is also wide variation in the measurement of outcomes and an over-reliance on parental self-report and proxy measures of outcome. Within low-income countries there is a lack of rigorous research across all types of abuse and prevention levels.

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 evidence 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 in relation to the prevention of child maltreatment focus on both the effectiveness and cost-effectiveness of preventive approaches and address the four main types of maltreatment in terms of the different levels of prevention highlighted above. 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 with serious mental illness, or who are abusing drugs; or for whom intimate partner violence is the main issue); and whether interventions that have been found to be effective in high-income countries can be translated to low-resource settings, and what cultural adaptation is needed.

Key Research Results

Part (a) of this section describes evidence-based interventions at the three different levels of prevention referred to above – primary prevention; prevention of recurrence, and prevention of impairment. Part (b) describes possible intervention strategies that go beyond the level of intervention.

a. Interventions for prevention

Primary prevention

There is, to date, limited evidence of the effectiveness of population-based interventions in high-income countries for the prevention of child maltreatment. One promising intervention appears to be population-based Triple P involving the delivery of Triple P professional training for the existing workforce, in addition to the delivery of universal media and communication strategies.[4]

The research also suggests that a number of targeted primary preventive interventions have potential in high-income countries. Although home-visiting is not uniformly effective, the Nurse-Family Partnership has been found to have the greatest number of benefits in terms of reducing the risk of child maltreatment.[5]

Other primary preventive approaches that have been shown to have promise in high-income settings include hospital-based educational programs to prevent abusive head trauma, alongside enhanced paediatric care, for families of children at risk of physical abuse and neglect.[4] Although school-based educational programs appear to be effective in improving children's knowledge and protective behaviours, it is not currently known how effective they are in preventing sexual abuse.[6]

There is limited evidence available regarding the effectiveness of primary preventive approaches in low- and middle-income countries (LMICs), most of which is focused on middle- rather than low-income settings, and in many cases involves the adaptation of interventions developed in high-income countries.[7] Promising approaches include home visits (via existing health services; health clinics; or as stand-alone interventions) and group-based delivery (in community settings or work places), by paraprofessionals or professionals, with limited evidence currently of the effectiveness of intervention by lay individuals.[7]

Prevention of recurrence

There is also limited evidence available concerning what works to prevent the recurrence of maltreatment.8 Parent-Child Interaction Therapy (PCIT), a behavioural skills training intervention, has been found to be effective in preventing the recurrence of child physical abuse, and home-based training such as SafeCare can also produce small reductions in the recurrence of child maltreatment for preschool children.[8] There is also some evidence that multisystemic therapy can lead to small reductions in recurrence for children (aged 10-17 years) exposed to physical abuse.[8] There is no randomized controlled trial evidence available addressing what works to prevent recidivism of the other types of abuse,[8] or that are effective in LMICs.[7]

Prevention of impairment

The research suggests that the prevention of impairment requires a thorough assessment of the child and family. Evidence regarding the reduction of mental-health problems for maltreated children in high-income countries suggests that psychological interventions, such as cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT), should be considered for children and adolescents who have been exposed to maltreatment and are experiencing emotional disorders, and that trauma-focused CBT should be provided for children who have been sexually abused and are suffering with post-traumatic stress symptoms.[5] There is also some evidence of the benefit of child-parent psychotherapy, and trauma-focused CBT for children with intimate partner violence-related post-traumatic stress disorder (PTSD) symptoms.[5] There is no English language evidence from RCTs currently available regarding the prevention of impairment in children in LMICs.

For maltreated children who need to be removed from the parental home

The research shows that in high-income countries, 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.[4] There is no English language evidence from RCTs currently available regarding effective alternatives to parental care for maltreated children in LMICs.

b. Strategies for prevention

The Spectrum of Prevention describes seven levels at which prevention activities can take place, and moves beyond individual services and community education.[9] It encourages creative and effective prevention projects, and can help communities develop activities that have a greater chance of success as a result of the fact that they complement the strengths that already exist within a community.[9]

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 maltreatment. 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 mentalization-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 of a child’s life, and for the use of multi-method and multisource approaches to the assessment of maltreatment.[10] 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.

Further research is also needed on the effectiveness of programs in LMICs, including the extent to which existing evidence-based programs can be adapted for use within low resource settings, and the possibility of using lay providers to deliver such interventions.[7] Other research issues in these settings include the need for more complete reporting, increased standardization of outcomes and use of validated measures, and more studies focusing on older children.[7] Further research is also needed to identify interventions to prevent recurrence and impairment among maltreated children.

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 effective methods of prevention and intervention are identified. 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.

Implications for Parents, Services and Policy

The research suggests that strategies to prevent maltreatment should begin early and encompass both population-wide approaches that aim to provide pregnant women and parents of 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 PCIT), and child-focused interventions (e.g., school-based educational programs, trauma-focused CBT). Foster care and enhanced foster care programs can also lead to improved outcomes for children.

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Child Maltreatment and its Impact on Psychosocial Child Development: Epidemiology

Nico Trocmé, PhD

McGill Centre for Research on Children and Families, Canada

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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 provides a brief discussion of implications for policy and practice.

Definitions

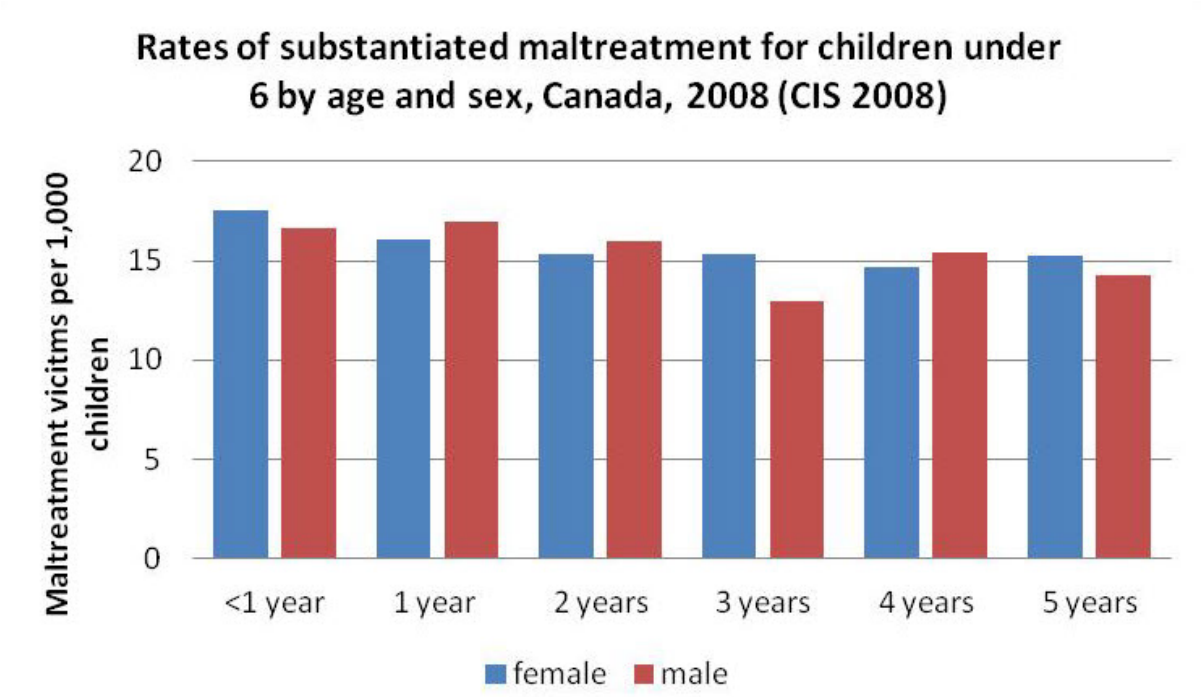
Child maltreatment is the broad term used to describe abusive and neglectful acts perpetrated by adults or older youth against children. These fall into four broad categories: physical abuse, sexual abuse, neglect and emotional maltreatment. Physical abuse ranges from severe assaults against children 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 failure to supervise or protect a child or to meet a child's physical needs. Neglect often occurs in a context of extreme poverty where parents may not have the resources or supports needed to meet a child's needs. 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.[a]

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 one year of age compared to 14.57 for those under five), 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,[2] whereas in Australia, the rate of victimization for fiscal year 2008-09 was 6.9 per 1000 children.[3]

Childhood Prevalence

Prevalence studies measure rates of victimization during childhood, as opposed to incidence statistics that measure rates of victimization during a specific year. Results from a Canada-wide health survey show that 32% of respondents aged 18 years and older reported some type of child abuse, including physical abuse (26.1%), sexual abuse (10.1%) and exposure to intimate partner violence (7.9%).[4] Women were more likely than men to report sexual victimization (14.4% v.

5.8%). These findings are consistent with results from surveys conducted in Ontario[5] and Quebec.[6] Notably, the Quebec survey found that only 21.2% of adults reported disclosing their victimization within a month of the first abusive event.

Injury and Death

Physical injuries due to maltreatment 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 of age. 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 four years of life. Children under five are at highest risk of being killed by a parent: 50% of children from birth to 17 who are killed by a family member are under four years old.[7] Rates of child and youth homicides perpetrated by family members have been declining: the rate of family-related homicide against children and youth decreased by 18%, from 3.4 in 2007 to 2.8 per 1 million population in 2017.[8]

Emotional Harm

Most cases of maltreatment reported to child welfare services involve situations where children have already suffered some sort of emotional harm or are at significant risk of experiencing emotional harm. Young children are particularly vulnerable to a range of long-lasting negative cognitive, psychosocial, and behavioural outcomes, including learning problems, problems relating to peers, depression, anxiety or aggression.[9] Maltreatment of young children changes the way they interpret interpersonal interactions, which in turn affects the nature of relationships with family and peers.[10] Of particular concern is the growing evidence of neurobiological effects of maltreatment, especially emotional maltreatment and neglect, during early childhood.[11]

Trends

Child maltreatment is increasingly recognized as a public 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.[1] 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.[12,13] 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 school personnel, who account for nearly 90% of all domestic violence reports. The decrease in reports of child sexual abuse is more difficult to interpret. While the decrease in reports could be attributed to a decrease in rates of victimization in the population, there also is evidence that the decline reflects changes in reporting patterns and investigation procedures.[14]

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.[12,13]

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Note:

[a] 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 for future risk of maltreatment where no specific allegations of past incidents of maltreatment had been made.