

A photograph of a woman with dark skin and curly hair, smiling broadly. She is wearing a light-colored top and has a baby in a blue and white striped sling on her back. The background is a green lattice fence.

IACAPAP Textbook of Child and Adolescent Mental Health

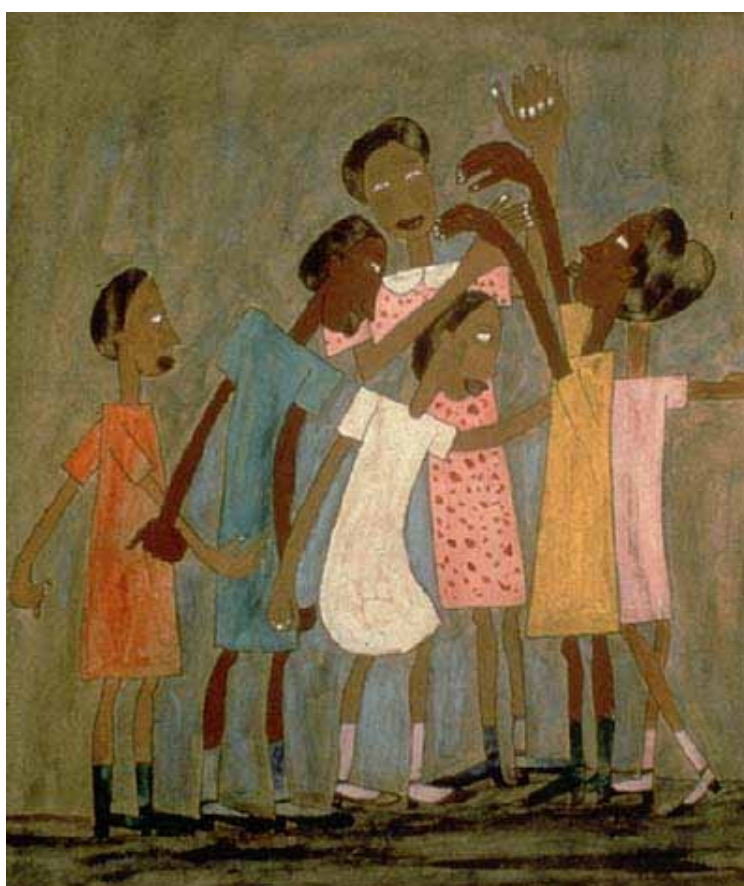
Section B

PERINATAL AND EARLY CHILDHOOD RISK AND PROTECTIVE FACTORS & DISORDERS

Associate Editors: Sarah Mares & Louise Newman

EARLY MALTREATMENT AND EXPOSURE TO VIOLENCE

**Susan MK Tan, Norazlin Kamal Nor, Loh Sit Fong,
Suzaily Wahab, Sheila Marimuthu & Chan Lai Fong**



Children
Playing
London
Bridge,
by William H.
Johnson

Susan MK Tan MD (UKM),
DCH (London), MMed
Psych (UKM), Adv.M.Ch.
Ado.Psych (UKM), AM

Child & Adolescent Psychiatrist,
Department of Psychiatry,
Universiti Kebangsaan
Malaysia Medical Center, Kuala
Lumpur, Malaysia

Conflict of interest: none
declared

Norazlin Kamal Nor
MRCPCH(Lon), MBBS(Lon),
BSc(Lon)

Paediatrician, Department
of Paediatrics, Universiti
Kebangsaan Malaysia Medical
Center, Kuala Lumpur,
Malaysia

Conflict of interest: none
declared

Loh Sit Fong B Eon(Kobe),
M Clin Psych (UKM)

Psychologist, Department
of Psychiatry, Universiti
Kebangsaan Malaysia Medical
Center, Kuala Lumpur, Malaysia

Conflict of interest: none
declared

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Children need a safe and secure environment that they can call home. Besides providing shelter, home needs to be a place of both physical and emotional safety where children can find comfort, protection and security. Thus, optimum development depends on the interaction of positive environmental influences and inherent genetic disposition starting even prenatally (Shonkoff et al, 2000). Negative experiences at an early age have been shown to have long term consequences for children, including changes in brain structure (National Scientific Council on the Developing Child, 2004). These stressors are not necessarily just physical insults such as injury or infection; psychological or emotional ones are equally “toxic” for the process of growing up healthily, especially if there are no supportive adult attachment figures to help the child buffer the stress. When the immediate environment in which a child lives – his home – becomes a “war zone” with verbal and physical aggression, the suffering of the child is not only limited to the point in time when it occurs but has repercussions for the rest of his life. Research has shown that exposure to violence in the household has a lasting developmental impact (US Department of Health and Human Services, 2003). In this chapter the term “child” is used for human beings aged less than 18 years, “he” is used to describe both girls and boys and “parent” is used to describe parents, carers, guardians and other individuals who have parental responsibilities.

HISTORICAL NOTE

Dr Henry Kempe created the terminology and concepts which are now universally recognized. The “shaken baby syndrome” was identified in 1972 by American pediatrician and radiologist John Caffey (American Academy of Pediatrics, 2001). However, it was not until the 1970s that sexual abuse began to be acknowledged and the 1980s and 1990s that emotional abuse was recognized.

CHILD MALTREATMENT

The definition (see Table B.1.1) of child maltreatment varies across continents and cultures but the focus is on similar salient points, which are:

- *Ill treatment* (i.e., the opposite to nurturing)
- *The potential to cause harm to the child*, including threats to harm as well as neglect (failure to provide the basic necessities required for normal development)
- It usually involves parents or other people in the context of a relationship of responsibility, trust or power (this includes teachers, religious leaders etc.)
- *Exposure to (witnessing) violence*, especially between parents.

In 1873 animals had rights but children did not

In 1873, a church worker, Mrs Etta Wheeler, who had been asked to visit the family, found a 9 year-old-girl, Mary-Ellen, shackled to her bed, grossly malnourished, scarred and badly beaten. Mrs Wheeler was so appalled by what she saw that she went to the authorities to report this horrifying child abuse.

The authorities turned her away. Mrs Wheeler refused to take no for an answer and petitioned the American Society for the Prevention of Cruelty to Animals (ASPCA). She was appalled that animals were protected but children were not. Mrs Wheeler appealed to the ASPCA that children were members of the animal kingdom and must therefore be protected. It was on these grounds that the ASPCA did finally intervene. Mary-Ellen was removed from her abusive home and placed in foster care, where she thrived. She went on to marry, have 2 daughters, and lived to the age of 92.

Suzaily Wahab MD(UKM),
MMed Psych (UKM)

Psychiatrist, Department
of Psychiatry, Universiti
Kebangsaan Malaysia Medical
Center, Kuala Lumpur, Malaysia

Conflict of interest: none
declared

Sheila Marimuthu
MBBS(Cal), MMed
Paeds(Malaya)

Paediatrician, Department of
Paediatrics, Hospital Kuala
Lumpur, Malaysia

Conflict of interest: none
declared

Chan Lai Fong MD(UKM),
MMed Psych (UKM)

Psychiatrist, Department
of Psychiatry, Universiti
Kebangsaan Malaysia Medical
Center, Kuala Lumpur, Malaysia

Conflict of interest: none
declared

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Table B.1.1 The various types of child abuse*

Physical abuse	Physical harm or injury
Neglect /negligent treatment	Failure to provide for a child's basic needs and development in all spheres
Emotional abuse	Failure to provide a developmentally appropriate, supportive emotional environment which results in impairment of a child's emotional development or sense of self-worth
Sexual abuse	The involvement of a child in sexual activity that he (by virtue of his age or stage of development): <ul style="list-style-type: none"> • Does not fully comprehend • Is unable to give informed consent to • Is not developmentally prepared for. Sexual abuse may be by adults or children who are in a position of responsibility, have obtained children's trust, or have power over the victim.
Exploitation	The use of the child in work or other activities for the benefit of others, for financial gain, e.g., child labor.

*World Health Organization and International Society for Prevention of Child Abuse and Neglect (2006).

The diversity of legal definitions, practices and laws represents a wealth of models to choose from to develop a suitable legal framework and practice in one's own country. One can thus model on what is deemed most appropriate for a particular society. International organizations, which span countries and cultures, usually adopt definitions and legal guidelines from the country most appropriate for their practice. The [World Health Organization](#) (WHO) distinguishes several types of child maltreatment: physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.

Cultural values, standards of care in a community and poverty are important considerations in determining the presence of maltreatment and how it is addressed. What are *reasonable* standards of discipline may change with time as well as between societies. For example, physical punishment, which was considered an aspect of appropriate parenting in days gone by – spare the rod, spoil the child – is now widely seen as harsh or inappropriate (Creighton, 2004). Although non-violent approaches to disciplining children are the most commonly reported method (Runyan et al, 2010), violent disciplinary practices still occur worldwide (UNICEF, 2010). A higher level of education in primary caregivers is associated with lower levels of violent disciplining. Research in Sweden has shown that legislation banning corporal punishment, if used in conjunction with public promotion of alternative non-violent parenting methods, may reduce the use of violent disciplining (Ziegert, 1983).

So, how do we know if a child is being maltreated? If the universal principles of children's rights are violated or the child is at risk, at that time or at a later time, to suffer negative consequences as a result of that action or lack of action, alarm bells should ring. However, it was only with the Universal Declaration of Human Rights (1948) and the Convention on the Rights of the Child (UNICEF, 1989) that international legal instruments for the promotion and protection of children's

The "father" of child abuse

Serendipitously, the advent of radiology, took the diagnosis of child abuse to a new level. Dr Henry Kempe, a US pediatrician, used X-rays to prove non-accidental injuries in a large number of children admitted to his care. The

X-rays changes of old fractures and abnormal skeletal changes led to the identification and official recognition of physical abuse and child neglect by the medical community through his seminal work "The Battered Child Syndrome" bringing the issue of child abuse to the fore of modern medicine in the 1960s.

Children's Rights (see also Chapter J.7)

The Convention on the Rights of the Child states that children everywhere are entitled to basic human rights which include the right to:

- Survival
- Develop to the fullest
- Protection from harmful influences, abuse and exploitation
- Participate fully in the family, cultural and social life.

rights became available (see Chapter J.7). In 1873 animals had rights but children did not. Mary-Allen, the 9 year old child in the vignette, did not suffer in vain. As the first recognized child abuse victim in North America, her case led to the founding in 1874 of the Society for Prevention of Cruelty to Children (Finkelhor, 1984).

EPIDEMIOLOGY

Globally, there is a lack of reliable estimates of the prevalence of child maltreatment, especially for low- and middle-income countries. Most prevalence and incidence studies have been conducted in Western countries (Figure B.1.1). Estimates vary widely depending on the country and the method used; hence, comparisons between countries should be interpreted with caution. Increasing awareness amongst professionals and the public has resulted in greater reporting of abuse.

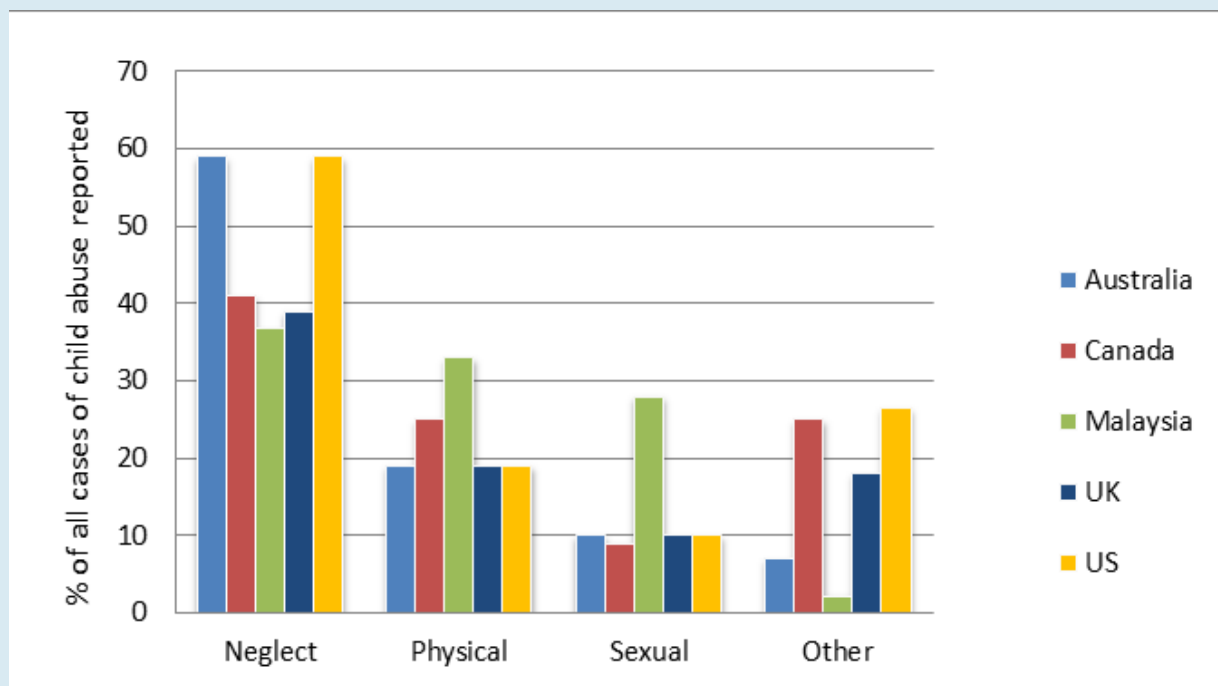
Approximately 40 million children globally are estimated to suffer abuse each year (WHO, 2001). Between 25% and 50% of all children report having been physically abused. Many are also victims of emotional abuse or neglect and what is reported may only be the tip of the iceberg. There is potentially a large pool of undetected maltreatment which may not have been recognized to be due to abuse. For example, there are approximately 31,000 homicide deaths/year of people younger than 15 years. Many children who die are classified as “accidental deaths” – falls, burns, drownings – which may have been died due to maltreatment. Further:

- The International Labor Organization reports that there are 250 million child laborers aged 5 to 14 years in developing countries. 15 million



In 1873 animals had rights but children did not. In 1989, children had rights too! (CRC,1989)

Figure B.1.1 Rate* of child maltreatment in several countries according to type.



*Estimates vary widely depending on the country and the method used; comparisons between countries should be interpreted with caution. Sources: Australian Institute of Health and Welfare (AIHW, 2004); Canada (Trocmé & Wolfe, 2001) in Creighton, 2004; UK: Department of Education and Skills (DES 2004); US: Department of Health and Human Services (US DHHS, 2003).

children in India are bonded laborers, working to pay off family debts (Human Rights Watch, 2001).

- Approximately one million children are introduced to commercial sexual exploitation worldwide (Casa Alianza, 2001)
- In armed conflict and refugee settings, girls are particularly vulnerable to sexual violence, exploitation and abuse by combatants, security forces, members of their communities, aid workers and others (WHO, 2010)

Table B.1.2 Features of risk factors of abuse*

	Risk factors	Features of risk factors	Common presentations
Child	<ul style="list-style-type: none"> • Younger age • Constitutional vulnerabilities (e.g., cerebral palsy, mental retardation, prematurity etc) • Difficult temperament • Chronic illness • Gender – for school aged children, female gender higher risk for sexual abuse while male gender higher risk for physical abuse 	<ul style="list-style-type: none"> • Vulnerable & dependent state • Attachment issues 	<ul style="list-style-type: none"> • Fractures • Shaken baby syndrome (especially below 3 y/o) • Bruises • Internal bleeding • Choking • Smothering
Family	<ul style="list-style-type: none"> • Low socioeconomic status (poverty, unstable housing, low education, unemployment, single parenthood, young parental age) • Criminal history • Substance abuse • Chronic physical illness and disabilities • Psychosocial factors (mental health problems, poor coping skills; lack of support from spouse, family, community; marital disharmony; domestic violence) • Parents victims of abuse • Violence within the family 	<ul style="list-style-type: none"> • Lack of resources and education • Increased caregivers' burden • Lack of parental supervision • Ineffective coping skills and parenting skills 	<ul style="list-style-type: none"> • Malnourishment • Inadequate health care • Emotional Abuse • Harsh physical punishment • Lack of supervision • Exposure to pornographic materials
Society	<ul style="list-style-type: none"> • High local unemployment • Social isolation • Socio-cultural • Legal aspects • Disasters: natural or man-made 	<ul style="list-style-type: none"> • Cultural practices that condone certain types of abuse • Policies, or lack of, leading to child exploitation • Lack of enforcement 	<ul style="list-style-type: none"> • Sanctioned physical and sexual abuse (e.g., genital mutilation) • Child soldiers • War rape • Prostitution

*Sources: Herrenkohl et al (2008); Mersky et al (2009); Stith et al (2009); Whitaker et al (2008).

RISK FACTORS

Table B.1.2 shows there are certain children, parent and family characteristics that increase the likelihood of children being abused or neglected. Early identification of such unmet needs with timely and sensitive intervention to meet them could avoid the situation from becoming more serious and many children being abused.

Mother's poor health or compromised nutritional status (for example teenage mothers with an unwanted pregnancy living in poverty) may result in inadequate nutrition and in preventable problems such as folic acid deficiency (increasing the risk of *spina bifida*), rubella, exposure to environmental toxic substances such as mercury, lead and organophosphate insecticides, and both legal and illegal drugs.

CONSEQUENCES OF MALTREATMENT

For child survivors of maltreatment the suffering happens not just at that point in time; the deleterious impact, without adequate intervention, lingers on decades later into adulthood. Mental health and physical health problems occur during childhood as well as when they have grown up. Certain types of abuse may cause long-term injuries, for example when the brain is directly damaged as in the "*Shaken baby syndrome*". Maltreated children with bone fractures may have a higher risk of developing cancer (Fuller-Thompson et al, 2009).

Beside social problems, children who survive abuse or neglect are more likely to have cognitive difficulties affecting learning, language development and academic achievement. They are more likely to develop antisocial behavior with subsequent delinquency, and teenage pregnancy (Johnson et al, 2006). They are more likely to smoke cigarettes, use alcohol or illicit drugs (Dube et al, 2001); up to two-thirds of people in drug treatment programs reported having been abused as children (Swan, 1998).

Childhood maltreatment is strongly associated with poor physical and mental health outcomes in adulthood. As young adults, victims are at increased risk of depression, anxiety, eating disorders, obesity and attempted suicide (Silverman et al, 1996), are more likely to have physical symptoms (both medically explained and unexplained) and to engage in health-risk behaviours such as smoking, risky sexual behaviors, alcohol and drug misuse. The greater the severity of maltreatment the stronger is the association with poor outcomes in adulthood.

Science has refuted the belief that infants and young children are too young to be affected by stressors. Exposure to stress during critical developmental periods can have long term damaging effects to the developing brain resulting in structural changes (National Scientific Council on the Developing Child, 2010). Adverse early infant experiences such as neglectful maternal care has been shown to have a negative impact on the developing brain. Drug and alcohol exposure in pregnancy may also lead to neurobehavioral and neurohormonal changes in the offspring that could have long-term adverse effects on memory, learning, and behavior (see Chapter G.1).

Mechanisms

Maltreatment causes stress. Stress responses include activation of hormonal and neurochemical systems, the sympathetic adrenomedullary system, producing

Parental factors associated with child abuse

- Unemployment
- Poverty
- Family and marital conflict
- Domestic violence,
- Drug or alcohol use,
- Trouble with the law
- Previous involvement with child protection services
- Parental exposure to physical abuse or family violence in their childhood.

adrenaline, and the hypothalamo-pituitary-adrenocortical system, which produces cortisol. Sustained or frequent activation of these hormonal systems can have serious developmental consequences. For example, when children experience severe or prolonged stress, their cortisol levels remain elevated for prolonged periods. This toxic stress can turn specific genes “on” or “off” (Gunnar et al, 2006). The relationship children have with their caregivers play a critical role in regulating stress hormone responses. For example, children who have secure attachment relationships have a more controlled stress hormone response when upset or frightened; the contrary occurs in children whose attachment relationships are insecure or disorganized (Loman et al, 2010).

EVALUATION

Concluding that child maltreatment has taken place has important implications for the child and the family (e.g., a child may be removed from a family or a person may be imprisoned). While in some cases child abuse can be clearly seen to have occurred (e.g., if the child has evidence of physical injuries or of being prostituted in the presence of witnesses), this is not clear cut in the majority of cases, when ascertaining whether maltreatment has taken place is usually difficult. This is because, depending on their stage of cognitive development, children are often unable to remember events, are very suggestible and experience conflicting emotions. For example, it has been shown that up to one-third of three year olds misidentify their own father in a photo-lineup – casting doubt on their ability to correctly identify a potential perpetrator (Lewis et al, 1995).

It needs to be distinguished between a mental health evaluation of children in which maltreatment is suspected (e.g., in which a disclosure has been made or if the clinician suspects that maltreatment has taken place) and the forensic interview – to elicit facts with a view to legal action. Optimally, once clinicians form the view that maltreatment has occurred, they should report it to the appropriate authorities according to their local law; in these circumstances it is not the role of clinicians to investigate whether maltreatment has actually occurred. Therapists should never be the forensic examiner in those specific cases; not separating both roles (investigation and treatment) will cause problems and hinder prosecutions because therapists would not be objective and could be accused of contaminating the child’s memories or planting new ones. The clinical – therapeutic – assessment would not differ greatly from the clinical assessment of other children (see Chapter A.5) and is not repeated here. This section focuses on the forensic evaluation (however, in societies where the luxury of adequate number of specialists is not available, forensic evaluation needs to be completed before intervention by the same person for the reasons described above).

The age of the child and cognitive development needs to be kept in mind and should influence the way in which the interview is conducted and the type of information that can be obtained:

- *Toddlers* have difficulties identifying time and place and will probably not be able to say how often something has happened, when it happened, or even where it happened
- Three to five year olds cannot think abstractly, may be easily distracted during the interview or become restless. They may be able to date things in relation to events such as before or after birthdays, bedtime,



Click on the picture to view a video describing how toxic stress derails healthy development (1:52)

Behaviors that that may indicate that a child may be abused

- Unexplained delay in seeking medical help, especially following a fracture, serious burn/scald
- Explanation offered by child or guardian is not consistent with the injury
- Discrepant explanations given by members of the family and other caregivers
- History of ingestion of poison, alcohol or drugs, suicidal attempts or running away
- Inappropriate response of caretaker to child’s injuries such as denial that child is in pain, or minimizing of symptoms
- Repeated presentations with injuries, often to different doctors or health care facilities.

etc. Asking them to draw or demonstrate what happened might be easier for them than verbal communication

- *Six to nine year olds*, although concrete thinkers, are increasingly capable of understanding concepts, able to orient themselves in time and space and draw simple floor plans. They can deceive more convincingly than younger children and are more capable of keeping a secret. They usually feel conflicted, confused, guilty and embarrassed, and may be afraid they may be punished. They are reluctant and tentative in their disclosures and withdraw if the interviewer is perceived as unsupportive. Role play, drawing and the use of dolls by trained personnel can be helpful
- *Preadolescents* (aged 10-13) are typically more comfortable with an interviewer of the same gender; feel awkward and self-conscious about their bodies and about discussion of sexual issues. They normally understand that what has happened to them is wrong but are likely to feel responsible for the abuse; overwhelming guilt and shame often leading to denial. They may respond better to brief, clinically oriented questions and to a more formal approach to the interview. They need reassurance that they are not to blame for what has happened.
- *Teenagers* are more likely to respond to an honest, open and direct approach, showing respect for their concerns and support for their needs; avoiding coming across as critical or judgmental (Craig, 1998).

Disclosure of abuse, particularly sexual abuse is gradual. Most children go through stages, which include denial-disclosure-recantation-reaffirmation. Up to 70% of sexually abused children may initially deny the abuse. Younger children are more likely to disclose the abuse accidentally through inappropriate statements or actions such as sexualized play. Older children and teenagers are more likely to disclose the abuse purposefully because they are angry at the perpetrator or are influenced by their peers.

The interview should be conducted by someone experienced in this area in a child-friendly and non-threatening setting. The number of interviews should be kept to a minimum by having as many of the multi-disciplinary professionals involved as possible present. Ideally this should be done in a viewing room with a one way mirror or by videoing the interview, so as not to overwhelm the child.

The clinical history is most important and includes obtaining a history from the child, in particular the social history, as well as corroborating evidence from others. Family and social history are important to understand the family background, living arrangements and support systems. As already highlighted, certain risk factors are strongly associated with child abuse.

While the forensic interview aims to clarify *who, what, where* and *when*, this does not mean that a good understanding of the child's and family's background is not important. Questions should be open ended, backing off when sensing the child is uncomfortable. Walking the child through familiar routines so the child can describe them spontaneously is often helpful.

According to Craig (1998), the basic format should include:

- A short rapport-building phase
- An attempt to determine the child's developmental level, communication skills, and knowledge of truth/lie, pretend/real



Click on the picture to view a slide show on child abuse (warning: extremely graphic) (8:54)

Shaken baby syndrome: a 'hidden' abuse

This is a preventable cause of long-term neurological damage and disability in a previously healthy child. It can be caused by vigorous shaking of a baby (usually younger than 2 years) by the carer resulting in rupture of intracranial blood vessels when sheared against the skull. It can present with:

- Drowsiness, lethargy and fits
- Subdural hemorrhage or generalized cerebral edema
- Retinal hemorrhages
- Fractures, for example rib fractures.

- The child's knowledge of body parts and ability to use words such as “on top of”, “under”, “in front”, “behind” etc
- Next, the main part of the interview (who, what, where and when) by asking open ended questions like: "Do you know why you are here?" "Your Mommy told me you've been having a problem with..."
- Avoid teaching the child about sexual activity, correcting the child's statements, or giving judgments (e.g., the alleged perpetrator being a bad person)
- Don't use words the child does not understand
- Don't ask complicated or double-barreled questions
- Avoid questions that can be answered with “yes” or “no”
- Good ways to elicit information include questions such as: “Tell me more”; “What makes you think so?” “Then what happened?” “Is there anything else you want to tell me?”

Details that need elucidating include events that preceded the injury or abuse, when and who first noticed the child was injured, how the child's symptoms developed and in what order. Certain circumstances are highly suspicious of abuse (refer to Box).

The physical examination

A thorough pediatric physical examination is imperative in all cases of suspected child abuse and many countries have their own guidelines setting out how this is to be performed. The physical examination should be conducted in a comfortable, child friendly environment, where the child can be put at ease. If appropriate and available, the presence of a person known to the child may help. The examination should be non-threatening, starting with the routine measurements normally carried out on pediatric patients such as height, weight and head circumference. As the child is being examined for evidence of injury, assessment of language and social skills can also be done as one interacts with the child. Physical examination findings such as bruises, burns, abrasions or skin lesions should be documented accurately, including descriptions, measurements, diagrams and photographs. Use simple diagrams to accurately draw and label correctly the site of injury, left or right.

Suspect maltreatment if the answer is yes to any of the following questions (Mcdonald, 2007):

- Is there an unusual distribution or location of lesions?
- Is there a pattern of bruises or marks?
- If there is a bite or handprint bruise, is it adult size?
- If there is a burn, are the margins clearly demarcated with uniform depth of burn?
- If there is a burn, is there a stocking and glove distribution?
- Are there lesions at various healing stages or ages?
- Is the reported mechanism of injury inconsistent with the extent of trauma?

Careful documentation is vital as doctors examining the child might be asked to testify in court regarding the evidence obtained and can refer to their

Key features in the physical examination of abused children

- General demeanor and appearance
- Cleanliness, signs of neglect, emotional disturbance
- Edema, bruises and redness of the scalp
- Infant's fontanelle for fullness
- Fundoscopy findings of retinal, pre-retinal or vitreous hemorrhages
- ENT: bleeding, tears of the frenulum, bruising or abrasion inside the lips or pharynx
- Rib tenderness, lung contusions; ruptured spleen or viscous, duodenal hematomas on chest and abdominal examination
- Bony or joint tenderness or swelling

Farah, a 15 year old girl, was brought to hospital by police for attempting to jump off the 4th floor of a shopping mall after her boyfriend broke off with her. She admitted to feeling sad for a “long, long time” – since her parents divorced when she was seven years old. Of all the four siblings she missed her father the most as he used to spoil her. After the divorce he remarried, had other children, stopped visiting and ceased maintenance payments.

Farah’s grades deteriorated as she started to skip classes going from an A-level student to the bottom of her class. Her mother remarried a businessman three years ago. He seemed to be the father figure and provider they all longed for until his business failed and he turned to drugs. He became increasingly violent towards her mother and all the siblings and started raping Farah and her 10 year old sister when their mother was working. He silenced them with

threats that he would kill their mother if they told anyone. Farah tried to escape stepfather’s abuse by staying away from home at a shopping centre till late at night when her mother came home. Farah began mixing with the boys in the shopping complex and became a “girlfriend” to a “kind” 20 year old convenience store worker because he listened to her problems. She started having intimate relations with this boyfriend 10 months ago; she felt the need to please him to keep his support.

She stopped having periods seven months ago and guessed she was pregnant because she “felt something moving inside” although her periods had been irregular for about a year. She told her boyfriend that she might be pregnant and he refused to have anything to do with her anymore. She now wants to die or have an abortion.

own notes, which can be subpoenaed. All the information gathered should be clearly written up immediately to prevent errors and should be factual, concise and accurate (in the child’s own words as far as possible), signed with the name of the doctor, clearly written and dated (with an official stamp if required by local procedures).

Investigations

A skeletal survey is recommended for children under the age of two years. All children with head injuries should have X rays, CT or MRI scans, depending on availability. Ultrasound examinations can detect excessive free fluid and hematomas to help diagnose intra-abdominal injuries. Blood tests needed include a full blood count and coagulation tests to diagnose bleeding disorders in patients who present with bruising; drug screens are useful if poisoning, accidental or otherwise, is suspected.

SEXUAL ABUSE

There is no universal definition of child sexual abuse. The WHO defines it as the involvement of children in sexual activity (a) that they do not fully comprehend, (b) to which they are unable to give informed consent or for which children are not developmentally prepared and cannot give consent, or (c) that violate the laws or social taboos of society. Other definitions include the use of a child for sexual gratification by an adult or significantly older person (Tomison, 1995 p2). In practice, identifying child sexual abuse is complex and what is considered sexual abuse may vary depending on local customs (e.g., female genital mutilation), legislation (criminal or child protection laws), and the relationship between the child and the perpetrator. While some behaviors would be considered sexually abusive by almost everyone (e.g., the rape of a 10-year-old child by a parent), others are more ambiguous (e.g., consensual sex between a 19-year-old and a 15-year-old). Legal age of consent also varies between countries. Unlike in other types of maltreatment, whether sexual abuse has occurred or not varies depending on the relationship between victim and perpetrator:

- *Adults with no familial relationship to the child.* Any sexual behavior between a child under the age of consent and an adult is abusive

Physical indicators of child sexual abuse (not necessarily present):

- Bleeding from the vagina, external genitalia or anus
- Injuries such as tears or bruising to the genitalia, anus or perineal region
- Sexually transmitted diseases (STD), vaginal discharge
- Trauma to the breast, buttocks, lower abdomen or thighs
- Adolescent pregnancy

- *Family members of the child.* Any sexual behavior between a child and an adult family member is still abusive (consent, equality and coercion concepts are usually inapplicable in instances of intra-familial abuse)
- *Adults in a position of power or authority over the child* (e.g., teachers, health professionals). Age of consent laws are usually not applicable due to the imbalance of power that exists and the breach of personal and public trust when professional boundaries are violated
- *Adolescent or child perpetrators.* Existence of abuse would depend on whether the activity is consensual, the age differential and whether there is an imbalance of power (e.g., sexual activity between two 15-year-olds where one suffers from an intellectual disability). Sexual exploration between consenting adolescents at a similar developmental level is not considered abuse.

Forms of child sexual abuse include physical contact (such as touching, fondling or any form of contact with breasts or genitalia, including using objects, vaginal intercourse, and sodomy) and nonphysical abuse (such as exposing children to pornography, erotic talk, and exhibitionism); this may occur in dyads, groups, sex rings, as sexual exploitation, and as ritual abuse.

Child sexual abuse may be uncovered in various ways. A child may disclose the sexual acts directly or indirectly with age inappropriate behavior, particularly overtly sexualized behavior. Older children may present with self-destructive behaviors, drug use, suicide attempts, self-mutilation or running away from home. These children may also have an unexplained accumulation of money and gifts. There are indicators peculiar to child sexual abuse listed in the Box.

Examining victims of child sexual abuse

Once sexual abuse has been uncovered, there is a need to protect the child from further harm and help in treatment and rehabilitation. It is important to emphasize again that the therapist *should not be* the forensic examiner unless there is no one else available, in which case the forensic examination and legal procedures should precede the therapy.

Physical examination is no different from that of maltreated children, as described above, although the emphasis would be on those aspects and areas relevant to sexual abuse. The absence of abnormal physical findings *does not* exclude the possibility of abuse – less than 10% of substantiated child sexual abuse cases have physical findings on examination. This may be due to, among other reasons, the type of abuse (e.g., nonphysical) or the timing of the examination in relation to the abuse. In the physical examination of females one should keep in mind the possibility of normal and abnormal variants of external genitalia (e.g., hymeneal cleft) and non-specific findings including erythema, labial adhesions (normally found in 17%-39% of prepubertal girls), vaginal discharge, condyloma acuminatum or anal fissures in a young child.

For the proper procurement of medico legal evidence, timely and accurate collection of samples is needed. Forensic issues to be mindful of include *not* allowing the child to bath or clean up, although the child may feel disgusted and dirty, until the physical examination is completed and samples taken. To reduce distress, perform the physical examination as soon as possible after the incident (also seminal DNA degenerates after 72 hours). Label correctly each item of

The role of the physician

The role of the physician (as separate from the therapist) in child sexual abuse cases

- To identify any injury (including ano-genital, extra-genital trauma, other physical signs of abuse or neglect)
- To detect the presence of STD, pregnancy (pregnancy prevention may be indicated in some countries)
- To consider post-exposure prophylaxis for HIV.
- To identify any other forensic evidence that may corroborate the existence of abuse (e.g., body fluids)
- To accurately record any physical findings and the result of investigations (e.g., through photographs)
- To explain and initiate any necessary treatment
- To rule out psychiatric emergencies (e.g., suicidality).

Examination in sexual abuse cases

Never use any type of force or coercion to perform the medical examination, which may re-traumatize the child. Sedation (with the appropriate consent) may be necessary to facilitate proper examination as well as to procure medico legal evidence.

clothing packed in bags provided with the child's name in the presence of police and utilize a "rape kit" to obtain samples (individual countries may have different kits, like they have different guidelines as to how the forensic examination should be conducted).

LEGAL ISSUES

Each country has its own legislation about child protection. Many countries have legislated mandatory reporting to child protection bodies; a police report may also be required. For example, in Malaysia (Child Act 2001), Child Protectors (social welfare officers) are authorized to conduct home visits and place victims in a safe environment and it is mandatory for all doctors to report to the Child Protectors once child abuse is uncovered.

MANAGEMENT

Regrettably, even in high income countries such as the US, a very large proportion of the victims of maltreatment do not receive any treatment or services – apart from investigation. Thus, given the frequency of this problem, the unmet need is enormous; welfare services dealing with maltreatment are stretched if not overwhelmed everywhere in the world.

Treatment will require different targets depending on the type of abuse (e.g., physical, sexual, neglect), the symptoms and their severity, whether the child has been removed from the family (e.g., it is in foster care or in an institution) and what treatment seeks to achieve (e.g., family preservation or reunification). There is very limited evidence about what treatments are effective (Wathen & MacMillan, 2005). In practice, the parents and not the child are often the main focus of intervention. In these cases, the stronger effects are achieved by targeting parents and the parent-child interaction context in home-based settings during early childhood, designing multicomponent interventions delivered by professionals for teaching parenting competency skills, and targeting families of higher risk children (Thomlison, 2003). For example, a controlled trial in the US involving 192 parents in child welfare – with an average of six prior referrals and most with all of their children removed – in which parents attended a program of "parent-child interaction therapy" found a significant reduction in future child welfare reports (Chaffin et al, 2011). Trauma-focused cognitive behavior therapies and parent-child interaction therapy appear to be superior to general psychotherapeutic treatments.

The first step is to ensure that the effects of maltreatment are not worsened by the subsequent management delay as the child's development marches on, which regrettably often happens due to poor coordination of services and care planning (system abuse). While the focus should be on the welfare of the child, the traditional practice of managing child maltreatment by physically removing the child to a place of safety focuses primarily on the physical well-being of the child alone. This protects the child from further harm from the same perpetrator but might not address his emotional and psychological needs vital for healing.

In general, psychiatric management can be divided into acute and long term. During the initial presentation, a full assessment of the victim's condition is needed. In severe cases, inpatient admission might be considered, for example, in cases of severe depression, high suicide risk or acute psychosis. Admission may

Issues to keep in mind following sexual abuse in adolescents

- Teenage pregnancy, parenthood and abortion (illegal in some countries), abandoned babies
- Culturally unacceptable sexual practices (e.g., homosexual practices)
- Impact of sexual abuse and exploitation
- Implications of chronic illness (e.g., pelvic inflammatory disease)
- Chronic psychological and emotional complications
- Stigma
- Impact on academic and occupational functioning and opportunities.



Click on the picture to access the Malaysian Guidelines for Hospital Management of Child Abuse and Neglect (2009). Most countries have their own guidelines.

also be required for treatment of physical injuries or for the protection of the child. Acute and short term problems often observed include: fear and anxiety, sleep problems and nightmares, somatic problems, anger/acting out, lowered self-esteem, social withdrawal or isolation, school difficulties, feelings of powerlessness, stigmatization, and symptoms associated with trauma. Ongoing problems such as depression, post-traumatic stress disorder, relationship issues, juvenile delinquency and substance abuse have to be anticipated. Factors affecting the consequences of child abuse and neglect include the:

- Child's age and developmental stage at the time of abuse
- Type of abuse (physical abuse, neglect, sexual etc.)
- Frequency, duration, and severity of abuse
- Relationship between the victim and abuser (English et al, 2005).

In the long term, there is a considerable body of evidence showing that maltreatment during childhood is a factor that increases the risk for almost all psychiatric conditions, and these should be appropriately managed as described in other chapters of the book. Another important aspect of management is to support the child with the help of an attachment figure, e.g., helping the child deal with non-supportive family members and cope with court proceedings (Center on the Developing Child, 2007).

PREVENTION

Preventing child maltreatment before it occurs is as important as treatment (Finkelhor, 2009). Reducing child abuse is possible but requires a coordinated multi-sectorial approach. Effective prevention programs support parents and teach positive parenting skills. Ongoing care of children and families can reduce the risk of maltreatment reoccurring and can minimize its consequences. Longitudinal data from the Perry Preschool Project research shows that successful intervention results in decreased expenditure in the juvenile and criminal justice systems, decreased special education costs, increased tax revenue from higher incomes, and decreased reliance on government assistance. Cost-savings from reductions in crime were the primary saving mechanisms observed (Rolnick & Grunewald, 2003).

While some prevention programs are universal (e.g., education about parenting through advertisements or media programs, creating awareness of the evil of family violence, universal home visitation for new mothers), most are targeted to families with the risk factors highlighted. These would include more intensive home visitation, screening, detection and treatment of maternal depression, and parenting programs. The last, based on the principles of social learning theory, deliver lower intensity modalities of parent management training programs such as "Triple P" (Positive Parenting Program) (Graaf, 1998) (see Chapters A.9 and D.2). Both home visitation and parent training programs have been shown to be effective but much more work and resources are required in this area. Policymakers, NGOs and important community figures (e.g., religious, academic) have role to play in this endeavor.

Policymakers

Using the information gathered over decades of research, it is imperative that policy makers be convinced of the importance of implementing policies to

"It is easier to build strong children than to repair broken men."

Frederick Douglass (1817–1895)

Effective interventions for children and families at risk of poor outcomes

- Early and intensive support by skilled home visitors for vulnerable families who are expecting a first child
- High-quality, center-based, early education programs for young children from low-income families
- Two-generation programs that simultaneously provide direct support for parents and high-quality, center-based care and education for young children from families experiencing significant adversity
- Interventions that provide specialized services matched to the problems they are asked to address for young children experiencing toxic stress from abuse or neglect, severe maternal depression, parental substance abuse, or family violence
- Parent management training programs.



Prevention strategies from an NGO's perspective

P.S. The Children, a non-profit organization in Malaysia built its framework on research from the US, UK and Australia and adapted it to the Malaysian context. Research indicates that far more children are abused than actually reported. Thus, preventing sexual abuse is paramount and it seeks to:

- Educate adults to better protect children
- Galvanize communities to develop support systems for children
- Teach all children appropriate protective behaviors
- Teach high risk children how to use support systems
- Teach abused children who are too afraid to tell that what abuse was not their fault and help with other emotional health issues to minimize long-term negative effects of the abuse
- Prevent child abuse victims of today from becoming offenders of tomorrow.

meet the needs of vulnerable children. They need to be aware that:

- No single program, approach or mode of service delivery has been shown to be a “magic bullet”. There are ways to promote the healthy development of young children. The key is to select strategies that have documented effectiveness, assure they are implemented well, and recognize the critical importance of a strong commitment to continuous program improvement
- Successful large-scale programs require rigorous assessment and periodic monitoring of the quality at individual implementation sites, as well as training and technical assistance for continuous quality improvement
- Return on investment is more important than up-front costs. Long-term societal benefits are of greater importance than short-term costs. Four key challenges of note are:
 1. Matching support and services to the needs and strengths of the children and families to be served
 2. Paying careful attention to the quality of implementation when effective model programs are taken to scale
 3. Developing new intervention strategies for children and families for whom conventional approaches appear to have minimal impact
 4. Providing an environment that supports ongoing, constructive evaluation and continuous program improvement
- “Contexts” for policy consideration include:
 1. The nuclear family
 2. Out-of-home settings
 3. Multi-generational programs
 4. Family economics and maternal employment
 5. Environmental contamination.



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Children celebrating eid Mubarak in Malaysian traditional costumes.