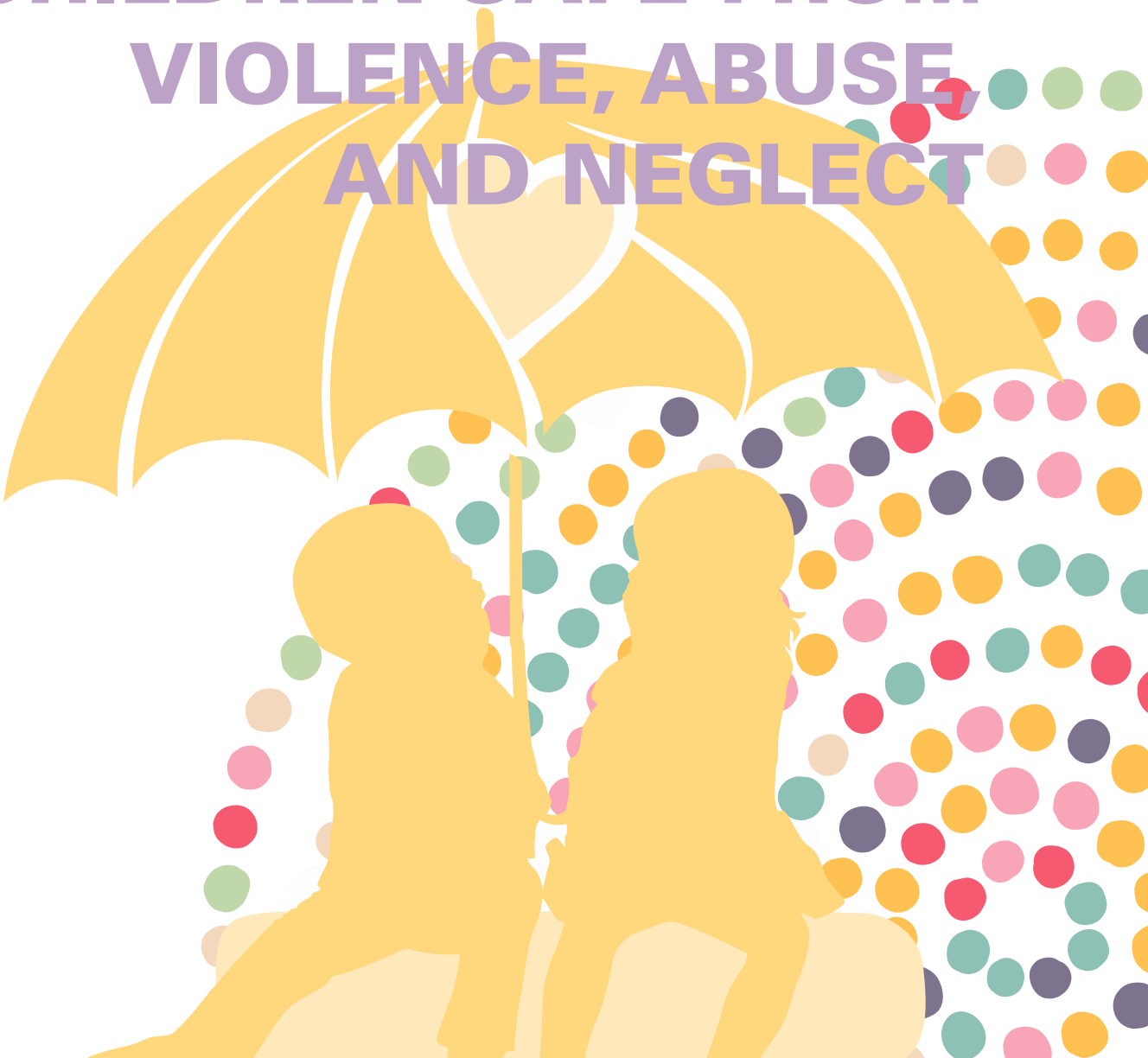
unicef
unite for children

INTERNATIONAL
STEP by STEP
ASSOCIATION

MODULE 14

KEEPING YOUNG CHILDREN SAFE FROM VIOLENCE, ABUSE, AND NEGLECT



DRAFT

© UNICEF/McConnico

CONTENTS

KEY MESSAGES - why is this topic important for you?

- No violence against children is justifiable, and all violence against children is preventable (UNICEF, 2013).
- Any form of child maltreatment – violence, abuse, neglect and abandonment (including exposure to domestic violence and violence outside the home) – is a violation of the fundamental rights of the child.
- Although poverty is a risk factor for physical violence and abuse, neglect and abandonment, child maltreatment can happen anywhere. It is present in every country, society, and income group.
- The family has the greatest potential to protect children and provide for their physical and emotional safety. In your role as the home visitor, you can support and cousel your families, and in this way, you can contribute to safeguarding children. You can promote the development of positive parenting skills and a secure parent-child attachment, and you can connect families with different services in the local community. Above all, you can be there for the child and family when they are facing difficult times.
- Every person in society, but particularly professionals working with families and children, have an obligation and responsibility to report cases of child abuse and neglect. As a home visitor, safeguarding children from maltreatment is one of your primary professional responsibilities. You are entering the family's home, and maybe you are the only person who can see or sense what is happening behind closed doors.
- Dealing with child abuse and neglect or domestic violence requires special training. In such cases you must follow your countries referral pathways and engage the relevant agencies.
- Child maltreatment includes physical, psychological and sexual abuse and neglect; these often occur together or in sequence. In some cases, maltreatment leads to serious physical injury, disability and even death. Psychological abuse, exposure to violence, and neglect can leave invisible scars that may be harder to detect, but have serious negative impact on the individual.
- Being a victim of maltreatment has lifelong physical and mental health consequences for the individual as a child, adolescent, and adult. It affects their self-esteem and confidence, personal autonomy and achievement, relationships and their own parenting skills.
- When there is violence against women in a family, children are also at risk, with partner violence being the greatest risk factor for child abuse, neglect and abandonment.
- The individuals committing violence against children are usually those that children trust the most – their parents/caregivers, relatives, neighbors, some with a history of maltreatment of their own, in an intergenerational transmission of violence.

LEARNING OUTCOMES

By the end of this module, you will be able to:

- Understand the provisions of the UN Convention on the Rights of the Child in relation to violence against children and neglect
- Understand the short and long term consequences of child abuse and neglect for an individual child and for society as a whole
- Know the different types of child abuse and neglect
- Be able to recognize some physical and behavioral signs of child abuse and neglect
- Understand protective and risk factors for child abuse and neglect
- Understand that all professionals working with young children are accountable for safeguarding children from child abuse and neglect
- Know the roles and responsibilities of other professionals and entities and understand when and how to engaging them
- Understand the barriers to reporting child abuse and neglect in the population and among professionals
- Understand the importance of working with other sectors when you are aware or strongly suspect that abuse and/or neglect has occurred, and the importance of following the referral pathways of your country
- Understand how you can contribute to the prevention of child maltreatment.

1 INTRODUCTION

- The UN Convention on the Rights of the Child (CRC) has been ratified by all but one country in the world. Article 19 of the CRC clearly stipulates that **Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and mistreatment by their parents or anyone else who looks after them.**

- The **UN Secretary General's Report on Violence against Children** states that physical corporal punishment (e.g. smacking) is an unacceptable form of discipline.

- In some countries e.g. USA and UK, "reasonable" corporal punishment (spanking) is not considered child abuse. However, in other countries, such as Sweden, any form of corporal punishment including spanking is against the law. In these countries, corporal punishment and society's tolerance for it has reduced significantly. It has been seen, that in time, immigrant populations adjust to the social and cultural norms of the land (Gilbert et al, 2009).

The CRC applies to **all children whatever their ethnicity, gender, religion, abilities, and regardless of their family origins (Article 2)**. There are further responsibilities for children looked after by the state (i.e., placed into residential or foster care), children who are refugees, and children with disabilities.

Article 7 of the UN Convention on the Rights of the Child (UNCRC) clearly states that every child has "the right to know and be cared for by his or her parents". When a child is abandoned, this right is violated. Infants and young children are at the greatest risk of being abandoned. This is of great concern, as a child deprived of a stable upbringing in his or her early years of life may experience difficulties in terms of cognitive, social-emotional and behavioural development throughout life.

The **UN Secretary General's Report on Violence against Children** stipulates that governments should ensure "comprehensive systems to prevent violence and protect children in ways that respect the whole child and their family, their dignity and privacy and the developmental needs of girls and boys" (UN Secretary General, 2006, p. 93). The report recommends that coordinated responses to prevent violence to children can be strengthened by:

- providing prenatal and postnatal care and home visitation for optimising early childhood development

- implementing culturally appropriate and gender sensitive parenting programmes that support families to provide a violence free home

- protecting vulnerable children in the family and addressing gender issues such as spouse/partner violence which is highly associated with all types of child maltreatment (50-60% of cases).

Additional resources

To learn more go to:
http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_summary.pdf and
http://www.unviolencestudy.org/

Children have the need and right to be loved and nurtured in their home and in society. We want to maximise the chances that all children will reach adulthood, capable of leading a fulfilling, productive, and healthy life. Children are the present and the future of our society, and we want them to have the best opportunities for their lives.

Generally, health care professionals have the privilege of being trusted by the families they serve, while professionals from some other sectors may be viewed with more suspicion. In your role as home visitor, you have the opportunity to support families in caring for their children. However you also need to be able to recognise when children are being abused, neglected by their families, caregivers, or others in their environment. When you and your colleagues have concerns that a child is being abused and neglected, you must immediately follow your country's referral pathways and involve the agencies and professionals that have the necessary expertise to address the child protection needs.

Self-assessment

Please answer the following questions:

1. The highest rates of fatal child abuse (i.e., child abuse resulting in death) are found in adolescents? True or False

2. Complete the following: Violence to children includes

A. physical and sexual abuse

B. sexual abuse, but not abandonment and neglect, as these are usually not considered a form of violence

C. physical, sexual, and mental/psychological abuse, neglect, as well as abandonment

3. Children are most likely to be abused and neglected by their parents or close relatives in their own homes. True or False

4. When working with families, home visitors are placed into a situation of trust. Therefore, home visitors only have to report abuse and neglect when a child shows signs of physical injury. True or False

5. Match types of maltreatment with the group of children that is particularly at risk:

- all types of abuse & abandonment
- beatings and physical abuse
- emotional abuse & physical abuse
- infanticide
- all types of abuse
- sexual abuse
- neglect & emotional abuse
- educational and nutritional neglect
- all types of abuse

Risk factor	Vulnerability to particular type of abuse
Male child	
Female Child	
Male and female children	
Child with disabilities	

Risk factor	Vulnerability to particular type of abuse
Child of single or young parent	
Child living in relative poverty	
Child living in household with violence between adults	
Child raised in an institution	

6. What are some of the short- and the long-term consequences of child abuse and neglect?

Short-term consequences	Long-term consequences

ANSWERS

1. **FALSE** - the highest rates are found in 0-4 year olds. Adolescents are also affected by abuse and neglect that occurred when they were younger, in their teenage years or both. Maltreated teenagers have an increased rate of deliberate self-harm, risky behaviors, and mental health problems, and these can result in death.
2. **C.** Violence against children includes physical, sexual, psychological abuse, neglect or abandonment of children under 18.
3. **TRUE** - this is the case in multiple studies. In addition, children can also be exposed to intimate partner violence and sibling abuse. Note that in some parts of the world children grow up in institutions. This can make them very vulnerable to abuse by both care staff and older peers. For example, in Poland, the rates of child abuse and neglect in residential care institutions has been found to be three times higher than in the community.
4. All professionals are accountable for safeguarding children from abuse and neglect. Countries generally have guidance for professionals as well as pathways for mandatory reporting when a professional suspects child maltreatment. If in doubt, discuss your concerns with your supervisor.

5. ANSWERS FOR MATCHING THE RISK FACTORS FOR CHILD ABUSE AND NEGLECT WITH THE GROUP THAT IS PARTICULARLY AT RISK.

Risk factor	Vulnerability to particular type of abuse
Male child	Beatings and physical abuse
Female Child	Infanticide
Male and female children	Sexual abuse
Child with disability	Educational and nutritional neglect
Child of single or young parent	All types of abuse
Child living in relative poverty	Neglect and emotional abuse
Child living in household with violence between adults	Emotional abuse, physical abuse
Child raised in an institution	All types of abuse, abandonment

ANSWERS FOR QUESTION 6.

Short-term Consequences	Long-term Consequences
Bruising	Alcohol and drug abuse
Burns	Cognitive impairment
Sexually transmitted infection	Increased risk of prison sentence
Bleeding into the brain	Mental health problems
Mental health problems	Risky sexual behavior
Behavioral problems	Obesity
Death	Criminal behavior
Disability	Suicide

II

TYPES OF CHILD ABUSE AND NEGLECT

Definition /Clarifications

Child abuse or maltreatment consists of all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust or power (Butchart et al, 2006).

- **Child abuse** and neglect is the physical, sexual, mental abuse and/or neglect of children younger than 18 years.

- **Physical abuse** of a child is defined as the intentional use of physical force against a child that results in – or has a high likelihood of resulting in – death and disability, harm for the child's health, survival, development or dignity. This includes smacking, spanking, hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating (sometimes incorrectly identified as cot death or sudden infant death syndrome - SIDS). Much physical violence against children is inflicted with the object of disciplining the child or in a state of intense frustration and irritation with a crying or fretting child (e.g., infant with colic). This is particularly dangerous for newborns and infants under 9 months who can suffer severe injury and intra-cranial bleeding from being shaken vigorously.

- **Sexual abuse** is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, for which the child is not developmentally prepared, and/or that violates the laws or social taboos of society. Children can be sexually abused by adults, but also by children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim.

- **Mental, emotional and psychological abuse** involves both isolated incidents, as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. Acts in this category may have a high probability of damaging the child's physical or mental health and physical, mental, spiritual, moral or social development. Abuse of this type includes: the restriction of movement; patterns of belittling, blaming, threatening, frightening, discriminating against or ridiculing; and other non-physical forms of rejection or hostile treatment. Sometimes parents fake illness in their children to seek emotional, social and financial support (fictitious illness by proxy).

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

- **Abandonment** is defined as a child being knowingly left behind by his or her parent, who can be identified, and whose intention is not to return, but to willingly relinquish parental responsibility. Further, no other family members are able or willing to take on the responsibility to parent and care for the child. Factors associated with child abandonment include very serious economic problems, low maternal education, low availability of specialist services, particularly during pregnancy, poor housing and homelessness, teenage parenting, and poor preparation for birth and traditional practices of peri-natal care.

- **Trafficking and Exploitation is also a form of child abuse and maltreatment**. Trafficking of children is defined in the Optional Protocol to the CRC (the Palermo Protocol) as the "recruitment, transportation, transfer, harbouring or receipt of persons for the purpose of exploitation (not always sexual)." Exploitation includes at a minimum prostitution or other forms of sexual exploitation, forced labour, slavery or practices similar to slavery, servitude or the removal of organs (Butchart et al, 2006).

- **Fatal Child Abuse.** The most common form of child killing is infanticide (i.e., the killing of a child under the age of 12 months). In the UK, 2-3 children in every 100,000 births are victims of murder or manslaughter. Approximately 40% of these cases involve an infant (less than 12 months), and most are related to neglect. Infanticide is underestimated as an infant's death is more likely to be unexplained or considered accidental (e.g., sudden infant/cot death).

UNICEF/Pirozzi

III

THE PREVALENCE OF CHILD ABUSE AND NEGLECT

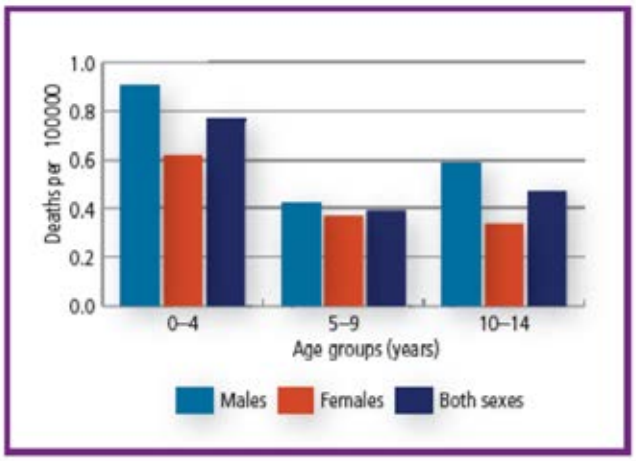
The most recent WHO Europe report on the prevention of child maltreatment (Sethi et al, 2014) indicates the following prevalence rates for child abuse and neglect in the larger European region:

Type of Maltreatment	Overall	By gender
Sexual abuse		Girls: 13.4% Boys: 5.7%
Physical	22.9%	
Emotional	29.1%	
Physical neglect	16.3%	
Emotional neglect	18.4%	

This means that one in 4-5 children in our societies are subject to some form, and often several forms of child abuse and neglect simultaneously. Furthermore, young children who are the most defenseless, are significantly more likely to die from violence than older children. As you can see in the chart on the right (Sethi et al, p. 12), boys are at a greater risk than girls.

Maltreatment rates tend to vary across and within countries in Europe and Central Asia. They are generally higher in the most disadvantaged communities that lack the protective factors (e.g., social and economic capital; supportive health, social, and child protection services; education; employment; adequate housing, etc.)

Figure 1. Age-standardized death rates from violence by age and sex, European Region, 2008



Source: World Health Organization *(15)*.

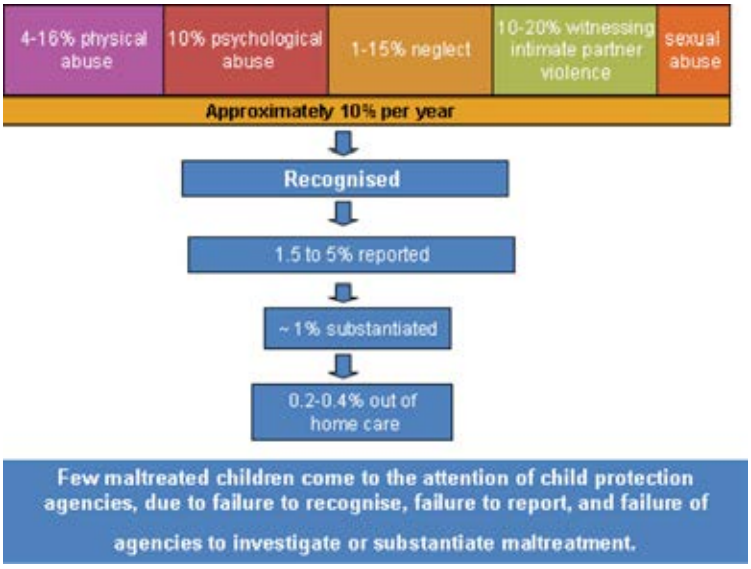
Additional resources - If you want to learn more on this topic you can look at:

http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf?ua=1

As can be seen below, of the number of suspected child abuse cases who come to the attention of child protection agencies, only a small proportion is recorded in the file as a verified case (i.e., substantiated with evidence) by the agency (e.g., child protection services), and an even smaller number of children is removed from the home and placed in some form of out-of-home care.

Important points

It has been estimated that in high-income countries, only one in ten abused and neglected children come to the attention of child protection agencies.



(slide from Browne, 2015)

The most vulnerable... Young children in residential care

Residential or institutional care is defined as "care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities including group homes." (UN, 2010). Children placed in residential care, particularly, children with developmental difficulties and/or disabilities are particularly vulnerable to abuse, neglect, and exploitation by care providers, peers and older children. These children are often cared for by a large number of care providers, with limited education, in impersonal settings, and are not able to form a close relationship with a significant caring adult who can provide protection, as well as a nurturing relationship. They become increasingly delayed in all aspects of development, including even physical growth. (See also *Module 4 on Falling in Love – Promoting Parent-Child Attachment*).

Additional resources - If you want to learn more on this topic you can look at:

http://www.unicef.org/ceecis/UNICEF_Report_Children_Under_3_FINAL.pdf

IV WHY IS IT SO DIFFICULT FOR OUR SOCIETIES TO ADDRESS CHILD ABUSE AND NEGLECT?

Child abuse and neglect happens everywhere, in every country and society and across all social groups. But in many countries, getting information about child abuse and neglect is difficult. This is not surprising for a number of reasons:

- Much privacy is given to families, and there is a great reluctance to intervene in what is considered the family's business.

- In many cultures, corporal punishment, as a form of disciplining children, is still widely accepted. Even some professionals working with children continue to tolerate and support harsh forms of punishment (e.g., spanking, smacking, psychological abuse, and other forms of discipline) in the home, in school and other settings, despite the increasing evidence that this can negatively affect the child's development. Change is possible. Several countries in Europe and Central Asia have issued laws against all the corporal punishment of children, and with public education and legal measures have managed to change the attitudes and practices of the public and professionals.

- Many countries have inadequate systems for reporting or responding to suspected or actual child abuse and neglect. Because child maltreatment is frequently hidden and not tracked and reported, decision-makers and the general public are not confronted with the fact that child abuse and neglect is a serious issue. Only the very tip of the iceberg is visible. Child abuse that ends in the death of a child is often attributed to a single, isolated act committed by a deranged individual, rather than as an outcome on a continuum of child abuse and neglect.

- Professionals working with children lack training in the detection of child abuse and neglect and are not held accountable for the safeguarding of children. This can also include uncertainty by professionals considering reporting that their information will be taken seriously, followed up reliably and confidentially, and that the child and family will actually be better off in the end, because they are provided with interventions that result in better outcomes for children and families.

- Collecting information about child abuse is not easy for ethical reasons, and getting information directly from children who have been abused and neglected is difficult. However, newly developed approaches have provided us with valuable information about child abuse and neglect (Gilbert et al, 2009). In one approach, adolescents or young adults are asked to report on the type and frequency of adverse childhood experiences to learn more about the long-term impact of child abuse and neglect. The data clearly indicate that the prevalence of all forms of maltreatment is high in many countries, and that there is a clear relationship between *adverse childhood experiences* (ACEs), including child abuse and neglect, and negative outcomes related to physical and mental health, personal achievement, and contribution to society across the lifespan (Bellis et al, 2014).

Reflection and discussion

Below find some barriers that have been mentioned by various reports for the health sector:

- Not being aware of one's professional or legal obligation to respond and report
- Not recognizing signs of maltreatment
- Not knowing how to make a report or who to make a report to
- Reluctance to make a report because of one of the following factors:
  - Not wanting to get involved (e.g. time, family privacy beliefs)
  - Not wanting to alienate a family

- Not wanting the child to be taken away or the offender jailed
- Confusion regarding an agency's policies about reporting
- Previous bad experience after filing reports – or not believing it made a difference.

Which of these barriers have you encountered in your country and work as a home visitor? What social and child protection systems are in place in your health center and community to report and deal with child abuse and neglect? What would you do if you suspected that a child was being abused or neglected? What are the organizations and individuals in your work area to support families who are at risk for child maltreatment? What can you and your child protection colleagues do about this issue in your community?

Important points

It is important to recognise these barriers. However, **focusing on the child's needs must always be your priority** over concerns about the parent's response. It is difficult at times and very good support structures and case supervision should be an integral part of the health visiting service to support you in this challenging task

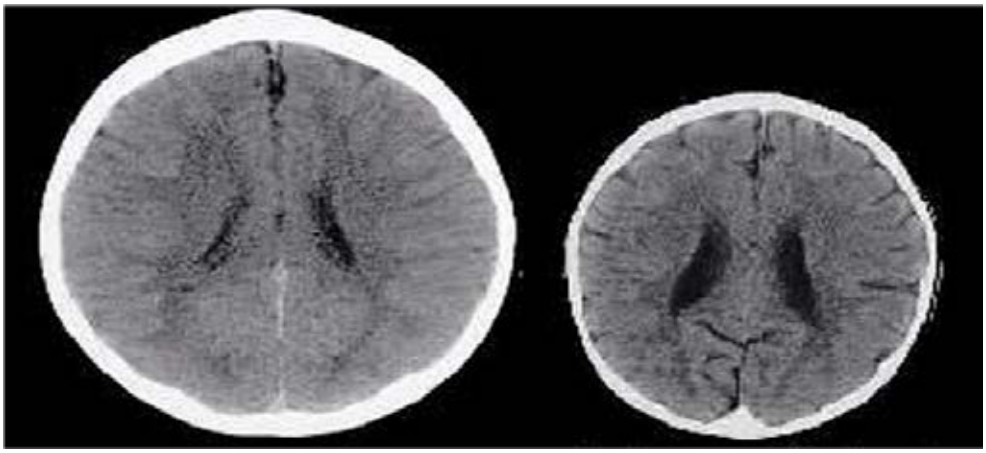
UNICEF/Pirozzi

V THE CONSEQUENCES OF CHILD ABUSE AND NEGLECT

1. CHILD ABUSE AND NEGLECT DAMAGES THE DEVELOPING BRAIN

Reflection and discussion

Carefully look at this picture of the brains of two three-year-old children below (Perry, 1997). Do you see any differences? If yes, where do these differences come from? What might be the long-term consequences for the development of these two children?



Comment:

- The brain on the left is much bigger than the one on the right.
- It has fewer spots, and almost none of dark areas, like holes.
- The brain on the right lacks some of the most fundamental areas present in the image on the left.

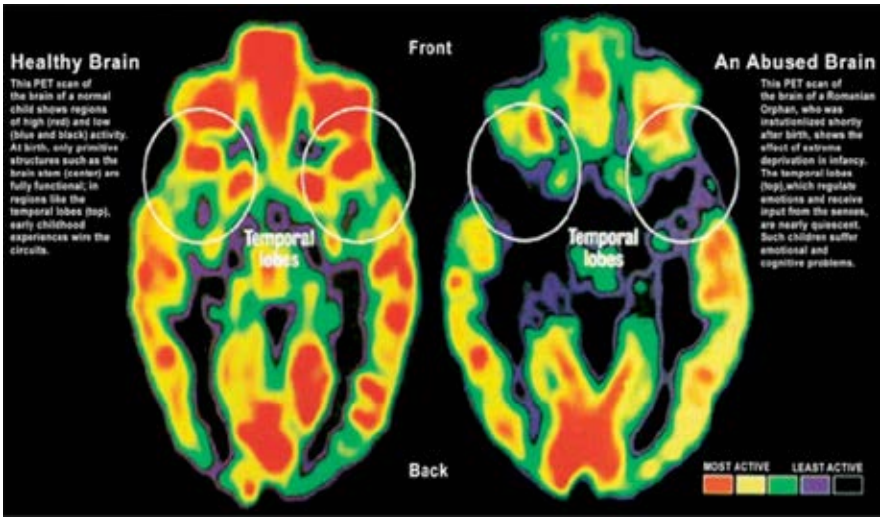
According to neurologists the child on the right is likely to have lower intelligence, be less able to empathise with others, more likely to become addicted to drugs or become involved in violent crime than the child on the left. The child on the right is much more likely to be unemployed, dependent on welfare, and to develop physical or mental health problems.

Why is the brain on the right so poorly developed compared to the one on the left? Why are the predicted outcomes so different? The obvious answer would be that the child on the right must have suffered from some serious illness or terrible accident. **However, this obvious answer is wrong**.

The primary cause of the extraordinary difference between the brains of these two three-year-old children is the way they were treated by their caregivers. The child with the brain that is more fully developed was nurtured by a caring family. The child with the smaller brain was neglected and abused. That difference in treatment explains why one child's brain developed fully, and the brain of the other child did not (Palmer, 2012).

Research into the developing brain during infancy and early childhood shows that the brain's development can be physiologically altered by prolonged, severe or unpredictable stress – including maltreatment, and that this negatively affect the child's physical, cognitive, emotional and social growth.

Since the brain adapts to its environment, it adapts to a negative environment just as readily as to a positive one. Chronic stress sensitizes neural pathways and overdevelops those regions of the brain involved in responding to anxiety and fear. It also often results in the underdevelopment of other neural pathways and other regions of the brain. The brains of children who experience stress – in the form of physical or sexual abuse or chronic neglect– will focus their resources on survival and respond to the threats in the environment. This chronic stimulation of the brain's response to fear means that particular regions of the brain will frequently be activated (see the images below of the two brains from the National Clearing House on Child Abuse and Neglect Information, 2001). It is therefore likely that these regions of the brain will be overdeveloped at the expense of other regions that cannot be activated at the same time, such as those involved in complex thought. The end result may be that regions of the brain not connected to the fear response are not "available" to the child for learning.



The effects of experiences during infancy and early childhood on brain development create the basis for the expression of intelligence, emotions and personality. When these early experiences are primarily negative, children develop emotional, behavioural and learning problems that persist throughout their lifetime, especially if targeted interventions are lacking.

For instance, children who have experienced chronic abuse and neglect during their first few years may live in a persistent state of hyper-arousal or dissociation, anticipating a threat from every direction. Their ability to benefit from social, emotional and cognitive experiences may be impaired. To learn and incorporate new information, whether from the classroom or a new social experience, the child's brain must be in a state of "attentive calm" – one that the traumatized child rarely achieves.

Children who, as a result of abuse or neglect, have not been able to develop secure attachments with their caregivers (see also the module 4 on Attachment), and whose early emotional experiences, through their impact on the brain, have not laid the necessary groundwork for positive emotional development, may have a limited capacity for empathy. The ability to feel remorse and empathy are built on experience. Where maltreatment has already occurred, there is some evidence that **intensive, early intervention can help minimize the long-term effects of adverse experiences on the development of the brain.**

While early intervention with abused and neglected children can ameliorate the effects of abuse and neglect, it is of course considerably more effective to prevent maltreatment before it occurs. The costs – both in human and economic terms – of trying to heal these children are much greater than the costs of preventing maltreatment and thereby promoting healthy development of the brain during the first few years of life.

2. CHILD ABUSE AND NEGLECT HAS LIFE-LONG CONSEQUENCES FOR THE CHILD AND SOCIETY

Maltreatment in childhood can have life-long outcomes. It is associated with

- Lower educational achievement, higher rate of attention deficit disorders, greater need for special education
- Higher prevalence of mental health issues (behavioural problems, depression, post-traumatic stress disorder, suicide, and drug and alcohol dependence)
- There is also some evidence showing the links between child maltreatment and a higher prevalence of non-communicable diseases (obesity, ischaemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease) and some communicable diseases (STIs), and
- Increased likelihood of violence or criminal behaviour, and the intergenerational transmission of violence or cycles of violence.

These negative outcomes, of course, translate into significant costs to society in terms of lost productivity, but also significant need for various types of services, as can be seen in the table below (Sethi et al, 2014).

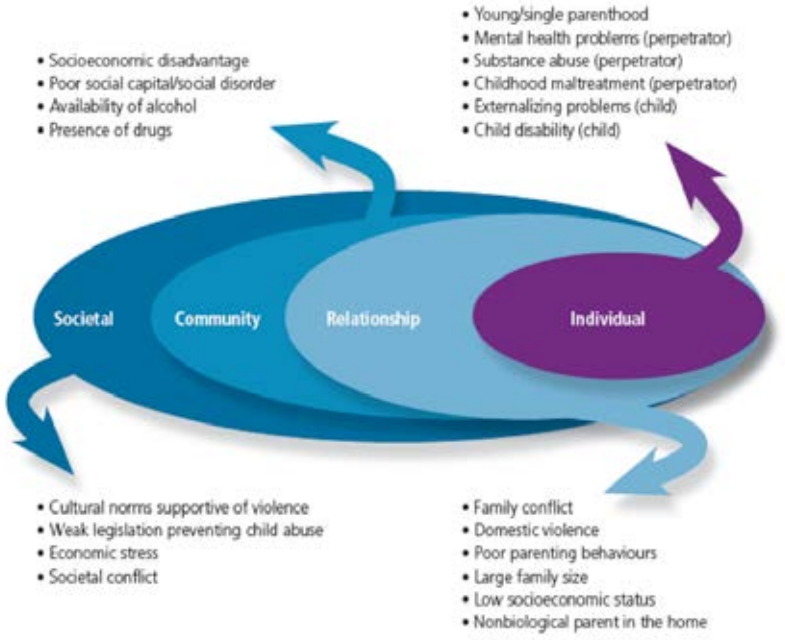
Short-term costs	Longterm-costs
Utilization of health and mental health care • Inpatient, outpatient, medication	Marginal increases in utilization of health and mental health care. • Due to chronic sequaelae (drepression, drug/ alcohol use, obesity, etc.)
Productivity losses • School loss for children, work loss for parents	Marginal increases in productivity losses • Sustained losses in future education and occupation attainment
Child welfare services • Investigation, foster care, in-home treatment	Special education costs • Temporary or permanent cognitive disabilities
Criminal Justice • Police, courts	Increased violence victimization: • Leads to increase in medical utilization, decreases in productivity, increases in criminal justice system costs, incarceration
Quality of life • Pain and suffering	Quality of life • Pain and suffering
Mortality • Value of life lost	Reducing life expectancy

Source: Corso & Fertig (133)

3. RISK AND PROTECTIVE FACTORS FOR CHILD ABUSE AND NEGLECT

Important points

Child abuse and neglect is a multi-faceted problem that must be addressed at the four levels of the **ecological model** depicted below (Sethi et al, 2014, p 4). The model shows that risk factors for maltreatment can be found in the individual (both the caregiver and the child), the relationship and home environment the child grows up in, the community and the larger society. To reduce risk at the various levels requires efforts from different agencies and sectors.



It is important to note that these risk factors are associated statistically with child abuse and neglect. **The presence of one or several of these factors does not mean that child abuse and neglect is inevitable.**

Information cards

Look also at the Information Card 1. Risk and Protective factors

Reflection and discussion

Of course, there are many ways that we can reduce the risk for maltreatment. In your role as home visitor, which of these factors can you influence in your work as home visitor? Can you give some examples from your professional experience?

Factors that can reduce the risk of child abuse and neglect (Sethi et al, p. 6).

Supportive family environment	Higher parental education
Strong social networks	Parental self-esteem
Strong parent-child relationships	Lack of parental support for corporal punishment
Strong parental relationships	Child social competence
Nurturing parenting skills	High levels of social capital
Parental employment	

Important points

You may be interested in knowing that home visiting and parenting programs are listed among the promising interventions for reducing some of the risk factors associated with abuse and neglect in children, as well as child abuse and neglect.

Video clips

Think about a world where children are only loved and cherished. Get inspired by the video clip below. Raise your hand against smacking.

https://www.youtube.com/watch?v=qtUdWJZ__ms

VI

COMMON SIGNS OF CHILD ABUSE AND NEGLECT

1. PHYSICAL ABUSE

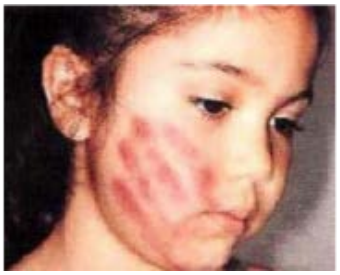
Case study

Consider and reflect on the following case and discuss with colleagues what features of physical abuse you might be concerned about.

You are doing a home visit to see a baby girl of 4 months. She has a six-year old sister. The father is a construction worker and often away on assignments overseas. You had the impression during previous visits that the mother's extended family is not supportive, and she is isolated. The house is cold when you arrive, the heat is not on, but the home is clean and tidy.

You examine the four-month old baby who is crying. The baby does not smile when you talk to her. She is dressed warmly. When you undress her for weighing her you notice bruises on both her legs and ligature marks on the wrists and ankles. The weight is satisfactory.

You also note that her older sister has a mark on her face (see photo). She is very active and keeps trying to get her mother's attention but her mother takes little notice. You remember that a few years ago, the little girl had a broken femur. Her mother said it was due to her father tripping over her when she was playing on the floor.



When the mother was asked about the marks and bruises on her baby, she says that her older daughter caused the bruise on the baby's arm and that she tripped causing the bruise on her cheek. She thinks the baby clothes must be too tight, and that this has caused the marks around the wrist and ankles.

From this information:

- List features that might make you suspect physical abuse?
- Is there anything else that you are worried about? Why?

POSSIBLE ANSWERS

1. The bruises on baby's legs and ligature marks around ankles and wrists

Any bruise or traumatic skin lesion on a young, non-mobile baby should be a cause for concern.

2. The slap mark on the older girl's face

The lesion shown is typical of a slap mark and not consistent with a fall.

Bruising or petechiae (tiny red or purple spots) not caused by a medical condition (for example, a coagulation disorder), with an unsuitable explanation, should prompt you to suspect physical abuse, including:

- in a child who is not independently mobile
- bruises that are multiple or in clusters
- of similar shape and size
- on non-bony parts of the face or body, including the eyes, ears and buttocks
- on the neck, looking like attempted strangulation
- on the ankles and wrists, looking like ligature marks.

3. The history of a fracture in the older sister

Suspect physical abuse if a child has suffered from one or more fractures and if there is no medical condition that predisposes the child to fragile bones (for example, osteogenesis imperfecta or osteopenia of prematurity), or if the explanation is absent or unsuitable. This includes fractures at different ages and X-ray evidence of occult fractures (for example, rib fractures in infants). You might be worried about this fracture and would need to know more about the circumstances - was the father actually there at the time? Was the baby taken to hospital for treatment promptly? Fractures can be very painful. Was there any evidence of other injuries, other fractures, concerns about neglect?

Note that the explanation from the parent about how the injury occurred is very important. It is a part of the evidence used to try and determine whether or not there might have been an abusive situation. It must be carefully recorded in the child's medical record.

4. Does the mother suffer from post–natal depression?

The mother is very isolated and unsupported. Did she appear to be passive and with little emotion? You noted that the baby is not as responsive to you as a normal 4-month old baby would be. You also noted that the older sister is trying unsuccessfully to get his mother's attention. Is this a depressed mother unable to give her baby enough stimulation and is the mother tying her up in her cot and leaving her there for long periods of time - hence the ligature marks. Is she exasperated by her lively older child's attempts to get her attention and has slapped her on the face?

What does this case illustrate? As a home visitor you need to:

- **Listen and observe** - taking into account the whole child, whole family and social circumstances – an ecological model. Can you identify the main stress factors in this family? Are there any factors that reduce risk to these two children? Observe the interactions between the mother and her baby, the mother and her older daughter, as well as the interactions between the two sisters.

- **Seek an explanation** about the history given, the demeanor and behavior of the two children. Observe the interaction between the parent and each child. Remember what you read about the older girl's medical history. Did you have concerns then?

- **Consider the options**. Is the story plausible and consistent? Is it in line with the developmental stage of the children? Children who are not 'cruising' (walking by holding on to something, a gross motor

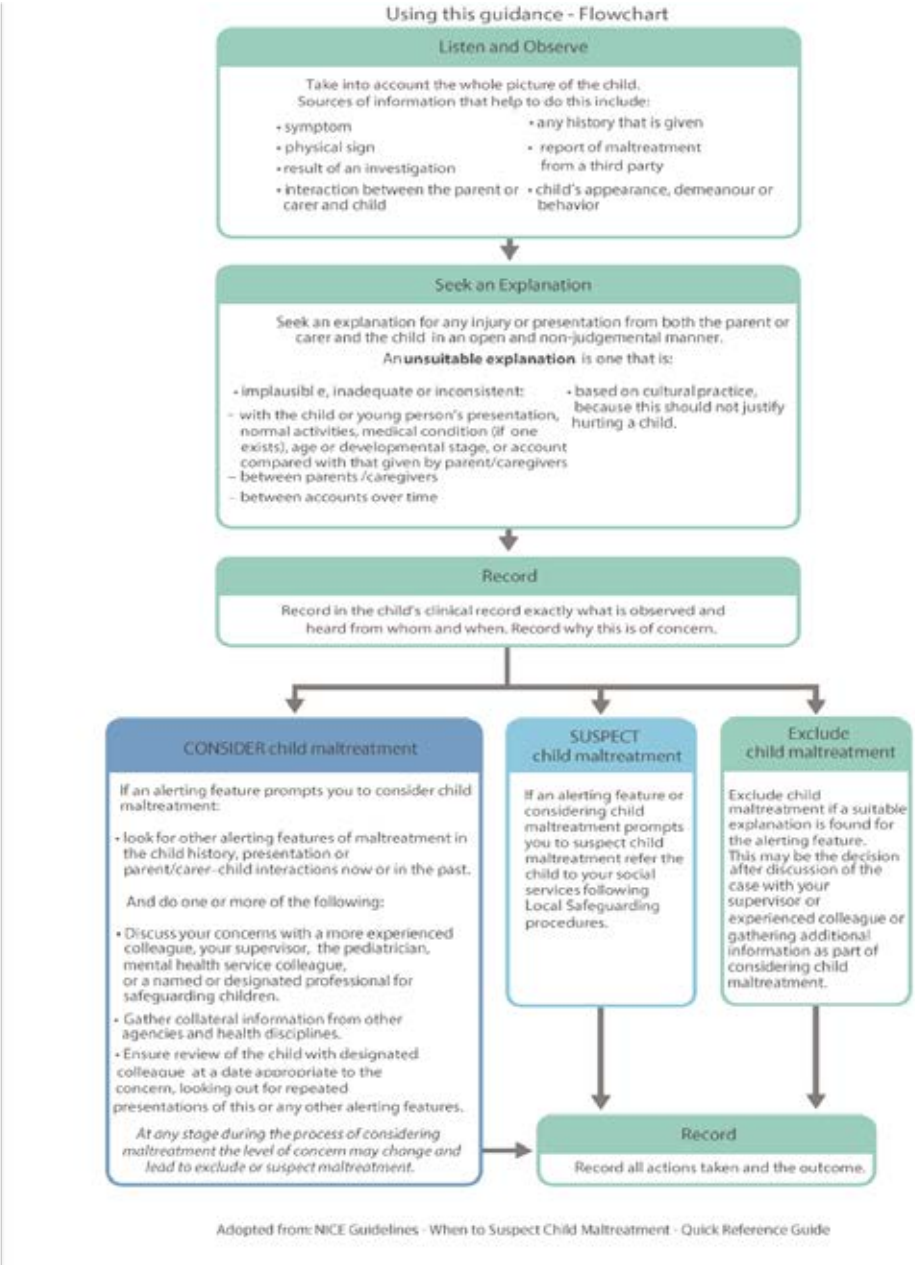
milestone achieved at about 11 months in the majority of children) should not have bruises anywhere unless there is a very plausible and consistent explanation. Compare this with an active 4 year old who attends nursery school and has a number of bruises on the shins - you would expect this and it is normal.

- **Make sure you have accurately recorded** the mother's explanation about the baby's injury and the sister's blemishes in the face as well as all your observations relevant to the situation.

- **Follow the protocol of your health service**. In this case, there are several reasons to suspect child abuse. You should be familiar with your referral pathways, and accordingly inform your supervisor and/or social/child protection services.

Now, look at a Sample Reference Guide adapted from the UK Nice Procedures (http://nice.proceduresonline.com/). Using the Guide for the case above, what do you note? What choice would you make, and how would you proceed? The Guide shows you what information you need to collect and how to use it when you decide to suspect or rule out child abuse and neglect.

When to suspect child maltreatment – quick reference guide in young children under three



Adopted from: NICE Guidelines - When to Suspect Child Maltreatment - Quick Reference Guide

Look at the following **Information Cards 2 and 3: Injuries – differences between accidents and abuse and normal and suspicious bruising areas**, which can help you ask questions and observe during the home visit. You can print this and other cards and take them with you and use them during the visits.

It is very important not to be biased against parents who are poor and/or come from marginalized groups and be less concerned when the parents have a higher income or are respected professionals. Remember, child abuse and neglect can happen in any family. In all situations, your foremost concern is the best interest of the child!

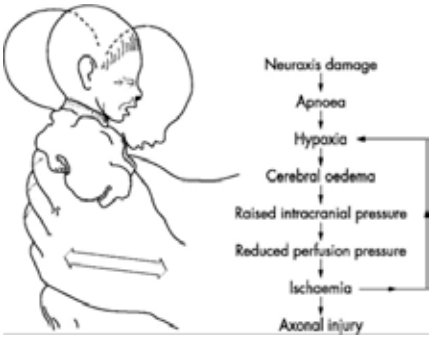
Other injuries that raise concern:

1. **Seen on the skin** (and therefore might be hidden by clothing or dirt or hard to see on dark skin) - abrasions, bites, bruises, burns, cold injuries, cuts, lacerations, ligature marks, petechiae (tiny red and purple spots), scalds, scars, and strangulation marks

2. **Internal injuries** - fractures, oral injuries, spinal, abdominal and intrathoracic injuries, eye injuries

3. **Head injury and shaken baby syndrome**

Shaken Baby Syndrome, also called *abusive head trauma* (AHT) or intentional head injury, refers to what occurs when someone (most often a parent or other caregiver) shakes a baby or throws a baby against an object. A baby may also be shaken by the arms, legs, chest, or shoulders.



Shaken baby syndrome may happen when a baby won't stop crying and a caregiver who is frustrated or exhausted shakes the baby to make it stop crying. It most commonly occurs in babies younger than 1 year of age (the highest rate of cases occur among infants just 6 to 8 weeks old).

In addition to bleeding in or around the brain, with or without skull fracture, there may be bleeding of the retina (back of the eye), rib fractures and fractures of the growing area of the elbows and knees.

After being shaken, a baby may appear sleepy or irritable, be vomiting, suffer from seizures or be unconscious. The worst outcome of shaken baby syndrome may be brain damage and death.

Important points

In Shaken Baby Syndrome, at first the baby cries more, but very soon he or she may stop crying as the brain is damaged. Some children like those with disabilities, with conditions such as colic, and infants multiple siblings have an increased risk of Abusive Head Trauma. Boys are more likely to be victims of Abusive Head Trauma than girls, as are young children of families who live at or below the poverty level.

For additional information on Shaken Baby Syndrome, please look at *Module 9 - Home Environment and Safety*

Watch the video: https://www.youtube.com/watch?v=l_toKPs9Jj4

Look at the *Information Cards 4 and 5* which can help you ask questions and observe during the home visit: *List of indicators - What to observe and Red flags – reasons to take into account child abuse and neglect and abuse.*

2. SEXUAL ABUSE

Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim. Much sexual violence against children is inflicted by family members or other people residing in or visiting a child's family home – people normally trusted by children and often responsible for their care. Familial sexual violence against children is surrounded by silence and shame. Children do not speak about it or, if they do, they are not believed. Most children do not report the sexual violence they experience at home because they are afraid of what will happen to them and their families or that their families will be ashamed and punish them.

Sexual abuse does occur in children younger than three years of age, even in infants.

Look at the *Information card 6: Warning signs in children of possible child sexual abuse*

Additional resources - If you want to learn more on this topic you can look at:

http://www.wikihow.com/Recognize-Signs-of-Abuse-in-a-Toddler-or-Baby

In some countries, sexually abused children are evaluated in specialist settings using well-defined protocols based on evidence.

3. MENTAL, EMOTIONAL, AND PSYCHOLOGICAL ABUSE

Mental, emotional or psychological abuse involves both isolated incidents, as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. This type of abuse has a high probability of damaging the child's physical or mental health, or physical, mental, spiritual, moral or social development.

Look at your *Information Card 7: Warning signs in children of possible mental, emotional or psychological abuse*

Compared to other forms of maltreatment, it is much harder to be sure about emotional abuse as it is behavior being observed rather than physical signs on the child. As a health visiting professional, with a good knowledge of the child, the family, and other significant adults, you are in a good position to observe interactions and/or changes in the child that might indicate emotional abuse.

4. NEGLECT

Neglect includes both isolated incidents, as well as a pattern of failure over time on the part of a parent or other family member to provide for the child's development and well-being, where the parent or family is in a position to do so. Neglect can affect one or more of the following areas: love, care and support; health and nutrition; education; shelter and safe living conditions. Even if neglect is not deliberate (e.g., when a caregiver suffers from mental illness, a devastating loss, violence…), the effects can be devastating for the child.

Video clips - Watch the video to see how neglect effects baby's brain: InBrief: The Science of Neglect http://developingchild.harvard.edu/resources/multimedia/videos/inbrief_series/inbrief_neglect/

The table below summarizes the effect "unresponsive" care can have on the young child and some actions that are proposed to address the unmet needs:

Science Helps to Differentiate Four Types of Unresponsive Care

	OCCASIONAL INATTENTION	CHRONIC UNDER-STIMULATION	SEVERE NEGLECT IN A FAMILY CONTEXT	SEVERE NEGLECT IN AN INSTITUTIONAL SETTING
Features	Intermittent, diminished attention in an otherwise responsive environment	Ongoing, diminished level of child-focused responsiveness and developmental enrichment	Significant, ongoing absence of serve and return interaction, often associated with failure to provide for basic needs	"Warehouse-like" conditions with many children, few caregivers, and no individualized adult-child relationships that are reliably responsive
Effects	Can be growth-promoting under caring conditions	Often leads to developmental delays and may be caused by a variety of factors	Wide range of adverse impacts, from significant developmental impairments to immediate threat to health or survival	Basic survival needs may be met, but lack of individualized adult responsiveness can lead to severe impairments in cognitive, physical, and psychosocial development
Action	No intervention needed	Interventions that address the needs of caregivers combined with access to high-quality early care and education for children can be effective	Intervention to assure caregiver responsiveness and address the developmental needs of the child required as soon as possible	Intervention and removal to a stable, caring, and socially responsive environment required as soon as possible

Source: http://developingchild.harvard.edu/wp-content/uploads/2015/05/InBrief-The-Science-of-Neglect-3.pdf

Use the *Information card 8 on Possible Indicators of Abuse and Neglect*

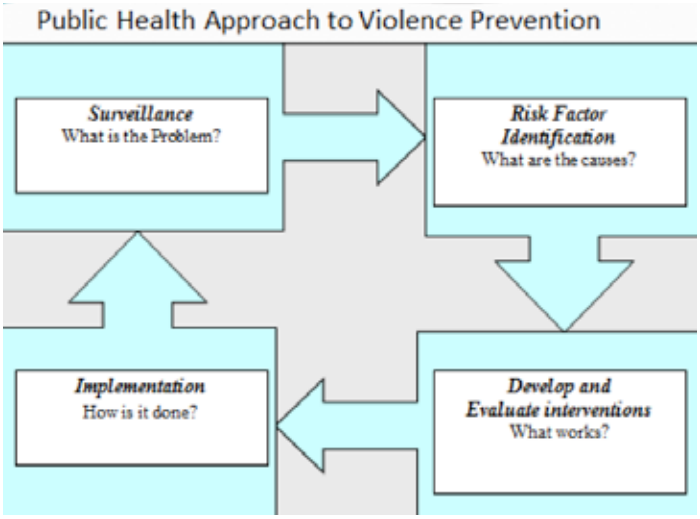
VII

A PUBLIC HEALTH APPROACH TO VIOLENCE PREVENTION

Looking at child maltreatment from a public health perspective entails a focus on populations rather than individuals and takes into account

- The health and developmental needs of children
- The capacity of parents to meet these needs
- The 'social' determinants of child maltreatment, and
- The cultural/environmental context of child maltreatment

It tries to maintain a balance between child protection and family preservation. Early deprivation and neglect has serious developmental consequences for young children, but placing a child in institutional care can be a worse alternative. This is an decision that will be weighed carefully by the child/social protection agency.



(slide from Browne, 2015)

An important objective of public health programs, including home visiting, is the focus on three levels of prevention:

- For **primary prevention**, a *Universal Service* is offered to the whole population to support responsive parenting and prevent adverse childhood experiences.
- **Secondary prevention** may be needed when parents, families, and children encounter difficulties or are exposed to situations that create risk (e.g., parent suffering from post-natal depression, a "colicky" infant, an infant with sleeping problems, a parent that himself/herself suffered from insecure attachment, etc.). In this situation, enhanced services (e.g., more frequent home visits, support to special areas of difficulty) may be sufficient to alleviate risk factors and potential harm.
- **Tertiary Prevention** with *intense specialist* services for treatment of families and communities may be needed where parents/caregivers are unable to meet the needs of their children. Depending on the problem, such intense services are usually provided by other sector professionals, including child/social protection, mental health professionals, early intervention specialists and others. In your role as home visitor, you are likely to such families and provide continued support together with other specialists.

Levels and Strategies for Prevention (adapted from WHO, 1999)

Primary	Secondary	Tertiary
Pre-natal, perinatal and early childhood health care that improves pregnancy outcomes and strengthen early attachment Promoting good parenting practices Public awareness activities (e.g. through media and campaigns) Community education programmes on UNCRC Availability and accessibility at social services, supports and networks School-based activities towards non violence	Perinatal and ongoing identification of at risk children and families Family support such as home visiting Clearly established referral system of support services Substance abuse treatment programmes Community-based, family-centred support, assistance and networks Information available about community resources and safety planning Schools based social services for high stress environment	Early diagnosis Proper inter-disciplinary services to ensure: medical treatment, care, counselling, management and support of victims/families Reintegration in a child-friendly community/schools Adequate child protection laws and child-friendly courts

.

(slide from Browne, 2015)

UNICEF/Pirozzi

VIII

CHILD ABUSE AND NEGLECT AND POVERTY

Poverty can be a major risk for all forms of child abuse and neglect. Parental stress, inadequate housing, displacement, and homelessness, lack of fulfilment of basic needs, inadequate supervision, substance abuse, and domestic violence all raise the risk of harm being done to children.

Poverty increases the risk of parenting difficulties and can affect parents' abilities to meet their children's needs. When parents struggle to provide for the day-to-day necessities of their children, they can feel anxious, depressed, fearful, and overwhelmed. The stress of living in harsh, deprived conditions can have a disabling effect on parenting capacities, resulting in inconsistent discipline, failure to respond to a child's emotional needs, or failure to prevent or address a potential risk to safety.

Housing problems are a dominant theme in child neglect cases. Also, poverty can be an underlying cause for various mental health issues or substance abuse as an escape from a dire and hopeless future.

Important points

Despite the relationship between poverty and child neglect, most poor families do not mistreat their children!

It is more important what parents DO, than what is their level of income!

Reflection and discussion

Protective factors can act as a buffer to risks exacerbated by poverty. Some of these protective factors include maternal employment, parents who were competently parented themselves, a strong informal social support network, and availability of supportive family members. By developing strategies to strengthen protective factors and reduce poverty-related safety risks, you can contribute to reducing the vulnerabilities of children by supporting and strengthening their families.

IX ACTIONS FOR SUPPORTING VULNERABLE FAMILIES – THINGS YOU CAN DO

Reflection and discussion

Based on what you have read in this and other modules (Attachment, Common Parenting Issues, etc.) what are some concrete actions you can take to prevent child abuse and neglect in your families? Your role with families at-risk is a very important one. It may be of interest to you, that home visiting has has been identified as a successful intervention to mediate some of the risk factors for child abuse and neglect and a promising intervention for reducing child abuse and neglect in itself (Sethi et al, 2014).

Actions for preventing child abuse and neglect generally aim to help families strengthen the protective factors and reduce the underlying causes and risk factors. This is done most effectively when you can provide your services through a continuum of care, from pregnancy through the early years and when you establish a relationship of trust with the family, where parents or caregivers are willing to openly share their concerns and challenges.

To support all, but particularly vulnerable families you may want to focus on the following actions during your visits:

- **Support effective and positive parenting** – support bonding, parent attunement, and and a secure attachment; teach parents/caregivers about child development and have realistic expectations of their children at different stages of development; assist parents/caregivers to use positive and effective approaches to address common parenting concerns (excessive crying, colic, tantrums, and sleeping problems, feeding problems, etc.).

- **Support positive parent relationships** - help parents access services for counseling related to their relationship and mental health issues, engage fathers and support bonding and attachment processes starting already during pregnancy.

- **Help families deal better with certain child-related factors** – such as difficult temperament, developmental difficulties or disabilities, unwanted child, "wrong" gender…).

- **Help families use their informal social networks** and access social protection and community services.

During your home visits, you will be observing caregiver-child interactions and promoting attunement as described in more detail in the *Module on Attachment*, focusing in on some of the following areas:

Areas	Actions
Support caregiver-child attachment	**During pregnancy:** increase parent readiness for life changes upon arrival of the child and support first bonding with the growing fetus **At/after birth:** support parents to become attuned to the newborn and young infant for bonding **5 – 12 months:** support parent-infant bonding and attachment **12 – 24 months:** infant/toddler attachment (secure / insecure) becomes observable and measurable
Assess parental perceptions of the child	**Positive attributions to child** • Abusive and neglectful parents attribute negative behaviours to the child (e.g. the child is crying to annoy me) **Realistic perceptions of child** • Abusive and neglectful parents have unrealistic perceptions of the child (e.g., a newborn will sleep through the night without waking and disturbing the parents)
Assess the quality of parenting	How **sensitive** are the parents to the child's needs and behavioural signals? • Over anxious, indifferent and intolerant parents are insensitive to the child's behavioural signals How **supportive and co-operative** are the parents to the child's demands? • Rigid parents do not respond on demand (e.g. when the child cries because of hunger or pain) How **accessible** are the parents to the child? • Parents need to be both physically and emotionally accessible. Parents under stress, anxious or depressed are unavailable. • Parents who are mentally ill or addicted to drugs/ alcohol are likely to be unavailable How **accepting** are the parents to putting the child's need before theirs? • Parents need to postpone their own needs and accept that their child takes priority. This requires self-esteem and maturity as a parent and a positive transition into parenthood. This is helped by the family and social support system, e.g., single mothers should be supported by their family and community to take care of their child and not abandon it because of social stigma. How **consistent** are the parents in their behaviour toward the child?

Parents and Caregivers at-Risk for Abuse and Neglect

When entering a family home, you may meet parents and caregivers that

- Tend to be more negative, hostile and punitive than the average parent and react more negatively to common parental challenges (e.g. infant crying)
- Have unrealistic attitudes and expectations of young children and a poor perception and empathy for a child's needs
- Believe in the use of punishment (often inconsistent and impulsive) to control their child
- Put their own emotional needs first (often with role reversal, expecting the child to understand and cater to the needs of the parent/s).

They may exhibit deficits in:

- Personal adjustment to being a parent
- Responsiveness, and
- Parenting knowledge, skills, and capacity.

Often, such parents/caregivers are less empathetic and sympathetic towards their children; have negative interpretations of a child's behaviour; exaggerate the severity and frequency of a problem behaviour, and a child's behaviour may be seen as deliberate and intending to harm the parent.

In such situations, you will have to make decisions, always "keeping the child" in mind. If you are uncertain, you may want to speak with your supervisor. If you are concerned, you will need to follow your national protocols and involve the child protection services and even the police, if you think that the child or another family member is at risk.

X

WORKING WITH OTHER SECTORS

Working with other sectors and services can become complex, and we have dedicated a module to this topic (*Module 15 Working with other services*). In addition, the modules on the *New Role of the Home Visitor, Falling in Love, and on Communication* have important information on how to identify, engage, and support vulnerable families. Generally when families require intense services for assessment and intervention, this requires new pathways that need to be followed.

CONCLUSIONS

As the family's home visitor you have an opportunity to:

- Offer a degree of privacy and flexibility that will allow families to be more open and share their concerns with you. However, families should be made aware from the beginning that in some situations you may be required to share information with their consent, or even without.
- Assess and enhance the quality of attachment and bonding of the infant or toddler and parent/caregiver, decreasing the possible risk of child abuse and neglect (*see module on Attachment*).
- Help to foster parenting that is responsive to the affective cues of emotions and needs of the child (*see the modules on Love, Play Talk, Read and on Common Parenting Issues*)
- Assess the safety of the child's living environment (*see module on Home Environment and Safety*),
- Discourage parents from using corporal punishment on their children and provide other ways of parenting that are less physically, psychologically and developmentally damaging to the child, but support young child wellbeing and development (*see module on Common Parenting Issues*).

With the support that you provide to families, you can contribute to helping them cope, building resilience, and strengthening bonds. In some cases, this could make a difference in keeping young children with their families. Some of your work will be achieved by working closely with other professionals and entities to ensure a holistic response to young child wellbeing (*see also module on Working with Other Sectors*).

ANNEX XI

INFORMATION CARD 1: RISK AND PROTECTIVE FACTORS

Adapted:
http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html

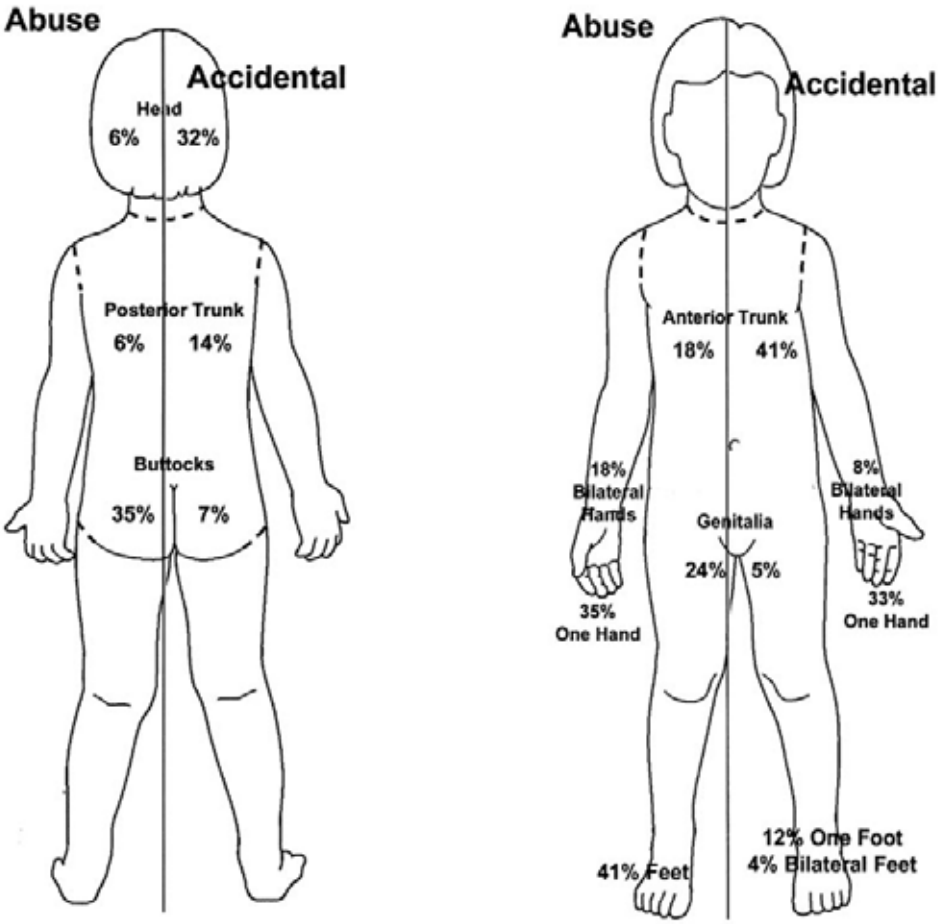
Risk and protective factors

	Risk factors
Individual	Age – under 4 years of age
	Special needs that may increase caregiver burden (e.g., disabilities, mental retardation, mental health issues, and chronic physical illnesses)
	Parents' lack of understanding of children's needs, child development and parenting skills
	History of intergenerational transmission of violence: Children who were abused, learn violence from their parents and tend to abuse their own children
	Substance abuse and/or mental health issues including depression in the family
	Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
	No biological, transient caregivers in the home (e.g., mother's male partner)
	Parental thoughts and emotions that tend to support or justify maltreatment behaviours
Family	Social stress: unemployment, illness, poor housing conditions, large family, presence of a new baby, death of the family member
	Family disorganization, dissolution, and violence, including intimate partner violence
	Household member with mental illness, alcohol, or drug problem
	Parenting stress, poor parent-child relationships, and negative interactions
	Poverty
	Social isolation: no network of support, no friends, not going out and socializing
Community	Community violence
	Concentrated neighbourhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections.
	Lack of enforcement of laws on banning corporal punishment
	Community and society in general approve violence against children

Protective factors buffer children from being abused or neglected. There is a growing interest in them because they are equally as important as risk factors.

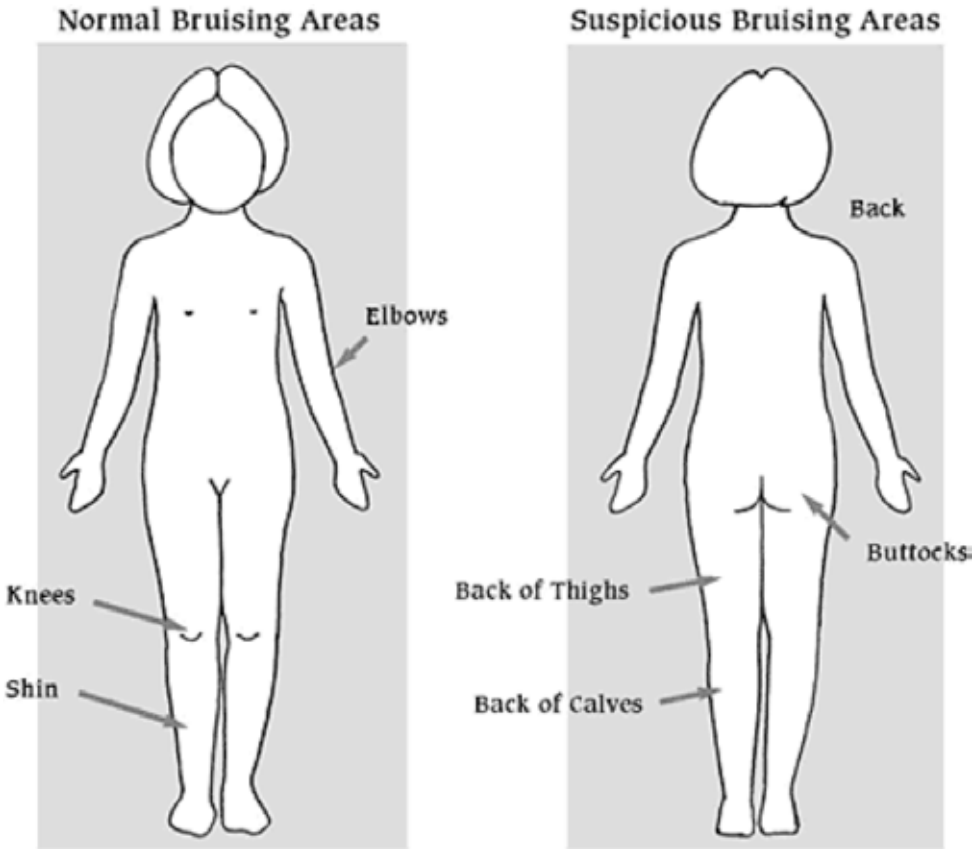
Protective factors	
Family Protective Factors	Supportive family environment and social networks
	Nurturing parenting skills
	Stable family relationships
	Household rules and child monitoring
	Parental employment
	Adequate housing
	Access to health care and social services
	Caring adults outside the family who can serve as role models and support
Community Protective Factors	Communities that support parents and take responsibility for preventing abuse
	Laws against corporal punishment and family violence that are enforced

INFORMATION CARD 2: INJURIES – DIFFERENCES BETWEEN ACCIDENTS AND ABUSE



Source: http://www.volcanopress.com/booksupplements/ChildAbuseandNeglect/Graphics/Misc/Patterns-of-Abuse.jpg

INFORMATION CARD 3: NORMAL AND SUSPICIOUS BRUISING AREAS



Source: www.nursingceu.com

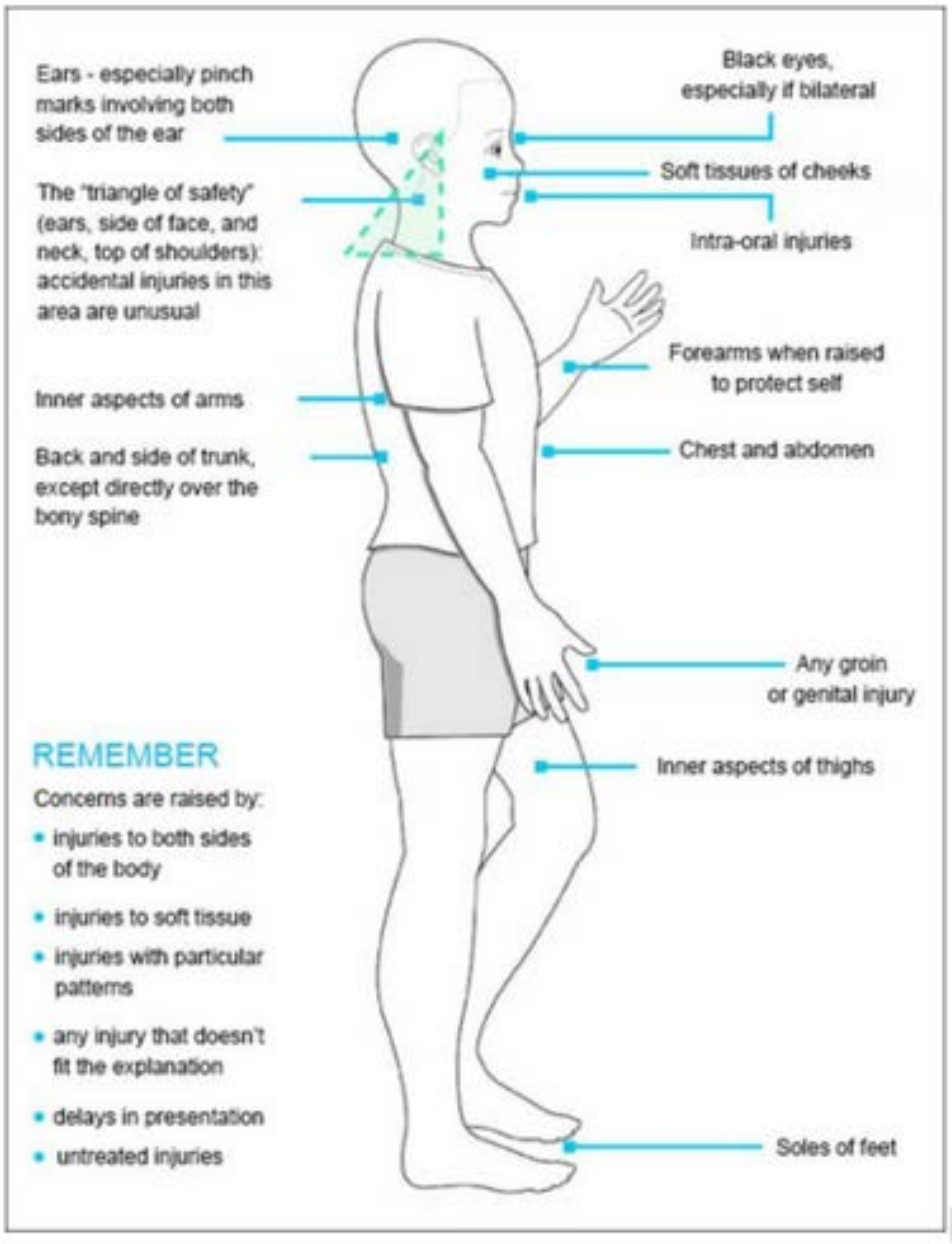
INFORMATION CARD 4: LIST OF INDICATORS - WHAT TO OBSERVE

Physical Abuse	Physical Indicators
Bruises, welts, and bite marks	Depends on location of injuries, severity, circumstances, frequency, and age of child • On face, lips, mouth, neck, wrists, ankles • On both eyes or cheeks (accidents usually injure only one side of the face) • Clustered, forming patterns reflecting the shape of an article (child was struck with something) • In the form of a hand (grab mark) on several different surface areas of skin • On torso, back, buttocks, thighs • In various stages of healing regularly appearing after absence, weekend, vacation Note: People of color such as African/American and Asian infants and children may have areas of darker pigment on their skin (known as Mongolian spots) that are not bruises, but rather a type of birthmark.
Lacerations (cuts) or abrasions (scrapes)	Depends on location of injuries, severity, circumstances, frequency, and age of child • To mouth, lips, gums, eyes • On back or arms, legs or torso
Burns	Depends on location of injuries, severity, circumstances, frequency, and age of child • Cigar, cigarette, especially on soles, palms, back, buttocks • Scalding water immersion (sock-like, glove-like, doughnut shaped on buttocks or genitalia) • Patterned, like curling iron, electric iron, burner, etc. • Rope burns on arms, legs, neck, torso
Fractures	• To jaw and nasal structures • To skull, facial structures • Skeletal trauma accompanied by other injuries, such as dislocations • Multiple or spiral fractures • Fractures 'accidentally' discovered in the course of an exam or in various stages of healing

Head Injuries	• Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking) • Retinal hemorrhage or detachment, due to shaking 'whiplash shaken baby syndrome' • Eye injury (such as black eye) • Tooth or frenulum (under the tongue) injury • Absence of hair and/or hemorrhaging beneath the scalp, caused by vigorous hair pulling
Munchausen Syndrome by Proxy	• Munchausen Syndrome by Proxy is a pattern of parental behavior in which a child is frequently brought into medical care with symptoms suggestive of parentally induced or fabricated illness. An example might be a parent seeking attention by repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea and dehydration, thus requiring hospitalization.

Source: Adapted from Created by Monroe County Department of Human Services. Reviewed and approved by New York State Office of Children and Family Services.

INFORMATION CARD 5:
RED FLAGS – REASONS TO TAKE INTO ACCOUNT CHILD ABUSE AND NEGLECT AND ABUSE



INFORMATION CARD 6: WARNING SIGNS IN YOUNG CHILDREN AND INFANTS OF POSSIBLE CHILD SEXUAL ABUSE

What to watch out for in young children:

Behaviour:

- Fear of getting undressed
- Extreme fear of being touched
- Inability to engage in age-appropriate play with other toddlers,
- Age inappropriate interest in sexuality and knowledge of sexual behavior - Acting out in an inappropriate sexual way with toys or objects, using adult language for body parts, sometimes masturbation
- Sudden changes in sleeping, frequent nightmares,
- Closing down, withdrawing,
- Sudden unexplained mood swings, personality change, unexplained anger and aggression
- A sudden fear of certain places, persons, or characteristics of a person (e.g., men or men with beards….)
- Changes in appetite, gagging, vomiting,
- Self-harm (head banging, biting).

Physical signs:

- Uncomfortable sitting or walking,
- Wetting and soiling accidents unrelated to toilet training,
- Pain, discoloration, bleeding or discharges in genitals, anus or mouth,
- Bruising, lacerations, burns, bites or scratches on the inner thighs, breast, genital or anal region,
- Persistent or recurring pain during urination and bowel movements,
- Unusual or excessive itching in the genital or anal area due to infections,
- Injuries to the mouth, genital or anal areas (e.g. bruising, swelling, sores, infection),
- Torn, stained or bloody underwear.

When you have any suspicion that sexual abuse may be happening, you need to warn parents and take child to the hospital!

INFORMATION CARD 7: WARNING SIGNS IN CHILDREN OF POSSIBLE MENTAL, EMOTIONAL OR PSYCHOLOGICAL ABUSE

During home visits you need to look for the following symptoms in child:

- low self esteem
- habitual body rocking
- indiscriminate affection seeking and over friendliness to strangers
- being very clingy
- constantly trying to get attention
- being 'too' good when the parent is present
- not needing to seek comfort from the parent when hurt or upset
- Being 'mute'.

In parents you should look for:

- negativity or hostility towards or rejection or scapegoating of a child,
- developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining
- exposure to frightening or traumatic experiences, including domestic abuse
- using the child to fulfil the adult's needs (for example, in marital disputes)
- failure to promote the child's appropriate socialisation (for example, not providing stimulation or education, isolation or involving them in unlawful activities)

INFORMATION CARD 8: POSSIBLE INDICATORS OF ABUSE AND NEGLECT

Neglect	Combined Physical and Behavioral Indicators
Child is not getting enough food	• Child appears malnourished • Child begging, stealing food • Consistently acts hungry or complains of hunger • Constant fatigue, listlessness, falling asleep in class
Child appears poorly cared for	• Has poor hygiene (skin, teeth, ears, hair) • Is inappropriately dressed for the season • Clothes are frequently dirty or torn
Lack of medical/ dental care	• Unattended physical problems or medical/dental needs
Lack of adult supervision	• Child being left home alone without supervision, especially in dangerous activities or for long periods of time • Child states there is no caretaker • Extended stays at pre/school; child arrives early and stays late
Abandonment	• Child left without knowing where parent is or when parent will return
Child is showing a delay in normal development	• Failure to thrive – physically or emotionally • Measurable lag in physical growth • Measurable lag in mental/emotional development
Positive toxicology (drug level)	• Especially in newborns • Drug withdrawal symptoms, tremors, etc. in older children/ teens
Behavioral extremes	• Compliant/passive, overly adaptive behavior • Aggressive behavior
Habit disorders	• Child sucking, biting, rocking, etc.
Speech disorders	• Failure to develop speech, abnormal speech patterns
Conduct disorders	• Antisocial and/or destructive behaviors • Torturing or killing small animals
Neurotic traits	• Includes sleep disorders, inhibition of play

(Source: Created by Monroe County Department of Human Services.
Reviewed and approved by New York State Office of Children and Family Services.
 - http://www.dorightbykids.org/how-do-i-recognize-child-abuse-and-neglect/checklist-of-possible-indicators-of-abuse-and-neglect-4)

INFORMATION CARD 9: WHAT CHILD ABUSE AND NEGLECT CAN DO TO CHILDREN – RESEARCH FINDINGS TO SHARE WITH FAMILIES

Robust Association	Plausible outcome/limited evidence	Plausible outcome/ emerging evidence
Physical abuse		
Depressive disorders	Cardiovascular disease	Allergies
Anxiety disorders	Type II diabetes	Cancer
Eating disorders	Obesity	Neurological disorders
Childhood behavioral/ conduct disorders	Hypertension	Underweight/ malnutrition
Suicide attempts	Smoking	Uterine/leimyoma
Drug use	Ulcers	Chronic spinal pain
Sexually transmitted infections	Headaches/migraine	Schizophrenia
	Arthritis	Bronchitis/emphysema
	Alcohol problem use	Asthma
Emotional abuse		
Depressive disorders	Eating disorders	Cardiovascular disease
Anxiety disorders	Type II diabetes	Schizophrenia
Suicide attempts	Obesity	Headaches/migraine
Drug use	Smoking	
Sexually transmitted infections/ risky sexual behavior	Alcohol problem use	
Neglect		
Depressive disorders	Eating disorders	Arthritis
Anxiety disorders	Childhood behavioral/ conduct disorders	Headaches/ migraine
Suicide attempts	Cardiovascular disease	Chronic spinal pain
Drug use	Type II diabetes	Smoking

Robust Association	Plausible outcome/limited evidence	Plausible outcome/ emerging evidence
	Alcohol problem use	
	Obesity	
Sexual abuse		
Sexually transmitted infections/ risky sexual behavior	Sexual revictimization as an adult	Chronic non-cyclical pelvic pain
Personality disorders	Sexual perpetration	Non-epileptic seizure
Depressive disorders		
Anxiety disorders		
Self-harm		
Suicide attempts		
Drug abuse		
Eating disorders		
Obesity		

http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf?ua=1. P. 21

XII

REFERENCES

Bellis MA, Hughes H, Leckenby N, Jones L, Baban A, Kachaeva M, Povilaitis R, Pudule I, Qirjako G, Ulukol B, Raleva M & Terzic N. (2014). Adverse childhood experiences and associations with

health-harming behaviours in young adults: surveys in the European Region. Bulletin of the World Health Organization; Type: Research Article ID: BLT.13.129247. http://www.who.int/bulletin/online_first/BLT.13.129247.pdf

Browne, K. (2015). A community health approach to keeping children safe. Workshop at the Training of Master Trainers, Belgrade.

Butchart A, Phinney A, & Furness T. (2006). Preventing child maltreatment: A guide to taking action and generating evidence. World Health Organization, Geneva.

CDC. Child abuse and neglect: Risk and Protective Factors.
http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html

Gilbert R, Spatz Widom C, Browne K, Fergusson D, Webb E & Janson S. (2009). Burden and consequences of child maltreatment in high-income countries. The Lancet, 373(9657), 68–81.

National Clearing House on Child Abuse and Neglect Information (2001). In focus: understanding the effects of maltreatment on early brain development. Washington, DC, 2001. Available at: http://nccanch.acf.hhs.gov/pubs/focus/earlybrain/index.cfm

Palmer A. (2012). What's the difference between these two brains. In Daily Telegraph, 28 Oct 2012. http://www.telegraph.co.uk/news/health/children/9637682/Whats-the-difference-between-these-two-brains.html

Perry, BD (1997) in Perry, BD (2004). Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture. http://www.lfcc.on.ca/mccain/perry.pdf

Sethi, D. Bellis, M, Hughes, K, Gilbert, R, Mitis, F & Galea, G. (2014). European report on preventing child maltreatment. WO/Euro, Copenhagen. http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf?ua=1

UK. NICE Quick reference Guide: When to suspect child abuse and neglect.
http://nice.proceduresonline.com/

UN General Assembly (2010). 64/142. Guidelines for the Alternative Care of Children. http://www.unicef.org/protection/alternative_care_Guidelines-English.pdf

UNICEF (2012). Children under the age of three in formal care in Eastern Europe and Central Asia. http://www.unicef.org/ceecis/UNICEF_Report_Children_Under_3_FINAL.pdf

UNICEF (2013). Violence against children. Retrieved from http://www.unicef.org/ceecis/protection_17332.html

UN (2010). 64/142. Guidelines for the Alternative Care of Children. http://www.unicef.org/protection/alternative_care_Guidelines-English.pdf

United Nations Secretary-General's Report on Violence against Children (2006). http://www.unviolencestudy.org/

United Nations Secretary-General's Report on Violence against Children (2006). Chapter 3. Violence against children in the home and family. http://www.unicef.org/violencestudy/3.%20World%20Report%20on%20Violence%20against%20Children.pdf

WHO (2014). Child abuse and neglect. Fact sheet N°150
http://www.who.int/mediacentre/factsheets/fs150/en/index.html

WHO (2013). How can violence against children be prevented?
http://www.who.int/features/qa/44/en/index.html

© UNICEF/Pirozzi