Child abuse: a community problem

Harriet L. MacMillan, MD

Editorial

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Dr. MacMillan is with the Centre for Studies of Children at Risk, Department of Psychiatry, Chedoke Division, Hamilton Health Sciences Corporation, Hamilton, Ont.

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It has been more than 35 years since "the battered-child syndrome" was first described, in the *Journal of the American Medical Association*.[1] Despite an increased alertness to physical abuse as a cause of childhood injury and growing awareness of other types of child victimization such as sexual abuse, we still understand very little about the epidemiology of child maltreatment. Although child abuse is often described as an important public health problem, research into its causes and prevention has been seriously lacking.

In 1997, findings from the Ontario Health Supplement regarding the prevalence of child physical and sexual abuse were published.[2] This general population survey involving close to 10 000 participants was carried out in 1990–1991 as an adjunct to the Ontario Health Survey to gather in-depth information about the epidemiology of mental disorders, including correlates. Respondents were 15 years of age and older. Within the study, a self-administered questionnaire (the Child Maltreatment History Self-Report) asked participants about their experiences of having been physically or sexually abused by an adult while they "were growing up." The definition of physical abuse applied to 6 categories ranging from being pushed, grabbed or shoved (often or sometimes) to being physically attacked (often, sometimes or rarely). Although questions were asked about being slapped or spanked, these acts were not included in the definition of abuse, even if they were reported as having happened often. Being kicked, bitten, punched or hit with something was considered severe abuse if it happened often. Being choked, burned, scalded or physically attacked in some other way was considered severe abuse whether it occurred often, sometimes or rarely. The definition of sexual abuse applied to 4 categories of unwanted events, ranging from being the victim of repeated indecent exposure by an adult to being sexually attacked. The definition of severe sexual abuse excluded the category of repeated exposure.

Although they are based on retrospective, self-reported data, the following prevalence rates provide important information about the extent of 2 types of child maltreatment: physical and sexual abuse. A history of physical abuse during childhood was reported by 31.2% of males and 21.1% of females. Sexual abuse during childhood was reported by 4.3% of males and 12.8% of females. Similar proportions of males (10.7%) and females (9.2%) reported a history of severe physical abuse, while severe sexual abuse was reported by 3.9% of males and 11.1% of females. Overall, 33% of males and 27% of females reported that they had experienced physical or sexual abuse or both during childhood. The message is clear: a history of maltreatment during childhood is common among Ontario residents.

These findings only begin to tell us about the scope and burden of this problem. The data provide few insights into factors that influence risk or protection. Moreover, no questions were asked about emotional abuse and neglect. What the field needs, and Canadian children deserve, is a longitudinal study of youth in which data about child maltreatment and its correlates are collected prospectively. This could address crucial questions such as What puts children and young people at risk for maltreatment? and Why do some abused or neglected children go on to develop emotional disorders while others do not?

The fact that few data are available about the extent of this serious problem is a matter of concern. The need should be obvious: such data are essential to the development of interventions and policy. Estimates of the extent of child maltreatment have been derived from official reports to child protection agencies and hence represent only the tip of the iceberg. Collecting information about child maltreatment is fraught with ethical and legal dilemmas. Even so, the burden of suffering associ-

ated with child abuse should induce us to make it a priority to address such dilemmas.

Given the paucity of research on child maltreatment, is there any good news for practitioners? Fortunately, knowledge about families at risk for maternal and child health problems has led to the development of an intervention aimed at preventing physical abuse and neglect. In 1986, David Olds and colleagues published results of a randomized controlled trial conducted in New York State showing that intensive home visits by nurses to pregnant women and continuing through the infancy of the child could reduce rates of child abuse and neglect among disadvantaged families.[3] Eighty-five per cent of the participants had at least one of the following risk factors: low socioeconomic status, single parenthood or teenage parenthood. Now, results of a follow-up study of the original trial[4] show that women who received home visits were identified as perpetrators of child abuse and neglect less often than those in the comparison group during the 15 years after the birth of their first child. Among a subgroup of unmarried women with low socioeconomic status, additional benefits were found. These included a reduction in subsequent pregnancies, criminal justice encounters, substance abuse problems and reliance on welfare payments.

Although there is now evidence of the long-term effectiveness of home visits by nurses in preventing child abuse and neglect in disadvantaged families, a few cautions are necessary. The program evaluated by Olds and colleagues was intensive, extended until the child's second birthday and focused on families at greatest risk.[5] Their findings cannot be extrapolated to interventions or populations that differ significantly from this model.[4] For example, research by the same investigators demonstrated that a less intensive program did not have the same effect.[3] The more intensive intervention was shown to be effective for disadvantaged families, but there is no evidence that its universal application would be equally effective.

In addition, we do not know how to target families most likely to benefit from home visits,[5] and there is no evidence that screening individuals for risk of committing abuse is effective.[6,7] Some authors suggest that the use of a screening instrument can be stigmatizing and may have negative effects.[7] However, this problem can be overcome by providing home visits in communities with high rates of poverty and of single and adolescent parenthood.[5]

Family physicians, pediatricians and allied health professionals can recommend home visits by nurses for disadvantaged families, beginning prenatally and extending through infancy. Referrals can be made through public health services. Because there is no evidence to support the use of screening for such services, home visits can be offered to all families with one or more of the sociodemographic risk factors discussed earlier. This also avoids the potential stigma of screening. If intensive home-visit programs are not available in communities, clinicians can emphasize the need for such services through referral and advocacy.[8] A program of prenatal and early childhood home visits is the only intervention with proven long-term effectiveness in preventing child abuse and neglect. Until clinicians and communities ask for such programs, they are unlikely to be provided, particularly in view of their cost. However, it is worth noting that an economic evaluation of the program implemented by Olds and colleagues showed that the service cost for families with low socioeconomic status was recovered before the children involved reached 4 years of age.[4]

As well as contributing to the prevention of abuse, clinicians also have a role in recognizing and identifying children who are maltreated. All provinces have legislation that requires those who work with children to report suspected abuse to child-protection agencies. Health professionals need to work closely with these agencies in ensuring that children are protected from all types of abuse and neglect. They can also assist in determining the health and developmental needs of children who have experienced maltreatment.

Studies to date, including the Ontario Health Supplement, show that maltreatment continues to be one of the most important public health problems facing children and youth. We need a range of interventions to reduce child abuse and neglect, but they must be rigorously evaluated. All clinicians who work with children and families have an essential role to play in advocating this research.

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Reprint requests to: *Dr. Harriet L. MacMillan, Chedoke Site, Hamilton Health Sciences Corp., 1200 Main St. W, PO Box 2000, Stn LCD 1, Hamilton ON L8N 3Z5; fax 905 574-6665; macmilnh@fhs.csu.mcmaster.ca*