Demographic and clinical features of child abuse and neglect cases

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The aim of this study was to present child abuse and neglect (CAN) cases of the Child and Adolescent Psychiatry Department of Hacettepe University Faculty of Medicine. The charts of all the patients seen at the Child and Adolescent Psychiatry Clinic between 2000 and 2004 were screened regarding the presence of CAN. The mean age of the children was 10.9 years. The offender was generally an extra-familial acquaintance (40.7%). The most common type of abuse was sexual (77.8%) and the most common associated types of abuse were physical and sexual (7.4%). Attention deficit hyperactivity disorder (ADHD) was observed as the most common psychiatric diagnosis (22.2%). Abuse types in relation to age and gender of abused child, risk factors and associated psychopathologies are discussed. Issues related to legislative process and ecology of the abuse experience are mentioned as restrictions for the prevention and treatment of CAN.

Key words: child abuse, sexual abuse, physical abuse, emotional abuse, neglect.

Child abuse and neglect (CAN) is a highly diffused problem among girls and boys of all ages, socioeconomic levels and cultures. It was reported by the United States' National Committee for the Prevention of Child Abuse that substantiated cases of CAN totalled 1 million in 1994. It was expected that an estimated one of every three to four girls and an estimated one of every seven to eight boys will have been sexually assaulted by the age of 18 years[1]. In Turkey, there is only one study with a large community sample. In this study, 16,100 children between 4-12 years were surveyed for CAN (including physical and emotional abuse and neglect) between 1980 and 1982, and frequency of CAN was found higher in preschool ages. Among these children, 34.6% of girls and 32.5% of boys were victims of CAN[2]. The actual occurrence rates in Turkey are still unknown because many maltreated children stay unrecognized, and many witnesses are reluctant to report the abuse. However, teams for the prevention and treatment of CAN have been founded in many settings. A hospital-based child abuse committee was organized and a consensus was reached at Hacettepe University Faculty of Medicine in 2003. The team consisted of child psychiatrists, pediatricians, and social workers, and was expanded to include representatives of forensic medicine, orthopedics, neurosurgery, gynecology, obstetrics, dermatology and nurses. The Department of Child and Adolescent Psychiatry played a central role in this team because of it serving as a psychiatric reference center for such cases. The aim of this study was to report the demographic and clinical characteristics of CAN cases referred to the Child and Adolescent Psychiatry Clinic. We hope this report will be a baseline for future studies.

Material and Methods

We conducted a retrospective review of demographic and clinical features of 54 cases of CAN evaluated at the Child and Adolescent Psychiatry Department of Hacettepe University Faculty of Medicine between 2000 and 2004.

Selection of Subjects

Child abuse and neglect cases were selected among 9,840 children referred to the Child and Adolescent Psychiatry Department between 2000 and 2004. The medical records were reviewed for each child. There were 54 (0.55%) children diagnosed as child CAN.

Procedure

The major reasons for referral to the department were noted and children were grouped according to the type of abuse[3,4]. Four groups of CAN were classified as follows:

- Sexual abuse: by the recognition of any sexual act directed to the child or the adult for the sexual gratification of the offender who is at least six years older than the child.
- Physical abuse: by the recognition of any inflicted trauma directed to the child by a care-taker which resulted in harm or potential harm to the child.
- Emotional abuse: by the recognition of an emotional harm in a child that was considered to be directly subsequent to offender's acts like humiliation, rejection, unacceptable punishments or expectations.
- Neglect was diagnosed when nutritional, medical, educational, emotional, and safety needs of a child were deliberately ignored.

Results

Age range was from 11 months to 20 years, with a mean age of 10.9 ± 4.6 years. It was observed that mean age was 7.2 ± 5.4 years for physical abuse cases, 11.8 ± 4.0 years for sexual abuse cases and 9.6 ± 10.0 years for emotional abuse cases. Of the 54 cases, 21 (38.9%) were boys and 33 (61.1%) girls. Most of the sample consisted of nuclear families from middle socioeconomic class. Sociodemographic characteristics are given in Table I. Referrals were from Ankara in 83.3% (n: 45) of the sample and were mostly at the family's initiative (31.5%; n: 17) or upon the suggestion of the pediatricians (22.5%; n: 12). Details of consultation process are given in Table II. It was observed that 47.9% (n: 23) of children were referred to the hospital by their mothers, 16.7% (n: 8) by their fathers, 14.6% (n: 7) by both parents, and 20.8% (n: 10) by someone extra-familial [relative (10.4%; n: 5), social worker (8.3%; n: 4), foster family (2.1%;

Table I. Sociodemographic Features

	Mean ± SD	
Mean age at referral	10.9 ± 4.6 years	
Family features	**n**	**%**
Nuclear	38	71.7
Extended	5	9.4
Divorced	5	9.4
Death	2	3.8
Step-parent	3	5.6
Parent separation history	13	24.5
Sibling presence	37	71.2
Father	**Mean ± SD**	
Mean age	41.5 ± 5.7 years	
Education	9.7 ± 3.8 years	
Occupational status	**n**	**%**
Working	45	88.3
Retired	2	3.9
Unemployed	4	7.8
Mother	**Mean ± SD**	
Mean age	38.4 ± 6.3 years	
Education	9.3 ± 4.1 years	
Occupational status	**n**	**%**
Housewife	27	54.0
Working	17	34.0
Retired	6	12.0

*Cases with missing data were not included in the statistics.

Table II. Referral Processes of the Cases

	n	%
Family's initiative	17	31.5
Pediatric consultation	12	22.5
Social pediatrics	2	3.7
Neurology	2	3.7
Adolescent	4	7.5
Infection service	1	1.9
Emergency service	1	1.9
Endocrine	1	1.9
Intensive care unit	1	1.9
Social work offices	5	9.3
Teacher	3	5.6
Adult psychiatry	3	5.6
Legal process	2	3.7
Rehabilitation center	1	1.9
Human rights foundation	1	1.9
Foster family	1	1.9
No information	9	16.7

n: 1)]. Forty-eight cases (88.9%) were living with their family, 3 (5.6%) were in institutional care, 1 was (1.9%) living with a relative, 1 with a foster family, and 1 in a rehabilitation center for youth during application.

The most common type of CAN was sexual abuse (77.8%; n: 42) and the highest comorbidity was between sexual and physical abuse (7.4%; n: 4). There was vaginal intercourse in 7 (16.7%) of the sexual abuse cases, anal intercourse in 5 (11.9%), both anal and oral intercourse in 1 (2.4%), and the rest involved sexual fondling. The offender was an acquaintance in 40.7% of the cases (n: 22) and an intra-familial person (sibling, parent, step-parent were grouped as intra-familial) in 33.4% of the cases (n: 18). Other characteristics of CAN cases are given in Table III. It was mentioned that the abuse was known in the neighborhood in 27.8% of the cases (n: 15), as a result of which, 5 cases (9.3%) relocated to a new area.

History of psychiatric disorders was positive for 15.1% of the mothers (n: 8), 28.3% of the fathers (n: 15), and 22.2% of the children (n: 12). Parental psychiatric disorders were depression, psychotic disorder, impulse control disorders, alcohol and substance abuse, antisocial personality features, suicide, dependent personality features, and paranoid personality features. The most common psychiatric disorder was depression (n: 3; 5.6%) in mothers and alcohol abuse (n: 8; 14.9%) in fathers. Family history was positive for psychiatric disorders in 21.1% of the cases (n: 8). Seven mothers (13.0%) and three fathers (5.6%) had a medical problem like hypertension, asthma, rheumatoid arthritis, gastritis, and lumbar hernia.

The most frequently recorded abusers were acquaintances for both boys and girls (61.9% of boys; 27.3% of girls). Fathers appeared with the second highest frequency (19.0% of boys; 24.2% of girls) for both genders. Relatives formed the third most common group as abusers for boys (9.5% of boys) and strangers for girls (21.2% of girls). Various factors such as gender, age, psychiatric history in the family, and parental separation were associated with intra-familial abuse. Features of intra-familial abuse are given in Table IV. The most common intra-familial offender was the father (22.2% of all cases; n: 12). Within the cases maltreated by the fathers, girls accounted for the higher proportion compared to boys during adolescence (1 boy and 1 girl in preschool, 3 boys and 1 girl in school age and 6 girls in adolescence). Features of the CAN cases in the three age groups are summarized in Table V.

Diagnostic distribution of CAN cases based on the time of the first abuse episode is given in Table VI. It was seen that attention deficit hyperactivity disorder (ADHD) was the most common psychiatric diagnosis (n: 12; 22.2%)

Table III. Characteristics of CAN

	n	%
Offender in CAN		
Acquaintance	22	40.7
Intra-familial (sibling, parent, step-parent)	18	33.4
Stranger	7	13.0
Relative	4	7.4
Relative and acquaintance	2	3.7
No information	1	1.9
Types of CAN		
Sexual abuse	42	77.8
Physical and sexual abuse	4	7.4
Sexual abuse and neglect	1	1.9
Physical abuse	9	16.7
Physical and emotional abuse	1	1.9
Physical abuse and neglect	1	1.9
Emotional abuse	2	3.7
Emotional abuse and neglect	1	1.9
No information	1	1.9
Frequency of CAN		
Single event	25	49.0
Recurrent event	19	37.3
Multiple events	7	13.7

Table IV. Features of Intra-Familial Abuse Cases

	n	%
Father	12	66.6
Psychiatric history	9	75.0
Parental separation	6	50.0
Referral due to abuse	4	33.3
Type of abuse		
Physical	6	50.0
Sexual	5	41.7
Emotional	1	8.3
Legal action	2	16.7
Mother	2	11.1
Psychiatric history	2	100.0
Parental separation	1	50.0
Referral due to abuse	2	100.0
Type of abuse		
Physical	1	50.0
Sexual	–	–
Emotional	1	50.0
Legal action	–	–
Both parents	1	5.6
Brother	1	5.6
Step-father	1	5.6
Step-mother	1	5.6
Total	18	100.0

Table V. Features of the CAN in Three Age Groups

	Age groups n (%)					
	Preschool		School		Adolescence	
	Boy	Girl	Boy	Girl	Boy	Girl
Type of abuse						
Sexual	2 (28.6)	–	9 (39.1)	10 (43.4)	6 (25.0)	15 (62.5)
Physical	1 (14.3)	3 (42.8)	2 (8.7)	1 (4.4)	–	2 (8.3)
Emotional	1 (14.3)	–	–	–	–	1 (4.2)
Unknown	–	–	–	1 (4.4)	–	–
Offender						
Intra–familial*	2 (28.6)	3 (42.8)	3 (13.0)	4 (17.4)	–	6 (25.0)
Extra–familial	2 (28.6)	–	8 (34.8)	8 (34.8)	6 (25.0)	12 (50.0)
Total	7 (13.0)		23 (42.6)		24 (44.4)	

*Intra-familial: parent, sibling, and step-parent.

Table VI. Diagnostic Distribution of CAN Cases Based on the Time of the First Abuse Episode

	Time of the first abuse episode n (%)			
	At referral	In the past	At follow–up	Total
Number of cases	34 (63.0)	18 (33.3)	2 (3.7)	54 (100)
Diagnosed cases	19 (35.2)	17 (31.5)	2 (3.7)	38 (70.4)
ADHD	6 (11.1)	4 (7.4)	2 (3.7)	12 (22.2)
Acute stress disorder	5 (9.3)	–	–	5 (9.3)
Depression	1 (1.9)	3 (5.6)	–	4 (7.4)
Mental retardation	2 (3.7)	2 (3.7)	–	4 (7.4)
Adjustment disorder	1 (1.9)	2 (3.7)	–	3 (5.6)
Encopresis	1 (1.9)	2 (3.7)	–	3 (5.6)
Conversion disorder	–	2 (3.7)	–	2 (3.7)
Conduct disorder	–	1 (1.9)	–	1 (1.9)
Bipolar affective disorder	–	1 (1.9)	–	1 (1.9)
Simple phobia	1 (1.9)	–	–	1 (1.9)
Enuresis	1 (1.9)	–	–	1 (1.9)
Separation anxiety	1 (1.9)	–	–	1 (1.9)

among the whole sample. Thirty-eight cases (70.4%) were treated for long-term and 28 (51.9%) were put on medication. The social worker of the department managed 20.4% of the cases (n: 11). A legal action was taken in 20.4% of the cases (n: 11), but one of the families cancelled the legal procedure due to their sensitivity for the further damage to their child as a result of the court procedure, i.e. as a witness and the object of media attention. One child (1.9% of the cases) was removed from the family by the regional social work office for institutional care. Only two (16.7%) of the fathers were reported to the police in CAN cases.

Discussion

Risk factors for CAN were described by Brown et al.[5] across four domains: individual child or adult characteristics, family functioning, community level, and the socio-cultural context. They described the significant risk factors at the individual level as child's gender, handicap, low intelligence, and difficult temperament, low maternal education, maladaptive maternal personality traits, maternal youth, parental sociopathy (particularly maternal substance abuse and paternal police involvement), perinatal problems, and unwanted pregnancy. At the familial level, they included parental conflict, poor marital quality, presence of a single

parent or step-father, maternal illness, low parental involvement, and harsh punishment. At the community and socio-cultural level, factors such as neighborhood dissatisfaction and poverty were defined as significant risk factors[5]. In our sample, some of these risk factors were present and they were psychiatric disorders in parents (n: 8; 15.1% of mothers and n: 15; 28.3% of fathers), marital discord (n: 13; 24.5%), disturbed family structure (n: 10; 18.9%), unemployment of father (n: 4; 7.8%), step-parent (n: 3; 5.6%), institutional care (n: 3; 5.6%), and psychiatric history in child (n: 12; 22.2%). The most common parental psychiatric disorders were depression (n: 3; 5.6%) for mothers and alcohol abuse (n: 8; 14.9%) for fathers. It is well known that paternal alcohol abuse is a highly accepted risk factor for CAN[6]. Depression of mothers may result in under involvement of mothers. Low socioeconomic level was not significant in our sample. This was attributed to the general population of hospital referrals.

In contrast to sexual abuse, gender and age distributions in physical and emotional abuse do not show large differences. Female to male ratio increases at adolescence[7]. According to the National Center of Child Abuse and Neglect, the ratio of sexual abuse is about four females for each male, with a peak time starting around age 7 to 8 years continuing through adolescence. For males, the period involving the sexual abuse is usually much shorter, and typically occurs prior to puberty[8]. Our sample was compatible with this data. Sexual abuse was more frequent in school-aged and adolescent girls, and at adolescence the ratio of sexual abuse was about two to three girls for each male (6 boys and 15 girls), and for males, sexual abuse mostly occurred prior to puberty.

In our study, sexual abuse was more frequent than the other types of CAN, unlike previous hospital-based reports in Turkey. In these reports, physical abuse was found at the highest frequency among CAN types and in one of them no sexual abuse case was reported[4,9]. Sexual abuse predominance can be related to the referrals to the Psychiatry Department. Some of the cases were diagnosed by their past histories after they were referred to the out-patient clinic for other reasons. Psychiatrists may face the long-term results of abuse in their practice more than in other professions. Most of the cases were taken to the hospital by parental decision. This suggests that CAN may be known mainly as a psychiatric situation by the families, or that families may be more likely to request help from a psychiatrist when the abuse type is sexual.

Psychiatric and psychological problems associated with physical abuse and neglect cover a wide range. Interpersonal problems like deficits in social functioning due to impaired styles of interpersonal attachment, cognitive and academic impairments, aggressive and delinquent behaviors, and suicidal and other self-destructive behaviors like smoking, substance use and sexual risk-taking were found among the correlates of physical abuse. Among them, aggressive and delinquent behaviors were most commonly correlated with physical abuse[7]. A variety of symptoms, such as anxiety, depression, dissociation, and abnormal sexual behavior, were suggested as core symptoms of sexual abuse. It was mentioned that these core symptoms might continue throughout childhood, adolescence, and into adult life, or sometimes new symptoms may emerge during adolescence and adulthood, such as substance abuse, somatization reactions, eating disorders, and borderline personality disorder[10]. Abuse victims are also found at increased risk for a variety of child and adolescent psychiatric diagnoses including depressive disorders, anxiety disorders, conduct disorder, oppositional defiant disorder, ADHD and substance abuse[5,7,8,11].

In our cases, it was not possible to differentiate the psychiatric disorders of the groups according to abuse types because of the limited number of cases. However, most of the diagnoses mentioned in the literature were present in our sample, like ADHD, acute stress disorder, depression, adjustment disorder, conversion disorder, conduct disorder, bipolar affective disorder, simple phobia, and separation anxiety. It was interesting to observe that ADHD was the most common diagnosis in our sample. Two of the ADHD patients were abused during the period of psychiatric treatment. These children might have been at higher risk because of their high levels of impulsivity. Further research is needed for detailed identification of risk factors. Another important observation is the absence of post-traumatic stress disorder

(PTSD) diagnosis. It may be related to the under-recognition of PTSD by the psychiatrists or to the fact that most of the cases in our sample were acutely presented.

A primary issue to consider when providing therapy to an abused child involves the need to address the ecology of the abuse experience. Cicchetti and Toth[12] mentioned that even when a therapist is providing individual child psychotherapy, it is important to remember that the child does not exist in isolation, but continues to be affected by home, school, and the broader community. Therefore, the role of a social worker is important in the process of evaluation and treatment of the families as well as the cases. The social worker of our department managed the complex cases as a part of the team.

Reporting for legal action still seems to the families as a further risk for the abused children and adolescents in many ways. A legal action was taken in 20.4% (n: 11) of the cases. As a preventive action, the legislative process may become more protective in the case of abuse. For intra-familial cases, fathers (66.7%; n: 12) were the offenders at the highest frequency and only in two (16.7%) of them was legal action taken into account. Reluctance to report the intra-familial cases can be explained by the intra-familial dynamics and insufficiency of economic resources of the family. Social support to the families, especially for mothers, may have a protective and facilitator effect on the reporting of such cases to social services.

This study shares the limitations of retrospective studies in general because data was obtained from hospital records retrospectively. Accordingly, much information surrounding injuries, psychosocial stressors or compliance and documentation of events could not be collected systematically for each subject. Another limitation was that the cases were restricted to the referrals to a psychiatry department of a tertiary care academic institution, and our results can not be generalized to hospitals in other settings or to other child protective services. The third limitation was the small number of the sample, which precludes generalizing the results.

In summary, CAN is a fairly new subject, especially as a research field, in our culture. Although the cases of sexual abuse seem to be in excess in our study population, more cases of physical and emotional abuse and neglect can be expected. It seems necessary to develop programs both for public education and for the training of professionals in the related fields to increase the awareness and to develop further specialized services for such cases.

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