E-ISSN: 2360 – 6754; ISSN-L: 2360 – 6754

European Journal of Law and Public Administration

2017, Volume 4, Issue 2, pp.105-109

<https://doi.org/10.18662/eljpa/19>

PHYSICAL CHILD ABUSE

Lăcrămioara BĂLAN

Covered in:

CEEOL, Ideas RePeC, EconPapers, Socionet,
HeinOnline

Published by:

Lumen Publishing House

On behalf of:

Stefan cel Mare University from Suceava,
Faculty of Law and Administrative Sciences,
Department of Law and Administrative Sciences

PHYSICAL CHILD ABUSE

Lăcrămioara BĂLAN¹

Abstract:

Physical child abuse is common and carries a significant morbidity and mortality. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Early identification of physical abuse and early intervention are essential to prevent ongoing abuse and avoid its consequences.

Keywords:

physical child abuse, bruising ,burns and scalds, skeletal injury, abusive head trauma, visceral injury.

INTRODUCTION

Physical abuse is recognized as one of four categories of child maltreatment, along with sexual abuse, emotional abuse, and neglect.

Physical child abuse is an act of commission both deliberate and intentional, although the intended consequence to the child may not be planned.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child.

A unified definition is important to inform a general framework for child Protection policy setting, multi-agency assessment, statutory and legal interventions, epidemiology, and an understanding of current and future research.

¹ Lecturer PhD, Faculty of Law and Administrative Sciences, Stefan cel Mare University from Suceava, Romania.

EPIDEMIOLOGY

The true prevalence of physical child abuse is difficult to determine. The number of cases that are recognized by statutory child protection agencies is the tip of a much bigger iceberg of victims who never come to their attention. Many cases go unreported or unrecognized. Information systems are incomplete or record a limited part of the picture. Many of these children are victims of repeated episodes of abuse which start in early childhood.

RISK FACTORS FOR ABUSE

Social, psychological, physical, economic, and environmental factors in the carer and the child may all contribute to an increased risk of child abuse. The way that these factors interact to increase risk is complex and ill understood. Care related factors include interpersonal violence within the household, substance misuse, known maltreatment of animals, poverty, mental health problems, low educational achievement, and exposure to maltreatment as a child. Child-related factors are disability, and emotional and behavioral problems and socioeconomic factors include single parent, young parent, new partner, poverty, family and neighborhood stress, and unemployment. The causal relationship between individual and associated factors is not inevitable as some households burdened with a number of risk factors develop resilience and are not abusive households.

PHYSICAL ABUSE

Physical child abuse results in a wide range of injuries that include the following:

- Bruising and soft tissue injuries that include bites and abrasions
- Burns and scalds
- Skeletal injury
- Abusive Head Trauma
- Visceral injury

Any clinician, indeed anyone who sees children on a regular basis, has a responsibility to recognize and report suspected physical abuse to statutory child protection agencies. [6: pp. 911-915].

BRUISING

Bruising remains the commonest abusive injury that children sustain and as such may be an important indicator that abuse has taken place, and that further enquiries / investigations are merited. Missing abusive bruising may be a lost opportunity to protect a child; it has been noted that 19% of children who were fatally abused had been seen by a doctor within the month prior to their death, and facial bruising was among the injuries seen. While accidental bruising is extremely rare in pre- mobile infants (<1%), with the exception of birth related bruises, bruising is the commonest finding in abused babies, and the face is a frequent site of abusive bruises. [2: pp. 552-558].

THERMAL INJURY

It is estimated that up to 10% of children admitted to burns units, may be suffering from an abusive burn , with burns due to neglect outnumbering intentional burns. Abusive burns not only carry a higher mortality, but they lead to changes, surgery, and possible scarring and contractures in addition to the psychological consequences. [2: pp. 552-558]

The commonest intentional burns described in the literature are scalds, with hot water immersion burns being the commonest pattern. While the typical pattern for abusive scalds involves the feet and legs, with or without buttocks / perineum, it may also involve both hands and feet, or one hand, or may involve only the face.

SKELETAL INJURIES

Most skeletal injuries in physical abuse occur in children under the age of 2 years.

80% of abusive fractures occurred in children under 18 months while 85% of accidental fractures are seen in children aged 5 years and over. Abusive fractures are frequently clinically occult; they may be multiple and of different ages. Any fracture can occur as a result of physical abuse, but some have a higher specificity than others.

Rib fractures have the greatest specificity for physical abuse. The fractures are most likely to be multiple, affecting ribs on one or both sides of the thorax.

ABUSIVE HEAD TRAUMA

Abusive head trauma is among the most serious forms of physical abuse. The clinical outcome for children with head trauma is poor and considerably worse than for those children with non-AHT. [4: pp. 245-249]. The clinical presentation includes infants who present with unexplained traumatic brain injury or infants with other signs of physical abuse where intracranial injury is identified in the course of a full clinical investigation. Symptomatology can vary from a child who is dead at admission to children who present to hospital with a variety of neurological symptoms of varying degrees of impaired levels of consciousness, seizures, or apneic episodes, and some children presented with minor degrees of irritability or impaired feeding without overt neurological symptoms. [5: pp. 70-74]

VISCERAL INJURIES

Although abdominal injuries are rarely recorded in abused children, prevalence estimated at 1–8% of abuse cases, they are recorded as the second commonest cause of fatal abuse after head injuries. Among abdominal injuries, liver and bowel injuries occur with almost equal frequency, although it is worth noting that accidental duodenal injury, which is the commonest abusive bowel injury is a rare accidental injury of children.

Certain characteristics have been observed in some cases to parents, such as the following: [3: pp. 107-133]

- Unusual calmness or knowledge of illnesses
- Parents who fit in contentedly with ward life
- Alcohol or drug misuse
- Criminal activity
- Personality disorders including hysterical and borderline types
- A personal history of being victims of child abuse or rape
- A history of conduct disorder or eating disorder
- Financial mismanagement
- Marital and relationship difficulties, often well concealed

However, some of these are factors that must be considered in the wider assessment of risk to the child as part of the core social services assessment.

CONSEQUENCES OF PHYSICAL ABUSE

Physical abuse carries a significant mortality and morbidity. Child homicide reflect the most severe cases of physical child abuse. The most serious abusive injuries include abusive head trauma and visceral injuries. Both occur in the youngest children and have an estimated mortality rate of 12–30%.

Significant neurological disability is seen in around half of the survivors of abusive head trauma and many victims of abusive thermal injury sustain serious scarring and disfigurement. [1: pp. 68-81] In terms of psychological outcome from physical abuse, it is difficult to disentangle the effects of associated types of abuse such as neglect and emotional abuse. However, studies confirm emotional and behavioral problems, post traumatic stress disorder, mental health problems, substance misuse, and criminality in survivors of abuse.

Early identification of physical abuse and early intervention are essential to prevent ongoing abuse and avoid its consequences. [1: pp. 68-81].

Physical child abuse is common and carries a significant morbidity and mortality.

Child health professionals have an important role in recognizing, assessing and managing children with suspected physical abuse.

References

- [1]. U.S. Department of Health & Human Services (2007). *Child Maltreatment 2007*. Available online at: <https://www.acf.hhs.gov/cb/resource/child-maltreatment-2007>
- [2]. Gilbert, R., Widom, C.S., Browne, K., et. al. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, 373, pp. 68–81
- [3]. Govindshenoy, M., Spencer, N. (2007). Abuse of the disabled child: a systematic review of population-based studies. *Child Care Health Dev*, 33, pp. 552–558.
- [4]. Berger, L.M. (2015). Income, family characteristics, and physical violence toward children. *Child Abuse Negl*, 29, pp. 107–133
- [5]. Jessee, S.A. (2015). Physical manifestations of child abuse to the head, face and mouth: a hospital survey. *ASDC J Dent Child*, 62, pp. 245–249
- [6]. Chang, L.-T., Tsai, M.-C. (2007). Craniofacial injuries from slip, trip, and fall accidents of children. *J Trauma*, 63, pp. 70–74