**Editorial [26:6]**

# Physical Abuse of Children

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This issue of *Child Abuse Re*view brings together a number of papers focussing on different aspects of the physical abuse of children, including issues to do with professional assessment, young people's disclosure of physical abuse and a preventative measure for parents to help reduce non-accidental head injury in babies. Physical abuse of children can involve:

> '...hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.' (HM Government, 2015, p. 92)

Physical abuse can result in serious long-term problems for children's social, emotional and physical development and at its most severe, result in serious injury or death. In a previous issue of *Child Abuse Review*, Peter Sidebotham (2015) reported on some of the challenges and complexities of physical abuse noting in particular some of the dilemmas professionals face in relation to recognition, diagnosis and management.

The first paper in this issue by Natalie Van Looveren and colleagues (2017) from Belgium sought to investigate whether parenting a child referred to a child and adolescent psychiatry department leads to a greater risk of physical abuse and if that is associated with a specific child psychopathology. In this study, all 156 primary caregivers of children aged 6-11 years old referred for a child psychiatric assessment were approached to participate. Fifty-nine children's caregivers gave informed consent and completed the questionnaire measures. The Dutch Child Abuse Potential Inventory (CAPI) was used to assess physical abuse risk (Milner, 1986; 1994), socio-demographic data were collected and at the end of screening a child psychiatric diagnosis was made using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IVTR). Findings showed that:

> 'Using the most stringent cut-off point of 215 on the Abuse scale of the CAPI… ten per cent of caregivers with a child with a psychiatric problem obtained an Abuse scale score indicative of a potential risk for physically maltreating their child.' (Van Looveren *et al*. 2017, p. XX).

Van Looveren and colleagues (2017) note that if a lower cut-off score of 166 is used instead, then 25 per cent of families would be regarded as having a risk for physical child abuse amongst this population. However, it is interesting to note that the researchers found no correlation between an elevated risk for physical abuse and any particular child psychiatric diagnosis. In a previous issue of *Child Abuse Review*, Sarah Laulik *et al*. (2015) detailed the psychometric properties of the CAPI in a paper examining its use in assessments of parents involved in care proceedings, including its strengths and limitations. These authors urged careful consideration when a decision is made to use the CAPI measure in clinical practice, emphasising its use should be only 'in the context of a wider assessment' and that assessors should have relevant experience and be properly trained in its use (Laulik *et al*., 2015, p. 342).

In our second paper that examines professional assessment, Lauren Matthews and colleagues (2017) from Cardiff conducted a qualitative study to explore the knowledge, attitudes and training of Child Protection Social Workers (CPSWs) with regards to assessing child bruising. Bruising is the most common sign of physical abuse (Maguire and Mann, 2013), with guidance suggesting that both the child's age and his/her stage of development, and 'the location and pattern of bruising' are 'important for distinguishing between accidental and non-accidental bruising' (National Institute for Health and Clinical Excellence, National Collaborating Centre for Women's and Children's Health, 2009, p. 26). In Matthews *et al.*'s (2017) study, paediatricians' views were also sought on the knowledge and training of CPSWs on child bruising, in addition to gathering information about the relationship between the two professional groups. In the research, interviews were conducted with 39 CPSWs and 16 paediatricians recruited through local authority social work departments and hospital paediatric units across South Wales and South West England. Data were organised using NVivo software and analysed using a thematic analysis approach.

The study findings revealed that the majority of social workers had received no past training during their social work degrees or through continuing professional development specifically about bruising or non-accidental injury. The paediatricians, in contrast, seemed unaware of the CPSWs' training or knowledge, either assuming they did receive training, or having no knowledge of their training or what it entailed. The authors concluded that the 'CPSWs lack confidence in assessing bruising with knowledge gaps regarding bruise patterns and the lack of evidence for ageing bruises' (Matthews *et al.*, 2017; p. xxx). As the authors note, 'ageing a bruise based on its appearance was historically performed, but has no evidence base to support it' (p. xxx). Instead CPSWs in this study focussed

more on the history or explanation for the bruise given by the child and parents, including social factors such as the home environment, chastisement strategies and parent-child interaction when referring a child for a medical examination.

A key theme to emerge from the study was that many of the CPSWs felt that the assessment of a child's bruising is solely the responsibility of the paediatrician conducting the child protection medical, despite often having to make urgent decisions themselves about which children with bruises should undergo a medical examination. In contrast, paediatricians expressed the view that CPSWs 'have an over-reliance on the child protection medicals to confirm abuse, or an unrealistic expectation of what a paediatrician could conclude from examination' (Matthews *et al.*, 2017, p. xxx). Matthews *et al.* (2017) conclude that the study findings indicated that both CPSWs and paediatricians have a misunderstanding about the others' role in assessment, suggesting a need for improved collaboration. They make a final recommendation that all CPSWs should have 'mandatory postgraduate training on the current research relating to physical abuse' (Matthews *et al.*, 2017, p. xxx)

Our next paper by Merav Jedwab and Rami Benbenishty (2017) also addresses attitudes to training and reporting of child maltreatment, this time among a sample of Israeli paediatricians. In Israel mandatory reporting has been in law since 1989 with a requirement for both 'professionals and ordinary citizens to report any reasonable suspicion that a child has been maltreated to child protection services (CPS) or to the police' (Jedwab and Benbenishty, 2017, p. XXX). A sample of 200 paediatricians were approached through the Israeli Paediatric Association and the researchers completed telephone interviews using a structured questionnaire with the paediatricians, exploring their attitudes and experiences about identifying and reporting suspected child abuse and neglect cases. Data were analysed using descriptive statistics and correlations. Unsurprisingly, a key finding of the study was that the majority of paediatricians had been involved in at least one case of suspected abuse or neglect. The paediatricians tended to emphasise the benefits of mandatory reporting, while highlighting some of the barriers which may result in a failure to report; these mainly related to negative consequences for the family and the paediatricians. Similar to Matthews *et al*.'s (2017) study, lack of training was an issue. Three quarters of the paediatricians reported only receiving minimal training in child maltreatment as part of their basic medical training and many identified current training needs, particularly to enhance their theoretical knowledge of child maltreatment and also to strengthen their practical skills. The authors conclude their paper by

recommending simulation based education for paediatricians to enhance both theoretical knowledge and practical skills relating to child abuse and neglect (Jedwab and Benbenishty, 2017).

Our next paper by Carolina Jernbro and colleagues (2017) from Sweden focusses on young people's experiences of physical child abuse. These researchers sought to examine disclosure of child physical abuse in a nationally representative sample of 3202 Swedish adolescents and to identify who had been the recipient of their disclosure. The national survey was conducted in September 2011 with ninth grade students aged 14-15 years, who completed the questionnaire while supervised in a classroom setting. This survey collected both quantitative and qualitative data and the analysis was based on the responses of 3198 students. Six hundred and fifty young people (20.3%) reported at least one type of maltreatment, with child physical abuse being the most frequently reported type of abuse (17.7%), followed by emotional abuse (10.9%). These findings are in keeping with rates found by Stoltenborgh *et al*. (2015) in a series of meta-analyses of child maltreatment prevalence. Those authors estimated self-reported lifetime prevalence rates of 23 per cent for physical abuse and 36 per cent for emotional abuse.

In Jernbro *et al.*'s study (2017), of those young people suffering physical abuse, a third had experienced severe child physical abuse, with more girls than boys reporting severe child physical abuse, as well as emotional abuse, being a witness to interpersonal violence and multi-type maltreatment. The survey findings showed that adolescents who had experienced any form of child maltreatment 'were less likely to be able to identify an adult confidant compared to those without a history of abuse' (Jernbro *et al.*, 2017, p. xxx). Among those young people reporting severe child physical abuse, 52 per cent reported that they had disclosed their abuse; of these 37.5 per cent reported disclosing to peers or a sibling and 18.2 per cent to a parent or close adult relative. Of the 11.4 per cent who disclosed their abuse to CPS, law enforcement agencies or professionals based in school, all had experienced at least two types of maltreatment.

Qualitative data revealed important findings around *barriers to disclosure* with lack of trust in adults being a primary factor. The authors note that: 'several adolescents who had disclosed abuse to professionals perceived an ineffective response, primarily because of professionals' lack of a child perspective' (Jernbro *et al.*, 2017, p. xxx). Fears about being disbelieved show similarities with Allnock and Miller's (2013) *No one noticed, no one heard* study, as well as some similarities with the literature on disclosure of sexual victimisation. Jernbro *et al.* (2017, p. XXX) conclude:

> '...it is the most vulnerable children, those exposed to multiple types of abuse, who may least often come to the attention of professional systems, and about whom we know the least.'

While, some adolescents reported experiencing supportive interventions from adults, in particular from social workers based in schools, the authors state that a key finding of this study is that only a minority of cases of child physical abuse come to the attention of school staff and official agencies. They argue that 'professionals need to address the adolescents' apparent lack of faith in the ability of professional systems to effectively intervene in the aftermath of disclosure' (Jernbro *et al.*, 2017, p. xxx). This issue of disclosure in terms of child sexual exploitation is also addressed in *The Northamptonshire Tackling Child Sexual Exploitation (CSE) Toolkit* which receives a very positive review by Jane Dodsworth (2017) in this issue. She highlights the toolkit's potential to increase the understanding of all safeguarding professionals around risk factors associated with CSE.

In our final paper of this issue, Denise Coster (2017) reports on a study evaluating an NSPCC funded preventative measure to help new parents in the UK cope with their babies' crying and to help reduce the incidence of non-accidental head injuries. The intervention is a psycho-educational film, called *Coping with Crying* which offers parents and caregivers a number of sensible strategies to employ to help them cope when their baby is crying including: taking a break/getting space, the use of soothing strategies and seeking help. The study is based on the hypothesis that by having strategies to use when 'they were struggling with their babies' crying would be one of the key factors in helping parents cope' (Coster, 2017, p. XXX). The evaluation adopted a quasi-experimental design and, during the pilot, focus groups were held with parents who were asked about the film and their experiences of watching it. Surveys were then completed with parents who had watched the film at three different time points: either antenatally (during or after the second trimester) (493 parents); postnatally in the early days following birth (428 parents) and postnatally when the baby was six weeks of age (253 parents). The survey was also completed by a control group of 1165 parents who had babies of a similar age but had not watched the film. The evaluation findings showed that parents who watched the film antenatally or postnatally following their discharge from hospital 'were significantly more likely to report using a range of coping strategies in response to their babies' crying, compared with parents who had not watched the film' (Coster, 2017, p. xxx). In contrast, those parents who had watched the film in the immediate postnatal period before being discharged from hospital were less likely to use the coping strategies. As Coster (2017, p. XXX) notes:

> 'A key message from the film was that it was normal to feel stressed; this seemed to make it easier for parents to seek support when they felt they were not coping as they did not feel they were failing but just experiencing common difficulties.'

Coster (2017) recommends that to have the greatest impact the film is shown to parents in the antenatal period or after parents have left hospital but before a baby is six weeks old. This could be an important preventative measure, if it is rolled out as a universal intervention, for helping parents to manage their babies' crying and respond appropriately, thus reducing the potential for non-accidental head injury in infants.

The papers in this issue highlight from a number of different perspectives the seriousness of child physical abuse and the importance of developing ways to address and manage this issue. The physical abuse of children remains a critically important topic that continues to present practitioners with challenges. It remains one of the most prevalent forms of child maltreatment, and, as Jernbro *et al.* (2017) point out, much continues to go unreported. The challenge for all of us as professionals is to ensure we have the knowledge and skills to recognise all forms of maltreatment and to robustly assess concerns of abuse, along with attitudes that encourage children and young people to feel safe and to be able to disclose abuse when they are experiencing it. However, as well as responding to abuse when it does come to light, much more needs to be done to support parents in appropriate, non-abusive ways of parenting.

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