

## **Follow-up of child abuse victims: challenges for the pediatrician**

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### **Abstract**

**Objective:** To review practical questions about the initial assistance and follow-up of child abuse victims and their families by pediatricians.

**Sources of data:** A literature review was carried out using the MEDLINE and LILACS databases, including the years 2000 to 2005. Some articles from past years and books were included due to their importance.

**Summary of the findings:** Initial assistance is one of the most important actions by health professionals for the protection of abused children in different healthcare sectors (community, outpatient clinics, emergency rooms and infirmary), and it is fundamental for the reduction of immediate and long-term negative consequences of violence. The protection services cannot monitor all the families under their responsibility and most child abuse cases are not even reported to those institutions; therefore, regular follow-up by a pediatrician is advisable. It is important to provide the family with support and guidance until the child is safe. The main challenges are: to be involved without causing more violence; to consider all the family as the focus of attention, including the family members who have committed the assault, helping them to change inadequate behaviors; to develop specific abilities to carry out this work, which must be multiprofessional, interdisciplinary and intersectoral.

**Conclusions:** Families face difficulties when their children are abused and when the situation gains notoriety, demanding interventions from many institutions. In this process, a pediatrician can guide and help them to guarantee the protection and healthy development of their children. To overcome challenges, health professionals have to be technically and emotionally prepared.

*J Pediatr (Rio J). 2005;81(5 Suppl):S173-S180: Child abuse, continuity of patient care.*

### **Introduction**

Since pediatricians often have to treat children submitted to some kind of violence, they are responsible for identifying, managing and preventing this problem, which involves changing the approach from merely clinical issues to social ones.

According to the World Health Organization, good-quality care of nonfatal victims may prevent future deaths, reduce the number of short- and long-term sequelae and help the victims to deal with the impact of interpersonal

violence on their lives.<sup>1</sup> In most Brazilian institutions, there are no especially trained teams to treat victims, and quite often, general pediatricians have to treat children and their families, meet clinical demands and help to solve social and legal issues that may arise after suspected victimization, which are arduous tasks for professionals who did not learn about these issues in their medical course.

All studies show the high frequency of violence in the pediatric population, even though it is officially underestimated all over the world.<sup>2-6</sup> In 2000, considering only those confirmed cases notified to the child protection services in the USA, 12 in every 1,000 children had suffered some kind of violence, distributed as follows: neglect – 62.8%, physical abuse – 19.3%, sexual abuse – 10.1% and psychological maltreatment – 7.7%.<sup>7</sup> Since not all cases are reported and not all reports can be checked, these data are just an estimate of what actually happens. As a matter of fact, a recent nationwide survey carried out with children

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**Suggested citation:** Ferreira AL. Follow-up of child abuse victims: challenges for the pediatrician. *J Pediatr (Rio J)*. 2005;81(5 Suppl):S173-S180.

and their parents/surrogates in the USA revealed that more than one in every eight children and adolescents aged between 2 and 17 years had suffered some kind of violence in the year of the study.<sup>8</sup> In Brazil, it is estimated that 20% of children and adolescents fall victim to some kind of violence,<sup>9</sup> but no nationwide surveys exist that have evaluated the extent of maltreatment in this age group.

"Domestic violence" against children and adolescents, according to the Brazilian Ministry of Health, encompasses physical abuse, sexual abuse, psychological maltreatment and neglect.<sup>10</sup> The Brazilian Ministry of Health, in another document, states that these forms of "maltreatment" often occur within the family ("intrafamily violence"), but that "they also occur in other places such as in admission units, in the community and in the social environment as a whole."<sup>11</sup>

As our intention is to address the subject in a practical manner, we believe it is not appropriate to discuss the differences that underlie each of the previously mentioned terms. When we mention "maltreatment," "violence" or "abuse" against children and adolescents, we will be referring to the four types of violence (physical, sexual, psychological and neglect), regardless of whether they were committed by family members or not, within or without the domestic environment. The distinction between each type of abuse and between intrafamily and extrafamily violence will be made whenever necessary.

Books, manuals, official documents and Brazilian articles have touched upon conceptual issues and sought to guide professionals of varied areas on how to identify and take the first actions regarding suspected or confirmed child abuse. In the present paper, we opted for addressing practical aspects related to intake and follow-up of victimized children and their families in health centers.

There was a significant number of studies on sexual abuse in this literature review, certainly due to the concern that this type of violence brings to society, resulting in more studies on the subject as pointed out in a previous study,<sup>12</sup> but also due to our decision to focus on follow-up, which is more often investigated in sexually abused victims. It should be highlighted that many of the issues reported in these studies also apply to the other types of violence.

### **Intake of children and their families**

The key functions of the health sector in the child protection system are:<sup>7</sup> to identify and report on suspected cases; to implement services for the diagnosis and treatment; to interact with protection agencies; to meet legal demands; to provide parents with information about the needs, care and treatment of their children; to identify and provide support to families at risk of maltreatment; to develop and establish primary prevention programs; to offer training courses and take part in multidisciplinary teams.

The health professional's capacity to detect or suspect of violence is the first step towards treatment. Since pediatricians are the only professionals who have a regular contact with abused children before they start attending

school,<sup>13</sup> listening carefully to them and having a broader view are essential to detect cases of violence.<sup>14</sup>

When treating the family of an abused child, health professionals should have a receptive, nonjudgmental, nonpunitive attitude, even if the offender is present. This behavior will avoid negative reactions or further suffering to children and family members, in addition to establishing confidence, thus facilitating the assessment of the situation and the planning of later follow-up, with greater chances of compliance.

The personal possibilities of each health professional and the possibilities of each service influence the intake screening of victims and require specific adaptations to deal with the cases. As a rule, hasty interventions should be avoided, since they do not allow a reasonable time for understanding the situation and deciding for the best actions,<sup>15</sup> which may even include the decision to act later if the child is not in imminent danger.

All children who suffered some kind of violence benefit from a psychological and educational intervention, which may be conducted by the professional who initially perceived the abuse. In the specific case of sexual abuse, clarifying the responsibility of the offender, discussing information about sexually abusive behaviors and future safety of the child are issues that can be addressed by pediatricians.<sup>16</sup>

Child protection should be the goal of any treatment, promoting the well-being of the children and their families, their safety and the guarantee that they belong to a family and have a home.<sup>7</sup> This view helps the health professional to receive the family and be empathic towards parents.

Multiple factors make emergency services have one of the major rates of admission of abuse victims: the acute nature of injuries, shortage of primary care, proximity to the place of residence and working hours of the service.<sup>17</sup> Thus, health professionals should have the skill to detect and diagnose violence, understand its consequences and manage it appropriately. Being able to assess physical and emotional traumas helps to detect patients with violence-related injuries without stigmatizing them for having "suspected" problems.<sup>1</sup>

When someone suffers an act of violence, he/she experiences feelings of helplessness and inability to control the situation.<sup>1</sup> If the victim is a child, these feelings are also felt by family members. It is crucial to consider and try to reverse these situations. In fact, one of the most important roles of emergency pediatricians is to prevent the posttraumatic stress syndrome (PTSS), which affects 15 to 67% of children and adolescents exposed to violence. PTSS is characterized by the persistence of a group of symptoms (reexperiencing the act of violence, avoidance and hyperarousal) for a time period greater than one month after the trauma. Both children and parents may develop the symptoms. During the necessary interaction between the health professional and the children and their families for emergency care, pediatricians may take some attitudes for resilience of parents and children and to help parents deal with possible PTSS symptoms, such as briefly talking with children and adolescents about the several normal

reactions to the trauma (“You may find yourself thinking a lot about it or trying not to think about it or feeling frightened ...”); teaching and encouraging parents to monitor their children’s and their own normal reactions to the trauma; explaining how parents’ reactions can help or hinder their own ability to give their children support.<sup>18</sup>

However, the dynamics of emergency care, which demands availability of health professionals and immediate actions after brief evaluations, is so problematic that it does not allow developing some appropriate actions. It is imperative that health professionals be sensitized to the problem and be qualified, that routines that facilitate care be created and that references be established so that good emergency care is guaranteed.<sup>19</sup>

Only a small share of maltreatment victims (4%) needs to be hospitalized after emergency care.<sup>17</sup> Besides medical recommendation, the American Academy of Pediatrics recommends the hospitalization of abused children who need protection (a hospital can be the most accessible shelter in a short time period) or of those who have to be diagnosed (diagnostic interventions and in-depth observation of family interaction).<sup>20</sup> Children may also be hospitalized due to varied clinical problems and the suspicion of maltreatment may arise during the hospital stay. This occurs due to the opportunity to observe family relationships and the care provided by the family members in charge of the hospitalized child.

On the other hand, when hospital stay is long, the full-time proximity of the health professionals to the family may cause problems. It is not uncommon that those in charge of other children or even unprepared professionals adopt a hostile attitude towards family members by either blaming them for not having protected the child or for being the offenders. This type of attitude does not help the patient at all and also thwarts any attempt to evaluate social and psychological aspects and to invest in the change of behavior of the involved family members – actions that can be taken during the hospital stay.

Suspicion of maltreatment may also arise during outpatient follow-up. Given the existence of safe and unsafe bonding between parents and children, the perception of the type of bond can help detect those bonds that could pose any risk of maltreatment.<sup>21</sup> Once isolated psychological abuse is the type of maltreatment that is allegedly most difficult to confirm, the interval between medical appointments may allow the observation of a psychologically abusive relationship of caregivers, thus helping to detect it.<sup>13</sup>

Pediatricians usually know the emotional, developmental, educational and physical characteristics of their patients before a possible abuse occurs, being therefore able to detect subsequent adverse effects that result from it.<sup>13</sup> On the other hand, it may be difficult for a pediatrician who treats a child submitted to intrafamily violence to accept that his/her task to strengthen bonds cannot always be achieved. Establishing a diagnosis of maltreatment is having to cope with one’s own limits of preventive action. Moreover, when maltreatment is confirmed, there is the feeling of guilt for possibly upsetting an apparent family balance.<sup>22</sup> The

difficulty breaking away from the ideal “family” model and the fact that we feel strange about our own references may worsen the situation.<sup>23</sup>

It should be underscored that the severity of the negative effects of maltreatment can be mitigated by protective factors, including early and efficient professional help.<sup>7</sup> However, early intervention should not be mistaken for hasty decisions, i.e., the attempt to help may not allow a minimum time for the health team to grasp the situation and for the family to acknowledge and expose their needs and possibilities.<sup>15</sup> In general, to be cared for is what an abused child immediately needs, even before legal protection.<sup>24</sup> Understanding the circumstances that led to the abuse and the context to develop any work together with the family may be a determinant factor for the protective measures that will be adopted by the Guardianship Council, since this information can and should be provided through reporting.

It seems that professional confidentiality, as far as child abuse is concerned, protects only the adult perpetrator, who may be harmed if the facts are unraveled.<sup>22</sup> The health services that treat victimized children have regularly explained the importance and necessity of notification to parents and have underscored that they should not acquiesce to violent behavior, giving priority to their children’s safety.<sup>4,25</sup> In order not to jeopardize the children’s life or psychological and physical health, it is crucial that health professionals think their own convictions through and not act out of excessive caution (which leads to hasty notifications with little or no evidence) or lack commitment to making the notification.<sup>22</sup>

Notification of suspected or confirmed cases of maltreatment is mandatory for health professionals, according to the Child and Adolescent Statute.<sup>26</sup> The Guardianship Councils, which receive the notifications, have the duty to defend and guarantee the rights of children and adolescents by applying treatment and accountability measures if necessary. However, the Guardianship Councils are considered inefficient problem-solving organizations for various reasons: work overload; many counselors are sworn in without due qualification, showing insufficient knowledge about the Child and Adolescent Statute and the work related to it; their actions go usually unplanned, and are based on relevant issues, often using fragmented and emergency interventions; the work infrastructure is deficient and there is no service support system, which bring them into conflict with other organizations that treat violence victims.<sup>4,27</sup>

Due to these problems, health professionals should not give up their role of treating, reporting on and preventing family violence. Child protection should not be mistaken for notification and investigation actions, i.e., protection should not be seen as the exclusive duty of services that are legally assigned to this function. This type of perception may expose children, due to the following reasons: the multiple nature of problems involved in cases of maltreatment requires the participation of several sources of help; it is not possible for protection services to monitor families on a permanent basis and there may reduction in the direct actions taken by the community and by professionals of

other areas. Sometimes the protection services refrain from protecting children, since they are legally obliged to gather evidence and prepare documents to be delivered to the Justice. In the USA and in Australia, approximately two thirds of investigated reported cases of suspected maltreatment will never be confirmed and a large share of the confirmed cases are provided with any other "service" but investigation.<sup>28</sup>

In most countries, there is a paucity of studies on the effect of notifications of suspected maltreatment to the protection agencies. The difficulty assessing the association between the work of these services and better results for victimized children lies in the wide variety of confounding factors involved in these situations, such as duration of the abuse, family situation, and level of family support.<sup>5</sup> Regardless of the results obtained through notification, the guardianship counselor should be seen as a partner that allows the possibility of complementary actions to those adopted by health professionals, and which are essential to the common goal of protecting children.

### **Follow-up by a pediatrician**

Several Guardianship Councils, similarly to protection agencies in other countries, have few resources to investigate all reported cases. On top of that, we believe that in Brazil, as also occurs in the USA, most cases of physical and sexual abuse are not reported to protection services.<sup>5</sup> Thus, pediatricians whose patient is or was a victim or is suspected of maltreatment have the duty to follow up this patient so as to protect him/her. In this process, it is important to openly question the child and parents about new episodes of violence; perform a careful examination in search of physical evidence and be attentive to behavioral and emotional changes that are compatible with abuse, as widely described in the literature.<sup>29-32</sup>

There are few systematic studies or not enough studies with robust results that show any particular form of intervention that effectively protects children from abuse, as is the case with prevention and revictimization. Rates around 25 to 31% of physical abuse revictimization in infants younger than one year reveal a serious failure in secondary prevention for these babies, who may even die as a result of the aggressive event. A previous abuse is regarded as risk for other episodes; therefore, the child must be monitored by health professionals and social assistants.<sup>33</sup>

One of the major goals of follow-up should be the strengthening of family bonds, as the "presence" of a family does not always mean a "present family" and structured one.<sup>24</sup> Showing affection to and concern with the suffering family and not treating them as risk or incapable are good options.<sup>34</sup> This attitude may help changing abusive behaviors (intrafamily violence) and developing strategies to avoid contact with external offenders. Fostering family relationships and safeguarding the growth of the child in his/her own environment are essential to convey safety and the feeling of belonging that are ideal for his/her development.

Therefore, the approaches should be aimed at the family and not only at children, respecting culture, creed and customs, and not using the health professional's own values as parameters. One should believe in the family's power and potential to change their lives<sup>7</sup> and help them to find and search internal and external resources. It is important to respect the differences between families and each of their members, trying to determine their specific needs.<sup>35</sup>

It is the health professionals' duty to provide parents with support and to teach them the importance of having a constructive response to an abusive event, but also to help them develop these skills.<sup>36</sup> It is recommendable to encourage protective responses that increase social support and reduce counterproductive strategies (e.g.: denial, increased alcohol consumption, etc).<sup>18</sup> Studies have shown that encouraging the response of families to sexual abuse is an efficient method for reducing the trauma in victims.<sup>36</sup>

In case of intrafamily violence, an attempt is made to establish a context of accountability for the perpetrator and of safety for the victim. For that purpose, it is necessary to offer tremendous help to perpetrators. The ability of family members to work cooperatively and see others as potential supporters is the mainstay of a solid rehabilitation plan.<sup>25</sup>

However, it is not uncommon that the offender does not accept the intervention for himself/herself, insisting that only the child needs to be treated, in an (often unconscious) attempt to shift the focus of attention. Helping to better understand the family situation can be a work carried out by the pediatrician in whom the family trust, whom they usually seek for advice and who will deal with later referrals. Making the offender take the blame for the violent acts he/she committed often causes him/her to develop empathy and the desire to understand the victim's point of view.<sup>25</sup> This facilitates compliance with the treatment, which aims to change his/her inappropriate behavior towards the child.

Active approaches for the inclusion of non-offenders in the treatment should respect individual choices and assess the hindrances to follow-up such as transport difficulties, child care (availability of day care centers), stigmas and the possibility of treatment outside the health service (e.g.: in the community). The participation of non-offenders in psychotherapy sessions is associated with benefits to sexually abused children, especially the younger ones.<sup>16</sup>

Since children who live in homes where spouse abuse occurs are at greater risk of being abused and as most of them suffer emotional sequelae even if they are not directly abused,<sup>25,35,37</sup> fighting couples should be referred to treatment as a way to protect the child. U.S. studies show that spouse abuse occurs in approximately 40% of severe or fatal cases of child maltreatment and in over 50% of suspected cases of maltreatment treated at hospitals.<sup>37</sup> Openly questioning the parents about couple conflicts should be part of the pediatric investigative interview, as a way to prevent child abuse.

In most studies on intrafamily violence against children, the biological father, and mainly other father figure substitutes (stepfather, mother's partner or boyfriend), are investigated as offenders. This results from the high

frequency at which they are involved, according to all studies, and also because there is an association between their presence in the household and a higher risk of maltreatment.<sup>37,38</sup> On the other hand, when the mother's partner abuses her son, she may be considered neglectful for not having protected the child and the action taken by the protection agency is therefore targeted at the mother. Such policies conceal the true nature of the initial episode of maltreatment<sup>38</sup> and do not allow men to undergo interventions that may help them.

On the other hand, studies show that the participation of fathers in child care is associated with a series of benefits to the child and the mother.<sup>35</sup> Living or not with the child, the biological father plays several roles (economic or others), which denote safety, risk and well-being to the child. He is also important to the well-being of the rest of the family and, especially, to the quality of care he and the mother provide the child with.<sup>37</sup>

Therefore, it is recommendable that protection agencies and health services include parents and father figure substitutes in their preventive measures and in the control of child and adolescent abuse. It is crucial to develop intervention strategies and models that meet parents' demands, be suitable to their motivation to attend the health services, match their risk profiles and their patterns of request for help, as well as strategies that develop protective elements and reduce the risks of maltreatment by fathers.<sup>37</sup> In this regard, it may be necessary to overcome the barrier that the mother represents through her reluctance to the participation of the father.<sup>35</sup>

Given the fact that most grandparents take care of their grandchildren sometime in their lifetime and the significant number of caretaking grandparents we find in pediatric practice, these family members also deserve special attention and care by health professionals. Many times, in the presence of family crises, grandparents take on a comforting role from the children's point of view, but they may also instigate the conflict and contribute to increasing family tension.<sup>39</sup>

Several periods during the follow-up of maltreatment victims may be regarded as delicate to the children, to the family, and even to the health professionals, after child abuse is made "public." It is essential that the health professional be aware that several feelings may be shown by all people involved for a long time, to a greater or lesser degree: fear, anguish, revolt, powerlessness, guilt, shame, etc.

In case of sexual abuse, the reaction of parents and health professionals to the revelation of abuse or to the revelation process can either help the victim to recover from it or traumatize him/her even more. The child usually wants the situation to change without confrontation, without external intervention and without the separation of family members. However, the revelation of this type of abuse often throws the child and the family into a crisis,<sup>36</sup> which is usually more severe when the abuse is committed by a family member. Health professionals should attach a great value on the revelation

made by the child, exempting him/her from any responsibility for what happened and for the consequences of his/her revelation, and on the credibility parents/surrogates who sought the health service gave the child.

There have been studies on the reaction of nonabusive mothers to the revelation of sexual abuse. There appears to be an expectation from health professionals that they could be able to believe in a revelation right away and act in favor of their victimized child, without ever receiving any training and sometimes with a personal history of untreated abuse and experiencing violent relationships in the home.<sup>36</sup> This expectation contrasts with the reaction most of these mothers have, who feel guilty for failing to protect their child, angry about the betrayal of trust by the offender (when he/she is an acquaintance or a family member), disbelieving at what happened, lost about the attitudes that should be taken. However, most of the time, they try to understand the situation and support and protect their child, even if they eventually do not manage to. Therefore, mothers need as much support as their children in the period that follows the revelation of abuse. In general, the protective person (whether or not this is the mother) needs this support, even in other types of abuse. Their responses are processes instead of events. When parents feel too overwhelmed that they cannot give their child support or if the family member who is trying to protect is threatened by the offender, it is necessary to find another protective person in the family or even outside it.

In case of sexual abuse, the mother's crisis and her necessity of support are often minimized by health professionals, due to the necessity to provide the child with physical protection. For good-quality care, it is recommended that the mother be seen by the health team both as a client (with support needs) and as a team member (taking part in the decisions about child safety).<sup>36</sup>

Given that the suspicion of any type of maltreatment can cause a lot of trouble to the family and to the child, the same precautions as those taken during the follow-up should be adopted regardless of whether abuse has been confirmed or not. Confirmation of maltreatment may be a hard task if there is no physical evidence or witnesses, and this is usually the case.

More often than not, the medical legal examination does not gather material evidence of child abuse (even in cases of rape), and may be understood as a false statement against the offender. Paradoxically, society requires that the victim, in addition to having been abused, have physical injuries.<sup>40</sup> In case of children, their word does not have the same value as that of the offender.<sup>40,41</sup> In Hamburg, Germany, coroners are available around the clock to carry out examinations on the victims. If they are summoned by emergency physicians, neither do the police have to be involved nor does a formal complaint have to be filed. The data are registered on the medical chart to be used as needed later on. This initiative was taken because only a small number of victims was submitted to medical legal examination, as such examination was linked to legal procedures.<sup>1</sup>

Even in countries where criminal justice and forensic services work quite well, only a small number of maltreatment cases (including those of sexual abuse, which more commonly result in lawsuits) goes to trial and yet a smaller number results in conviction.<sup>1,42</sup> Therefore, many victims of abuse are subjected to invasive forensic procedures, but the collected evidence does not lead to any charges.<sup>1</sup> The best predictors to know whether a case of sexual abuse is going to be criminally charged are the child's age (situation involving preschool children are less likely to lead to a lawsuit, probably due to the flimsiness of their competences: possibility of "contamination" and suggestibility, memory capacity, consistency over time), gender, and severity of the abuse (more severe cases involving girls are more likely to be legally charged). The literature suggests that the age of seven years is the "magical" age that allows distinguishing between chargeable and nonchargeable cases. Offenders who are more closely related to the child are less likely to be legally charged.<sup>42</sup>

Nevertheless, notification often produces hope for "justice" among family members. In general, the health professional who reported on the abuse is seen as co-responsible for the (positive and negative) unfoldings of different referrals established from the notification. In this regard, it is important to discuss the roles and limitations of each institution with the families, so that the doctor-patient relationship can be preserved. Therefore, pediatricians have to know the laws, the existing organizations and the functions of each organization, their possibilities and difficulties. This may help them understand some unexpected unfoldings and allow them to intervene in a more efficient way, also when instructing parents.

These are just some of the critical problems the patients and family involved in a case of abuse have to cope with. We could also cite separation or divorce of parents, the necessity for withdrawal of the child or of a family member by legal decision, need to move away or change schools, stigmatization of the family by the community, among other factors that require follow-up, support and guidance by health professionals.

Ideally, this follow-up should be made by an organized, available and sufficiently resourced interdisciplinary team, which is not yet a reality in most settings. Families need this team in their neighborhood and preferably where they first sought help. This possibility may be a determinant factor for treatment compliance or failure.<sup>22</sup> Treatment withdrawal of up to 30% of followed-up cases have been described in the literature.<sup>43,44</sup>

A multiprofessional team is recommended and necessary in cases of child abuse, since no institution, individual or discipline have all the knowledge, skills or resources to meet the needs of victims and their families.<sup>3,7,11</sup> Damage will be minimized if medical, psychological, social and legal needs are met.<sup>1</sup>

In order for several institutions to work cooperatively for child protection, there should be an environment characterized by respect and truth as far as information, perceptions and responses are concerned; an agreement on

essential values; a common language for communication; focus on common goals agreed upon by all people involved; respect for knowledge and experience of each individual; display of positive intentions by all parties involved, even if their ideas, perspectives and approaches are different; acknowledgment of the power, needs and limitations of each party; productive management of conflicts and shared decisions, risks and responsibilities.<sup>7</sup> Medical charts contain information on issues related to the necessities of families and to child protection, trying to find a balance between confidentiality and responsibility to protect children and give support to their parents/surrogates.<sup>21</sup> This partnership can prevent policies for the treatment of abused children from resulting in secondary victimization or from discouraging the search for help and revelation of abuse.<sup>1</sup>

The satisfactory result of an intervention in cases of abuse would be interruption of violence. Sometimes, the possible result is the safe separation of the couple or the safe contact of a violent parent/surrogate with the child.<sup>25</sup> Such difficulties in obtaining satisfactory results should not be regarded as failure of health professionals. It is important to make it clear that we do not always manage to go as far as it is theoretically desirable, but that we go as far as it is possible for each family and institution.

In the USA, the decision to terminate the participation of a protection agency is based on the monitoring and assessment of each case and is taken together with the family and other persons who are important to the family, always taking child safety into consideration. The agency may even support the right of the family to terminate the follow-up when risks have been significantly reduced and when the family believe they do not need the available services any longer.<sup>7</sup>

## Prevention

Primary preventive measures have to be developed in parallel to care measures so that the incidence of child abuse can be reduced in the future. Due to the large number of maltreatment cases (amounting to millions worldwide, not allowing the action of protection agencies) and also due to the perception that neglect is the most common type of maltreatment, it is more efficient to invest in primary preventive measures than in policies whose focus is on the identification and accountability of individual cases.<sup>28</sup>

Working with prevention means acting at several levels simultaneously: with individuals (children and adults, victims and offenders), with personal relationships, with the community and with society.<sup>3,45</sup> The identification of protective factors is as important as that of risk factors, since the former promote resilience.<sup>7</sup> Sometimes there are so many difficulties overcoming those risk factors that are not within the reach of the health sector that attempting to minimize them through the identification and strengthening of positive relationships that could give the child support is the only possible option.

As neglect and physical abuse are the most common types of child maltreatment and as these forms of violence

are closely related to the parent-children bonds and cultural issues of child education, it seems evident that pediatricians can identify at-risk families and help prevent abuses.

The care given by health professionals who work directly in the community and in basic health units allows implementing primary prevention. Home visits have proved efficient in changing the behaviors of parents at risk of child abuse.<sup>13</sup> Helping parents to develop a real perception of the child, by teaching them about their possibilities and necessities<sup>22</sup> and guiding them in a preventive way about the fact that the inappropriate use of words or gestures or the lack of supportive or affectionate words may harm the child,<sup>13</sup> are examples of simple actions that can help create a healthy environment to the family and to the development of children – future caregivers.<sup>2</sup>

### Conclusions

Child maltreatment arouses mixed, oscillating and contradictory feelings in health professionals. Its path is one of sensitization and learning, where each individual walks his/her own way compared to the unfoldings this topic has had in the medical community.<sup>22</sup> Since violence produces suffering, raises questions, arouses feelings of risk and insecurity, it is necessary that health professionals be inserted in systematic opportunities for discussion, sensitization and qualification.<sup>46</sup>

Some of the challenges facing pediatricians are:

- Getting involved without stimulating further violence.
- Focusing on the families and not only on children and mothers.
- Including offenders, helping them to change their behavior.
- Developing specific skills to deal with situations by acquiring theoretical knowledge and having a multiprofessional, interdisciplinary and intersectoral practice, especially working in conjunction with the Guardianship Council.
- Assessing risk and protective factors related to the child and to the family, strengthening protective factors and minimizing or eliminating risk factors.

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