PROCHILD
PROTECTION AND SUPPORT OF ABUSED CHILDREN THROUGH MULTIDISCIPLINARY INTERVENTION

Co-funded by the Rights, Equality and Citizenship Programme (REC) Programme of the European Union

WP3
Mapping of operators' needs and good practices for an early and integrated detection and treatment of abused minors

D3.5 Elements and criteria for early detection of abused minors

810109 — PROCHILD —
REC-AG-2017/REC-RDAP-GBV-AG-2017

1. Introduction

The aim of this report is to identify how to acknowledge symptoms of child abuse and neglect (CAN) at a very early stage. There is a vast literature on the risk factors and criteria of identification for child maltreatment. This report is based on studies and reports that draw from this literature. The report has been produced as a part of project PROCHILD – protection and support of abused children through multidisciplinary intervention. The project is a European transnational project co-financed by the European Commission under the Rights, Equality and Citizenship programme (REC). PROCHILD is creating a multi-professional, integrated model of cooperation among stakeholders involved in providing response to violence against children, in order to tackle underreporting and fragmentation of services and implement a joint approach based on complementary competences and child's best interest. More information of the project can be found from the project's website: www.prochildproject.org .

Professionals working with children and families play a crucial role in both detecting violence against children as well as supporting child victims and their families. There are individual level factors, family and caregiver relationship factors, community-level factors, and societal-level factors that influence the risk of child maltreatment (WHO 2016). The individual level deals with biological variables and factors of personal history, relationship level examines an individual's close social relationship, the community level relates to the setting in which social relationships take place and the societal level involves the underlying conditions of society that influence CAN (WHO 2006, p. 13).

Studies have shown an association between material deprivation and social exclusion and child maltreatment and rates of CAN are higher in communities with high levels of concentrated extreme poverty and unemployment (WHO, 2002, p. 68). Globally, the differences in gender roles and values attached to male and female children may have an impact on the risk factors for different types of CAN. Research has linked certain demographic, psychological and behavioral characteristics of the caregiver as well as features of the family environment to child abuse and neglect (WHO, 2002, p. 66). The size of the family can increase the risk of CAN and there are indications that household overcrowding may increase the risk of CAN (WHO, 2002, p. 67). Abusive parents may be uninformed and have unrealistic expectations about child development. Abusive parents also show greater irritation and annoyance in response to their children's moods and behavior, are less supportive, affectionate, playful and responsive to their children, and are more controlling and hostile. Parents maltreated as children are at higher risk of abusing their own children (WHO, 2002, p.67). Social isolation and stress of the parent have also been linked to child abuse and neglect (WHO, 2002, p.68). CAN has also been linked to

substance abuse (WHO, 2002, 68). Accumulation of risk factors has a negative impact on parenting. Nair et al. (2003) found that parents with five or more risks reported highest level of parenting stress and CAN potential. Naturally, relative risk varies depending on the type of CAN since at least child sexual abuse – at least to a major part of it – seems to be related with different conditions that increase its occurrence epidemiologically rather than physical abuse or neglect.

The question of risk factors is not a prediction in itself since on one hand some of the risk factors identified to have statistical relations with occurrence of CAN are also linked statistically to one another leading to secondary relations (such as i.e. relation between single parenthood with a mother in adolescence which is also linked with social exclusion and inequality, the latter accounting for the spurious statistical relation between the former and CAN). Additionally, it should be noted that statistical relations between risk factors and CAN incidence rates concern particular types of linkages not implying reverse relations also to apply (i.e. the statement that "extreme household poverty is related with increased rates of physical abuse and neglect" does not by any means imply the truthfulness of the reverse statement which is "families with incidents of physical abuse or neglect are more likely to face household poverty" or vice versa). Last but not least, it should be underlined that statistical relations between risk factors and increased rates of some or other type of CAN do not necessarily entail a causal relationship: they are rather a statistical finding of co-occurrence which need to be further explained and understood by other scientific resources to make sense what the causal factors and underlying mechanisms actually are that bring about such a statistical relation. Therefore such epidemiological findings are to be better understood as invitings to intensify the measures to provide sustained support for families at risk (e.g. early home interventions (Paavilainen & Finck 2015)) in order to prevent acts of violence and, if necessary, to be able to better detect them as well as to produce further research evidence that might shed more light to phenomena under scrutiny. Multi-professional cooperation should include a wide range of professionals. For example, abusive injuries frequently involve the face and oral cavity and thus, may be first encountered by dental providers (Fisher-Owens & Lukefahr, 2017). This report demonstrates risk factors, signs of early identification and forensic examination that different professionals working with children and families may encounter. The report is divided based on types of abuse (physical abuse, emotional abuse, sexual abuse and neglect). Each section contains a table that summarizes risk factors, signs of early detection, and means of forensic examination that different professionals should be aware of.

2. Physical abuse

Child physical abuse is defined as those acts of commission by caregiver that cause actual physical harm or have potential for harm (WHO 2002, p. 60). Physical abuse can be the result of punching, beating, kicking, biting, burning, shaking or other actions likely causing injuries, trauma or other physical suffering.

Risk factors

One risk factor for physical abuse is child's young age as fatal cases of physical abuse are found largely among young infants (WHO, 2002, p. 66; High Authority for Health, 2014). The younger a child the more he or she relies on parents or caregivers to satisfy their needs and to ward off potential harm. The necessary parental attention however binds psychological resources which are increasingly hard to free up in the presence of other risk factors such as mental health problems, emotional deficiencies or impulsivity. Male children seem to be at greater risk of harsh physical punishment in many countries, although girls are at increased risk for infanticide in many places (WHO, 2002, p. 66), but this varies across countries (High Authority for Health, 2014). The analysis of the international literature shows that the role of socio-economic factors in the occurrence of maltreatment is variously appreciated, even if for the majority of perpetrators, maltreatment occurs electively in families in the lower clusters of income distribution (in terms of either relative or absolute socioeconomic inequality), sometimes facing also additional conditions of social inclusion. However, some particular subtypes of physical abuse do not seem to follow such patterns: for example the literature on Shaken Baby Syndrome points out that all social classes are concerned with the issue. In fact, psycho-emotional factors take precedence over socio-economics ones (High Authority for Health, 2014).

The child's emotional investment from the time of pregnancy, or even before, and the establishment of a real bond between the newborn and his or her parents from birth are the keys to a harmonious relationship between the baby and later the child, and his or her parents (see John Bowlby's (1951) work on attachment theory). All situations that prevent the bond from being established as early as possible are potentially harmful (i.e. prematurity, all causes of neonatal hospitalization, postpartum depression, etc.) (High Authority for Health, 2014). Also, child disabilities and twins have been shown to increase the risk for physical abuse (WHO 2002, p. 66).

Physically abusive parents are more likely to be single, young, poor and unemployed and to have less education than non-abusing parents (WHO, 2002, p.67). Abusive parents have also been identified with some characteristics such as emotional deficiencies, immaturity,

depression, intolerance and feeling inappropriate (High Authority for Health, 2014). Parents with low self-esteem, poor control of impulses, mental health problems, and antisocial behavior are more likely to abuse their children physically (WHO, 2002, p.67). Personal history of violent childhood experiences by the parent is another risk factor for physical abuse. It has been shown that half of the perpetrators of shaken baby syndrome or intentional homicide have a personality marked by poverty of affect, immaturity, impulsivity and/or intolerance to frustration as well as a history of abuse in their childhood (High Authority for Health, 2014). In the Hague Protocol, child maltreatment is identified in the emergency departments based on parental characteristics. The protocol has included three parental categories: (1) domestic violence, (2) intoxication with alcohol or drugs and (3) suicide attempt or self-harm. If patients with these characteristics have children, the families are interviewed by child protective services according to protocol (Diederich et al. 2014).

Community and society level factors also play a role in the prevalence of physical abuse. As mentioned above, the differences in gender roles and values attached to male and female children may have an impact on the risk factors. In addition, beliefs about corporal punishment may impact parental behavior and use of violent punishment (Lansford et al. 2017). Ellonen et al. (2014) found that a larger proportion of Finnish parents approved slapping or hitting their children compared to Swedish parents, even if corporal punishment has been illegal in both countries for decades. The researchers suggested that cultural factors may influence these attitudes. This shows that even after corporal punishment has been penalized, there's still work to be done to change cultural norms and attitudes towards it.

Early identification

The National Institute of Health and Clinical Excellence (NICE) (2017) suggests that the possibility of child abuse should be considered if a child or adolescent has a marked change in behavior or emotional state that differs from that expected for his or her chronological and developmental age, and that is not explained by a medical cause, a known stressful situation other than child abuse (e.g., bereavement or parental separation) or a medical cause. These signs are e.g. extreme distress, low self-esteem, nightmares with similar themes, excessive need to stick together, aggressiveness, excessive kindness with strangers, unexplained withdrawal, excessive wisdom, anger or frustration expressed by rage in a school child, frequent anger due to minor frustrations, distress expressed by inconsolable crying, episodes of transient detachment regardless of waking dreams, unusual response and refusal or extreme passivity during a clinical examination.

Paek et al., (2018) developed a child abuse screening tool called "Finding Instrument for Non-accidental Deeds" (FIND). This tool can be used for children under the age of 14 years. It includes the following questions: (1) Does the child have suspicious signs of physical abuse? (2) Does the relationship between the child and caregiver(s) seem to be inappropriate? (3) Is the injury clinically significant for an infant (<2 years old) (e.g. intracranial haemorrhage, long bone fracture)? (4) Is the trauma history changing or inconsistent among caregivers? (5) Is the mechanism and type of injury incompatible/conflicting with the wound(s)? (6) Are the clothes and/or hygiene of the child inappropriate? (7) Is there an inappropriate delay in seeking medical help? (8) Is the mechanism of injury incompatible with the development (age) of the child?

There are other screening tools that have potential to be effective in increasing detection of child abuse. For example Dinpanah et al. (2017) found the screening tool "Escape" had a five times higher detection rate in screened children than not screened children. Ezpelata et al. (2016) found good validity for screening tool INTOVIAN, which should detect physical and emotional abuse. Some risk assessment tools have also been developed. For example C-CAPS is intended to identify risk and protective factors of child maltreatment and develop treatment plans to reduce the risk factors and strengthen protective factors. It comprises of historical factors, personality and mental health characteristics, family characteristics, parent-child relationship characteristics, ecological factors and protective factors. It could be used in a variety of settings including clinical, forensic and child protective agencies (Ezzo & Young 2012).

Physical abuse may manifest in the mouth, so dental health professionals need to be aware of how to evaluate and address these concerns. Oral injuries that are not consistent with a child's developmental capabilities or parents' accounts as well as multiple injuries in different stages of healing should arouse suspicion for abuse (Fisher-Owens & Lukefahr 2017).

One additional social policy measure that has been found effective in prevention of child's homicide is the national protocols implemented in several countries for an ex mortem multi-professional investigation for each and every child's death regardless of the cause in which the death was attributed with a clear mandate of publicly made available outcome with a binding timeframe (also identifying in the public report potential causes, omissions of acts or other shortcomings of services, professionals and caregivers that might have contributed to the lethal eventual outcome) (Christian et al. 2010; Child Death Review 2018). Such innovative social policies have been found to increase awareness of professionals and services in early detection and identification of families with children in increased risk of severe physical abuse (that potentially might be lethal).

American Academy of Pediatrics (2015) has issued a comprehensive set of guidelines for detection and substantiation of suspicions of child physical abuse including detailed tables on fractures susceptible for being the result of intentional injury and medical conditions that might complicate decision making on such cases (https://pediatrics.aappublications.org/content/135/5/e1337.figures-only).

Forensic examination

Head trauma caused by abuse is the most common cause of death in children under the age of two. Patterns of injury to the skin can provide clear signs of abuse. The skeletal manifestations of physical abuse include multiple fractures at different stages of healing, fractures of bones which are very rarely broken under normal circumstances, and characteristic fractures of the ribs and long bones (WHO, 2002, p.61). Shaking is a form of abuse seen in very young children. Very rapid shaking of an infant can result to intracranial hemorrhages, retinal hemorrhages and small fractures at the major joints of the child's extremities (WHO, 2002, p. 61).

It is important for health care professionals to be aware that physical or sexual abuse may result in oral or dental injuries or conditions. They should be aware how to document suspicious injuries and how to obtain evidence, and consultation with experts when appropriate. Also, injuries that are inflicted by a perpetrator's mouth or teeth may leave clues regarding the nature and timing of the injury as well as his/her identity. When consultation is needed, a pediatric dentist or a dentist with training in forensic odontology can ensure appropriate testing, diagnosis, and treatment (Fisher-Owens & Lukefahr, 2017).

Radiological diagnostic can be used to identify child maltreatment through a full skeletal survey up to three years of age. Radiological diagnostic procedure can be used in cases of clinically diagnosed injuries to the head, thorax, abdomen or extremities of a child, especially if there is no case history or if the reporting of an inadequate trauma suggests physical child abuse (Erfurt et al., 2011). The evaluation from health care professionals of physical abuse includes the history of the abuse/ injury, the family medical and developmental history, physical examination and additional medical exams.

	Risk factors	Early identification	Forensic examination

Pediatricians	prematurity and low neonatal weight perinatal diseases disabilities twins chronic diseases continuous crying irritability and hyperactivity school difficulties highly stressed or demanding parents	frequent access to the A&E unjust delay in accessing care repeated domestic accidents bruising in pre-mobile children discordant versions of the events by the adult and the child contradictory or confused explanations on the causes of injury injuries not associated with normal child accidents behavioral and emotional signals (embarrassment, tensions, anxiety, hypervigilance or apathy, detachment of parents, arrogance) disturbed sleep	collecting biological materials/evidence of potential abuse descripting the objectivity of the whole body and the oral cavity to verify the presence of current or past lesions detailing the area of lesions and their characteristics (e.g. photographic documentation) laboratory testing skeletal survey (mostly in children < 2 years old) eye examination ears examination head circumference measurement cardiovascular system examination examination of the abdomen

		bedwetting, incontinence, soiling, gastrointestinal problems severe anemia low stature and weight growth physical injuries (trauma, burns, fractures) and absence of clear explanation behavioral disorders and signs of discomfort bruising in unusual areas multiple lesions of diverse period repeated fractures at different stages	examination of the external genital organs examination of limbs examination of the skin (burn injuries, bites) evaluating the type of injury and chronology, body diagrams
Psychiatrists	previous child physical or mental abuse parental mental disorders (psychosis, maternal depression)	conduct disorders aggressive behaviors decreased cognitive functioning and poor academic achievement	analysis of root cause factors that may lead to emotional issues

	parental substance abuse/alcoholism intimate partner violence emotional trauma which an abuser may seek to exploit		
Psychologists	Previous physical or mental abuse parent's psychopathology parent's social deviancy parent's weak or absence of responsibility parent's distortion of emotions and empathy	conduct disorders aggressive behaviors decreased cognitive functioning and poor academic achievement	analysis of root cause factors that may lead to emotional issues
Social workers	chronic relative or absolute poverty; social inequality family's social exclusion low level of education	difficulty in communicating issues obstructions to participating in wider groups physical injury	evaluation of potential circumstances and physical evidence of abuse

	young mothers lack of interpersonal relationships single parent violence/abuse experienced in childhood parent's lack of trust towards institutions and social norms parent's acceptance of violence and punishment as upbringing parent's scarce knowledge and interest in the child growth domestic violence unwanted pregnancy or maternity parental involvement in criminal activity child's involvement in criminal activity		

	child lacking a strong family unit (i.e. in foster or other form of care)		
Police	previous history of abuse parental drug use/involvement in criminal activity domestic violence child lacking a strong family unit (i.e. in foster or other form of care)	frequently contacting the police over varying issues unexplainably fearful frequently in custody or committing infractions perhaps related to an underlying cause	analysis of root cause factors evaluation of potential circumstances and physical evidence
Legal experts	previous history of abuse parent's drug use/involvement in criminal activity child's involvement in criminal activity children with physical or mental disability child lacking a strong family unit (i.e. in foster or other form of care)	unexplainably fearful frequently in custody or committing infractions perhaps related to an underlying cause difficulty in articulating issues	analysis of root cause factors evaluation of potential circumstances and physical evidence
Multi-professional cooperation	Use of identifiable factors from other fields	behaviors that other fields might see as	analysis of factors that other fields and

	Focus on those who may fall between gaps, those less easily recognized when strictly adhering to existing protocols	conducive to child abuse	sectors identify as causing greater risk cooperation/liaising with other sectors in analyzing such behaviors

3. Emotional abuse

Emotional abuse is a very common but often underrecognized form of child maltreatment. Emotional abuse is defined as the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development of a child. These acts include restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment (WHO, 2002, 60).

Risk factors

Many same risk factors apply to emotional abuse as to physical abuse. Abusive parents have also been identified with some characteristics such as emotional deficiencies, immaturity, depression, intolerance and feeling inappropriate (High Authority for Health, 2014). The child's emotional investment from the time of pregnancy, or even before, and the establishment of a real bond between the newborn and his or her parents from birth are the keys to a harmonious relationship between the baby and later the child, and his or her parents (see John Bowlby's (1951) work on attachment theory). All situations that prevent the bond from being established as early as possible are potentially harmful (prematurity, all causes of neonatal hospitalization, postpartum depression) (High Authority for Health, 2014).

Early identification

NICE (2017) recommends that emotional abuse should be considered if there is concern that interaction between children and parents may be harmful. Signs of harmful interactions include

negativity or hostility towards a child or adolescent, rejection of the child or adolescent suffering, inappropriate expectations or interactions regarding the child's development (e.g. inappropriate threats or methods of discipline). According to Lusk et al. (2015) psychosocial identification training improved the ability of school psychologist to identify and report child maltreatment. School psychologists are uniquely equipped to identify and report child maltreatment, especially in older children and adolescents.

Forensic examination

Evidence has shown that emotional abuse can sometimes cause severe long-term emotional and psychological damage in children, just as in cases of other types of abuse. Children who have suffered emotional abuse or maltreatment can develop post-traumatic stress disorder (PTSD; Duncan 2000), aggression (Straus et al. 1991, p. 223), psychosocial maladjustment (Lamphear 1985, p. 251), self-esteem issues (Iwaniec et al. 2006), attempted suicide or self-harm, eating disorders, school problems (Doyle 1998), emotional dysregulation (Burns et al. 2010, p. 801), inability to form healthy romantic relationships into adulthood (Riggs 2008, p. 5), attention deficits and disassociation disorders (Shields & Cicchetti 1998, p. 381). Mental health professionals have found through forensic examination that children and caregivers who are exposed to abuse are at higher risk for developing mental health disorders, personality disorders, and dropping out of university (Duncan 2000). Indeed, children who experienced maternal emotional/verbal abuse were three times as likely to develop personality disorders such as narcissism, obsessive-compulsive disorder, and paranoia (Johnson et al. 2001, p. 16), in addition to maternal familial detachment (Shipman et al 2007, p. 268). According to neuroendocrine studies of animals and humans, McCrory et al. (2010) found that the stress responses of children who suffer from emotional abuse during their developmental stages can predispose them to psychiatric issues in adulthood, structural and functional brain malformations, and decreased neural activity which can worsen if they are genetically pre-disposed to mental health or structural brain issues. Research has also found that caregivers who emotionally or verbally abuse children are at a higher risk for mental health issues, therefore children who are abused by mentally unstable adults are at a higher risk of activating epigenetic mental dysfunctions following incidences of abuse (Bellis et al. 2001, p. 923). These children have higher rates of becoming juvenile offenders and/or violent criminals (Lamphear 1985, p. 251).

	Risk factors	Early identification	Forensic examination

Pediatricians	physical or mental disability behavioral issues highly stressed or demanding parents complex family dynamics (divorced parents etc.) parents appear controlling or overly protective of the outside parents with substance abuse of other forms of addiction chronic diseases	frequent access to the A&E unjust delay in accessing care or parents unwilling to seek help for child disparity between parents and minors in the retelling of family circumstances repeated domestic accidents behavioral and emotional signals (embarrassment, tension, anxiety, hypervigilance or apathy, detachment of parents, arrogance) disturbed sleep low stature growth behavioral disorders and signs of discomfort child substance abuse self-harm	collecting biological materials/evidence of potential abuse evaluating the type of psychological injury analysis of potential factors leading to specific emotional manifestations

		delinquency and aggressivity recurring movements (ex. rocking)	
Psychiatrists	previous child physical or emotional abuse parental mental disorders (psychosis, maternal depression) parental substance abuse/alcoholism intimate partner violence in family child disabilities emotional issues that run deeper than first appear to be the case external manifestations of internalized difficulties	delay in accessing treatment or parents unwilling to seek help for child unwillingness to consult outsiders for help disparity between parents and minors in the retelling of family circumstances conduct disorders aggressive behaviors decreased cognitive functioning and poor academic achievement depression and low self-esteem	analysis of root cause factors that may lead to surfacing emotional issues
Psychologists	previous physical or emotional abuse parents psychopathology	delay in accessing treatment or parents unwilling to seek help for child	analysis of root cause factors that may lead to surfacing emotional issues

	social deviancy of parents parent's weak or absence of responsibility compensation syndrome parent's distortion of emotions and empathy parent's impulsivity external manifestations of internalized difficulties	unwillingness to consult outsiders for help disparity between parents and minors in retelling of family circumstances school difficulty scarce school attendance unexplained withdrawal decreased cognitive functioning and poor academic achievement bedwetting, incontinence, soiling, gastrointestinal problems regression in behavior, school performance or attaining developmental milestones violent behavior	

Social workers	previous history of abuse chronic poverty low level of education young mothers lack of interpersonal relations lack of social integration networks single parent family violence/abuse experienced in childhood lack of trust towards institutions and social norms scarce knowledge and interest in the child growth child lacking strong family unit (i.e. in foster or other form of care)	difficulty in communicating issues obstruction to participating in wider groups physical injury	evaluation of potential circumstances and physical evidence of abuse
Police	history of abuse	unexplainably fearful	analysis of root cause factors

	drug use or involvement in criminal activity power dynamics in relationships lacking of support systems complete reliance on a certain individual or group of individuals	frequently in custody or committing infractions perhaps related to an underlying cause difficulty in articulating issues actions appear to be unnatural or perhaps influenced	evaluation of potential circumstances and physical evidence
Legal experts	history of abuse drug use or involvement in criminal activity power dynamics in relationships lacking of support systems complete reliance on a certain individual or group of individuals	unexplainable fearful frequently in custody or committing infractions perhaps related to an underlying cause difficulty in articulating issues actions appear to be unnatural or perhaps influenced	analysis of root cause and underlying factors evaluation of potential circumstances and physical evidence
Multi-professional cooperation	use of identifiable factors from other fields focus on those who may fall between gaps, those perhaps	behaviors that other fields might see as conducive to child abuse	analysis of factors that other fields and sectors identify as causing greater risk cooperation/liaising with other sectors in

	less easily recognized when strictly adhering to existing protocols		analyzing such behaviors

4. Sexual abuse

Child sexual abuse is the engagement of a minor or child in sexual activity that "he or she does not fully comprehend and is unable to give informed consent to" (WHO 1999). This also includes any activities "for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society"(WHO, 1999).

Risk factors

One belief that was previously considered as true was that child's age is a factor in sexual abuse, since highest rates of child sexual abuse occurs during adolescence (WHO 2002, p. 66) as well as that sexual abuse rates are higher among girls than boys (WHO 2002, p. 66).
In the following table you can see the rates of child sexual abuse in boys and girls through different surveys.

Research	**Male**	**Female**	
Sethi et. al. (WHO-E), 2013	5.7%	13.4%	Review, Europe
Barth et. al., 2013	6%	13%	Review, 24 countries
Pereda et. al., 2009	7.4%	19.2%	Global Review
Stoltenborgh et al., 2011	7.6%	18%	Global Review
Stoltenborgh et al., 2011	5.6%	13.5%	Review, Europe
Radford et. al. (NSPCC), 2013	12.5%	20.8%	UK

Radford et. al. (NSPCC), 2013	3.7%	13.2%	UK, contact CSA
Averdijk et. al., 2011	8.1%	21.7%	Switzerland, adolescents, contact CSA
Optimus, 2016	10.6%	12%	S. Africa, contact CSA
Nikolaidis et al., 2018	8-19.5%	6-18%	8 Balkan countries
Nikolaidis et al., 2018	3.8-12.2%	2-7.8%	8 Balkan countries, contact CSA
Tanaka et. al., 2017	4.1%	10.4-60.7%	Japan, Review
Tanaka et. al., 2017	0.5-1.3%	1.3-8.3%	Japan, penetrative CSA
Moore et. al., 2010	5.5%	14.1%	Australia, under 16yo

As a matter of fact these might indeed still apply regarding cases of child sexual abuse made known to authorities but it doesn't seem to equally apply on the actual occurrence of child sexual abuse rates (including the "dark/hidden number of cases which remain unidentified by services and represent the vast majority of cases actually occurring). Currently and over the last two decades there is complying evidence showing that (i) the vast majority of cases of child sexual abuse occurs within or near the child's family (what is sometimes called "the circle of trust" of the child") and (ii) that victimization of boys is much more frequent than it used to be thought to be, especially among younger ages of children-victims. In a research analyzing media files of child sexual abuse in the International Child Sexual Exploitation (ICSE) Database, it was found that 64,8 percent of unidentified media files depicted female children, 31,1 percent depicted male children and in 4,1 percent both male and female victims (INTERPOL 2018). Though, it is recommended to consider the possibility of intra-family sexual abuse regardless of the socio-economic level of the family, whatever the age of the minor, regardless of the minor's sex and regardless of the sex and age of the alleged perpetrator (NICE, 2017).

There are some high-risk circumstances where the possibility of intra-family sexual abuse might take place. For example, if the family is withdrawn and has little or no social relations with the outside world and the family refuses outside intervention. Also, if there are any problems of filiation, absence of familial reference points or confusion of generations within the family (e.g. adult authority having a slight age difference with the minor, one of parents in a situation of great submission to the other, very young age of the mother). Another sign might

be an ambiguous family climate with insufficient limits and prohibitions, eroticization of parent/child relationships, lack of respect for privacy or parental roles and functions not fulfilled. Also, co-existence or a history of domestic violence may increase the risk of sexual abuse. In addition, a breakdown in the family's balance in the form of moral abandonment of the minor, frequent conflicts with the couple or bereavement might be a warning sign. However, these situations are not specific to intra-familial sexual abuse and intra-familial sexual abuse can also occur in the absence of the various circumstances mentioned above (NICE, 2017).

More generally, it seems that there are at least three distinct subtypes of children's sexual victimization bearing different features, clinical profiles and epidemiological characteristics, namely (i) the sub-group of younger children-victims in which victimization occurs typically in the family or by adults introduced to the child by their own caregivers and in which there is not a large difference in the victimization of girls and boys, (ii) adolescent victims in which girls are more frequently victimized, some of which in the community with features bearing resemblance of the ones of sexual violence among adults and (iii) poly-victimized children living in households in extreme deprivation, social inclusion or severe family dysfunction in which sexual victimization comes as a part of a series of victimization incidents by different types of violence as a result of chronic lack of supervision and adequate care.

Early identification

Children who have been sexually abused may exhibit symptoms of infection, genital injury, abdominal pain, constipations, chronic or recurrent urinary tract infections or behavioral problems. Detection of sexual abuse requires a high index of suspicion and familiarity with verbal, behavioral and physical indicators of abuse (WHO, 2002, p. 61). The symptoms of sexual abuse may be general or nonspecific in nature, such as sleep disturbance, abdominal pain, enuresis, encopresis, or phobias. The pediatrician should exercise caution when considering sexual abuse, because the symptoms may indicate physical or emotional abuse or other stressors unrelated to sexual abuse (Kellogg, 2005).

Most cases of child sexual abuse are first detected when a child discloses abuse (Kellogg, 2005). At the same time, research has shown that the nature and dynamics of child sexual abuse make it exceedingly difficult for children to disclose their victimization. There are certain barriers that reduce disclosure such as cognitive and developmental factors, strategies employed by perpetrators to gain and maintain compliance and silence and internal and external factors that lead children to feel guilty or responsible for the abuse. Many child victims also fear that they

will not be believed or helped. Research has shown implications that disabled children and children belonging to cultural or ethnic minorities are faced with even greater barriers of disclosure. Also, some research indicates that boys are less prone to disclose sexual abuse than girls (Paine & Hansen, 2002; Lippert et al. 2009).

Most allegations, hints or reports of child sexual abuse become known to authoritative professionals a long time after the act or the series of act have been conducted especially in cases occurring within the child's "circle of trust" (which, however, represent the vast majority of cases, see e.g. Quayle et al. 2018). Moreover, it should be noted that (i) in most occasions sexual victimization especially of younger children less frequently includes physical force but rather deceiving, manipulation, blackmailing, threatening of the child in order for it to submit, (ii) the practices mostly preferred by perpetrators, especially with younger children-victims are not penetrative and (iii) the capacity of the skin and bodily tissues of younger children for regeneration is significantly higher than adults' thus any bodily signs of abuse are usually disappearing with 1-3 days. All the above, combined with the fact that usually in cases of child sexual abuse there are no bystanders or witnesses but only the perpetrator and the victims, makes the most usual evidence available in alleged cases the testimony of the child – victim.

Forensic examination

Even in confirmed cases of child sexual abuse, most children do not have physical findings diagnostic of sexual abuse (Sakelliadis et al., 2009). Therefore, the child's disclosure may often be the most important evidence in determining the likelihood of sexual abuse. When interviewing the child victim, the interviewee should be patient and friendly as children are often frightened by hurried or demanding examiner. Usually, the interview should be conducted with the child alone. Open-ended questions should be asked (Sakelliadis et al., 2009).

When interviewing a child on alleged abuse, proper interviewing techniques should be utilized to safeguard children's testimony from the effect of misinformation and suggestibility, as these could lead to false reports. Age or demographic variables are not consistent predictors of suggestibility (Hritz et al., 2015). Forensic interviews relating to child abuse are highly emotional and stressful events for children and this may affect children's encoding as well as retrieval of their abuse (Hritz et al., 2015). Another factor in child interviews is the timing of the interview after the original event. An immediate neutral interview can consolidate memory for an event and thus protect against forgetting, prevent normally occurring errors of commission and promote reporting of previously unmentioned details in later recall (Hritz et al., 2015).

For all the aforementioned reasons some widely accepted international protocols for forensic interviews of children victims have been developed including assessment of perceptional capacity of children, their ability to differentiate truth from reality as well as a series of non-guiding, emotion-free questions about historical events inquiry. The usage during these standardized interviews of anatomical dolls – which was quite popular a couple of decades ago – has substantially decreased in favor of more neutral anatomical diagrams. Additionally, a social technology of interdisciplinary collaboration for investigating child sexual abuse has been developed globally: initially emerging from the U.S.A. in the model of Child Advocacy Centers (https://www.nationalchildrensalliance.org/cac-model/) it was spread throughout the globe with services such as the Nordic Barnahus (https://www.childrenatrisk.eu/promise/barnahus-what-is-it/), Child Protection Centers etc. Since its early development almost 20 years ago or more, this social technology now widely expanded in most countries of the developed world has entered a phase of self-evaluation and setting of specific quality standards and criteria for its implementation (Johansson et al, 2017).

The physical examination of sexually abused child requires time and patience. As the child may be anxious, the examination should be explained to the child before it is performed. The examination should not result in additional physical or emotional trauma (Kellogg 2005). Sexual abuse may involve the mouth, even without overt signs, and thus, health care professionals (including dental professionals) should know how to collect a history to elicit this information as well as how to appropriately collect laboratory tests to support forensic investigations (Fisher-Owens & Lukefahr, 2017). If the alleged sexual abuse has occurred within 72 hours or there is an acute injury, the examination should be performed immediately. If more than 72 hours have passed, an emergency examination is usually not necessary (Kellogg 2005).

Examination for communicable diseases might play a role in examination of a child with an alleged or suspected case of sexual abuse. American Academy of Pediatrics has issued recommendations regarding which of the infectious diseases should be considered as definitely documenting some or other sexual abuse of a child, which might be regarded as potentially attributable to sexual abuse and which is not related to any other reason (https://pediatrics.aappublications.org/content/116/2/506.figures-only). According AAP, the age of the child, type(s) of child sexual contact, time lapse from sexual contact, signs or symptoms suggestive of an STD, family member or sibling with an STD, abuser with risk factors for a STD, request/concerns of child or family, prevalence of STDs in the community, presence of other examinations findings and patient/parent request for testing are the factors that the

health care professional should take into account in deciding which STDs to test for, when to test and which anatomic sites to test. (Kellogg, N., 2005)

Forensic evidence collection may include body swabs, hair and saliva sampling, collection of clothing or blood samples. The examination should also include assessment for signs of physical abuse, neglect, and self-injurious behaviors. Injuries and signs of trauma should be documented preferably by photographs (Kellogg, 2005; Sakelliadis et al., 2009).

Psychological assessment of sexually abused child may reveal post-traumatic stress disorder. Another common negative short-term effect of sexual abuse is the development of sexualized behavior. Nonspecific behaviors following the abuse include e.g. suicide gestures, fear of individual or place, nightmares, regression, aggression, depression and anxiety and poor school performance. However, the impact of the abuse may be minimal at the time of exposure and genuine psychological disturbances may appear in adult life (Sakelliadis et al., 2009). In cases of child sexual abuse, the duty of the doctor is to interpret trauma, collect specimens, treat injury and, help and support the vulnerable patient (Sakelliadis et al., 2009).

	Risk factors	Early identification	Forensic examination
Pediatricians	gender (females more likely to be abused regarding adolescent children-victims) absence of family mental or physical disability family power dynamics legal status (trafficking etc.)	Unexplained genital injury delay in accessing treatment or parents unwilling to seek help for child unwillingness to consult others for help, kept away from others by adults in their lives disparity in power relationships behavioral and emotional ques	collecting biological materials/evidence of potential abuse analysis of potential factors leading to specific emotional manifestations description or photos of acute trauma to genital/anal areas tissue laceration or bruising of labia, penis, scrotum or perineum

	unaccompanied children children in foster care, adopted children	(embarrassment, tension, anxiety) child's disclosure of sexual abuse trouble sitting or standing know and talk about sex despite age eating disorders abrasion/bruising/scars in the genital and perineal areas hymenal transections injuries at the clitoral, labia majora and minora erythema in the external genitals frequent vaginal bleeding anal dilation genital infections presence of sperm	acute laceration of the posterior fourchette or vestibule, not involving hymen acute laceration of hymen vaginal laceration semen identified in forensic specimen taken directly from child's body pregnancy STIs, sexually transmitted infections
Psychiatrists	previous child physical or emotional abuse	delay in accessing treatment or parents unwilling to seek help for child	analysis of root cause factors that may lead to surfacing emotional issues

	parental mental disorder parental substance use/alcoholism intimate partner violence in family child disabilities existing emotional trauma which an abuser may seek to exploit emotional issues that run deeper than first appear to be the case external manifestations of internalized difficulties	unwillingness to consult outsiders for help, kept away from others by adults in their lives disparity in power relationships child's disclosure of sexual abuse know and talk about sex despite age conduct disorders aggressive behaviors decreased cognitive functioning and poor academic achievement PTSD depression anxiety disorganized attachment self-harm/suicide attempts	
Psychologists	previous physical or emotional abuse	delay in accessing treatment or parents unwilling to seek help for child	analysis of root cause factors that may lead to surfacing emotional issues

	existing emotional trauma which an abuser may seek to exploit emotional issues that run deeper than firs appear to be the case mental of physical disability parent's psychopathology social deviancy of parents parental substance abuse parent's weak or absence of responsibility parent's distortion of emotions and empathy parent's impulsivity	unwillingness to consult outsiders for help disparity between parents and minors in the retelling of family circumstances behavioral and emotional ques (embarrassment, tension, anxiety, hypervigilance or apathy) regression in behaviour, school performance or attaining developmental milestones sleep disturbances eating disorders poor self-esteem sexualized behavior alcohol/drug use	
Social workers	previous history of abuse drug use/involvement in criminal activity	difficulty in communicating issues obstructions to participating in wider groups	evaluation of potential circumstances and physical evidence of abuse

	lack of interpersonal relations lack of social integration networks single parent family violence/abuse experienced in childhood lack of trust towards institutions and social norms scarce knowledge and interest in the child growth domestic violence physical or mental disability lack of strong family unit (i.e. foster or other form of care) child bad conduct	physical injury problems at school social problems	
Police	history of abuse	unexplainably fearful to a particular person	analysis of root cause factors

	drug use or involvement in similar activity power dynamics in relationships lacking of support systems	frequently in custody or committing infractions perhaps related to an underlying cause involvement in sex industry difficulty in articulating issues actions appear to be unnatural or perhaps influences child's disclosure of sexual abuse	evaluation of potential circumstances and physical evidence
Legal experts	history of abuse drug use or involvement in similar activity power dynamics in relationships lacking of support systems	unexplainable fearful frequently in custody or committing infractions perhaps related to underlying cause involvement in sex industry difficulty in articulating issues actions appear to be unnatural or perhaps influenced child's disclosure of sexual abuse	analysis of root cause factors evaluation of potential circumstances and physical evidence

Multi-professional cooperation	use of identifiable factors from other fields focus on those who may fall between the gaps, those less easily recognized when strictly adhering to existing protocols	behaviors that other fields might see as conducive to child abuse	analysis of factors that other fields and sectors identify as causing greater risk cooperation/liaising with other sectors in analyzing such behaviors

5. Neglect

Neglect refers to the failure of a parent or a caregiver to provide for the development of a child in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions. However, neglect has to be distinguished from circumstances of poverty in that neglect can occur only in cases where reasonable resources are available to the family or caregiver (WHO, 2002, p. 60).

Risk factors

Child neglect may manifest in non-compliance with health care recommendations, failure to seek appropriate health care, deprivation of food resulting in hunger, and the failure of a child physically to thrive. Other signs for concern may include the exposure of children to drugs and inadequate protection from environmental dangers. In addition, inadequate supervision, abandonment, poor hygiene and being deprived of an education have all been considered as evidence of neglect (WHO, 2002, p. 61). In cases of chronic neglect, one noted feature is unstable family environment in which the composition of the household frequently changes as family members and others move in and out (WHO, 2002, p.67). Neglectful parents may have difficulty planning important life events such as marriage, having children or seeking employment (WHO 2002, p. 67).

Early identification

According to NICE (2017), warning signs regarding negligence are the failure to provide for the child's physical (food, hygiene, shelter, clothing), emotional, medical (omission of care, refusal of treatment), educational or safety (inadequate supervision of activities, exposure to violent environment in the home or neighborhood) needs. Research has shown that parents and children rarely signal directly their need for help in cases of child neglect (Daniel, Taylor & Scott 2010).

Forensic examination

There is no diagnostic test for neglect. Decision-making in cases of apparent neglect can be difficult. It is essential to place the child at the centre of the assessment (NICE, 2017). One manifestation of child neglect is the failure to child to thrive, to maintain physical growth and development as a result from inadequate nutrition. (Block, R.W., 2005)

According APP, (2005), failure to thrive is a significantly prolonged cessation of appropriate weight gain compared with recognized norms of age and gender after having achieved a stable pattern (e.g. weight- for- age decreasing across 2 major percentile channels from a previously established growth pattern; weight-for-length < 80% of ideal weight). This is often accompanied by normal height velocity. The fundamental cause of FTT is nutritional deficiency, and poverty is the greatest single risk factor for FTT worldwide. FTT may result if parents/caregivers who are responsible for the growth of the child fail to avail themselves of community resources and/or assistance. The clinical evaluation for FTT should include a comprehensive history, physical examination, feeding observation, and a home visit by an appropriate health professional.

	Risk factors	Early identification	Forensic examination
Pediatricians	parents with substance abuse or other addiction chronic diseases premature birth	delay in accessing treatment disparity between parents and minors in the retelling of	collecting biological materials/evidence evaluating the type of neglect feeding observation

	physical or mental disability behavioral issues highly stressed or otherwise engaged parents failure to adhere to medical regimens lack of knowledge of normal growth and development infant with low birth weight or prolonged hospitalization.	how injuries occurred emotional distance between parents and child poor hygiene inappropriate clothes low stature growth wrong feeding frequent domestic accidents not having periodical medical check-ups no vaccination behavioral and emotional ques (embarrassment, tension, anxiety etc.)	physical examination: head circumference, using appropriate growth charts neurological examination assessment of suck-swallow coordination
Psychiatrics	previous physical or mental abuse parental history of mental/psychiatric problems and experiences of abuse in own childhood	conduct disorders aggressive behaviors decreased cognitive functioning and poor academic achievement	analysis of root cause factors that may lead to emotional issues

	parents' inability to read child emotional cues		
Psychologists	previous physical or mental abuse parental psychopathology social deviancy of parents parent's weak or absence of responsibility parental distortion of emotions and empathy parent's impulsivity	conduct disorders aggressive behaviors decreased cognitive functioning and poor academic achievement sleep disturbances "tired" children Distressed children with no obvious reason	analysis of root cause factors that may lead to emotional issues
Social workers	frequently changing family environment parental history of antisocial behavior/criminal offending drug use chronic poverty low level of education	difficulty in communicating issues lack of emotional intelligence and capacity trouble integrating socially information that the children stay alone at home without supervision	evaluation of potential circumstances and physical evidence of abuse

	young and single mothers without social supports lack of interpersonal relations lack of social integration networks single parent family lack of trust towards institutions and social norms scarce knowledge and interest in child growth unwanted pregnancy or maternity difficult relations with parent's own family or partner's family domestic violence parents are overly focused on career and/or activities away from home	frequent absences from school	
Police	previous history of abuse	frequently contacting the police over varying issues	analysis of root cause factors

	drug use/involvement in criminal activity frequently in custody physical or mental disability lacking strong family unit (i.e. foster or other form of care) use of existing protocols in case of interventions where minors are involved, notably domestic violence	unexplainable fearful frequently in custody or committing infractions perhaps related to an underlying cause lack of parental relationship or guidance (seeking that from other groups)	evaluation of potential circumstances and physical evidence
Legal experts	previous history of abuse drug use/involvement in criminal activity frequently in custody lacking strong family unit (i.e. in foster or other form of care) use of existing protocols in case of interventions where minors are involved, notably domestic violence	frequently contacting the police over varying issues unexplainable fearful frequently in custody or committing infractions perhaps related to underlying cause lack of parental relationship or guidance (seeking that from other groups)	analysis of root cause factors evaluation of potential circumstances and physical evidence

Multi-professional cooperation	use of identifiable factors from other industries focus on those who may fall between gaps, those perhaps less easily recognized when strictly adhering to existing protocols family that is resistant to recommended interventions despite multidisciplinary team approach	behaviors that other fields might see as conducive to child abuse	analysis of factors that other fields and sectors identify as causing greater risk cooperation/liaising with other sectors in analyzing such behaviors

6. Conclusion

This report lists many risk factors of child physical abuse, child emotional abuse, child sexual abuse and child neglect. The WHO (2006, 2016) recommends adopting an ecological and systemic model for child abuse. This means that CAN should be understood as a phenomenon that interplays between individual-level, close-relationship level, community-level and society-level factors. These factors share common root causes and because of that programs that effectively address root causes of violence have high potential for reducing multiple forms of violence against children (WHO 2016). No single factor on its own can explain why some people behave violently towards children or why CAN appears to be more prevalent in certain communities than in others (WHO 2006). This report should be read this in mind.

Most individual –level factors relate to caregivers and other adults, rather than children, but children with disabilities, conduct disorders and behavior problems can be at increased risk. Rates of CAN can also be affected by social and cultural acceptability of physical punishment of children, legislation, levels of inequality, and economic stress. Factors that protect against CAN

include strong relationships between children and parents, strong social support, parents' understanding of child development, parents' resilience and children's social and emotional competence (WHO 2013).

Elements of early identification of CAN listed in this report are signs that should initiate further actions by professionals working with children. When detecting these signs, professionals should investigate the case and – if needed - offer protective and supportive interventions and services for a child and their family. This may mean working with other professionals in multi-professional networks. Methods of forensic examination are to provide evidence in case of criminal investigation process.

Across all variations of abuse, personal histories, psychological maladaptation's and misconceptions; trauma, personal feelings, and other behavioral and psychosocial factors can all be factors in the underlying causes of abuse. Studies have discovered signals and developed assessment tools which provide the better detection of abuse at the beginning stages. Training programs for school personnel have been created to help detect abuse and arrange interventions for high risk children, whom often suffer from personality disorders, poor conduct or poor educational or behavioral outcomes, common indicators of abuse. Education plays a key role in abuse as well. Parents who are ill-educated are more likely to engage in abuse, with the cyclical impacts of this causing a generational effect on the children themselves, making them more likely to be abusive parents (Wilkinson and Pickett, 2009, pp. 211-212). There are areas of improvement on child protection protocols and policies around child protection in cases of abuse (O'Hagen 1995, p. 449). There is a vast array of literature regarding childhood traumas and the issues surrounding adolescents and adulthood for child abuse victims. However, early action is one of the key factors that determines recovery outcomes across all disciplines in both forensic and behavioral situations.

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