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Considerations on Child Abuse from a Medical and Psychosocial Perspective

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Abstract

The UN Convention on Children's Rights was adopted in 1989; the period leading up to the present day marks a continuous process for the implementation, observance and improvement of children's rights. According to the United Nations, over the last decade 2 million children were killed in armed conflict situations, more than 1 million became orphaned, over 6 million were severely injured, and over 10 million were left with severe psychological trauma. Child abuse takes the form of physical, psychological and social abuse, as well as neglect. Neglect of the child's physical and psycho-emotional needs is the most frequent form of abuse and violence against children. Socio-economic factors play a part in increasing the risk of child abuse. Child abuse entails multiple short- and long-term consequences, ranging from physical pain, loss of self-respect, suicidal behavior, depression, anxiety, post-traumatic stress, obsessive-compulsive disorder, bulimia, phobias, criminal or aggressive behavior, all the way to death. The medical care and approach to the abused child must be provided by a multidisciplinary team, based on collaboration between education, healthcare, and child protection specialists, the local authorities, and various non-governmental organizations.

Keywords: child, abuse, neglect, violence**,** rights, parental education, multidisciplinary team.

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Introduction

The idea to develop a special document to comprise children's rights belongs to Englantyne Jebb, the founder of the first "Save the Children" organization (1919, in London), who stated: "the child that is hungry must be fed, the child that is sick must be nursed, the child that is backward must be helped, the delinquent child must be reclaimed, and the orphan and the waif must be sheltered and succored." The UN Convention on Children's Rights was adopted by the General Assembly of the United Nations on 20 November 1989, based on the Declaration of the Rights of the Child proclaimed by General Assembly Resolution of 20 November 1959 (UNICEF, 2003). To this date, the document was signed by 194 member states. Every country signing the Convention acknowledges its contents and undertakes to observe it and adequately enforce it. Romania was among the first states to ratify the UN Convention on Children's Rights in the year immediately after its adoption at the United Nations, by means of Law no. 18 of 28 September 1990. The fundamental children's rights included in the Convention refer to the right to life, the right to a name and a nationality, the right to education, the right to freely express one's ideas, the right to health care, the right to be protected against any form of violence, abuse or neglect, the right to play and to leisure time.

Forms of child abuse

According to law no. 272/2004 regarding the protection and promotion of children's rights, abuse means any voluntary action of a person that is involved in a relationship based on responsibility, trust or authority towards the child, which endangers the child's life, his/her physical, mental, spiritual, moral or social development, his/her physical integrity, and physical or psychological heath. Abuse takes the following forms: physical, psychological, sexual, and neglect. Other authors proposed a classification of child abuse based on motive and degree rather than type of injury (Southall, Samuels, & Golden, 2003).

Physical abuse entails non-accidental painful physical touching or contact, including physical intimidation towards the child (for instance someone's gesture of raising his/her hand against a child). Physical abuse means the physical trauma (of varying intensity) resulting from stinging, slapping, hitting, biting, shaking, shoving, throwing, suffocating, hitting (with one's hand, foot or other blunt objects), burning, tying, handcuffing, forcible confinement, caused by the abuser; these traumas are deemed abuse regardless of whether the abuser intended to hurt the child or not. In addition, an adult person assisting without intervening to the application of violence against the children he/she cares for or encouraging such behavior also counts as a form of physical abuse (Christoffersen *et al*., 2013).

The updated Law no. 217/2003 defines *domestic violence* as violence against any member of the family. Pursuant to the provisions of Law 272/2004, it is

forbidden for parents or teachers to exert violence for so-called educative purposes. Although some physical punishments are assessed as mild, their potential emotional effects can be profound and long lasting, so there can be no recommended solution entailing "mild and accepted" physical punishments.

Sexual abuse entails: offensive comments towards the child, sexual harassment, unpleasant touching or allusions, various insults, indecent proposals, touching or caressing of the child's genital organs, penetration of the child's genitals or anus, exposure of the abuser's sexual organs in front of the child, forcing or encouraging the child to touch the abuser's sexual organs, forcing the underage child to watch pornographic materials, forcing children under the age of 18 to have intercourse with other people regardless of whether such other persons are also minors or adults, or mutilation of the children's sexual organs. The categories of sexual abuse are as follows: rape (sexual intercourse against the child's will), pedophilia (an adult's sexual attraction towards children), and incest (sexual relations between parents and children or between siblings), respectively (Sprober *et al*., 2014; Martin & Silverstone, 2013).

The Penal Code defines the acts of sexual violence that constitute criminal offences and are punished as such, namely rape, sexual aggression, sexual intercourse with minors, soliciting minors for sexual purposes, sexual corruption and incest.

Emotional abuse can manifest itself via insults, threats, killing or mistreating the child's favorite pets, slurs, name-calling, isolation, ignorance, rejection, indifference, and using demeaning appellations or derogatory labelling. Threats regarding physical violence also constitute a form of psychological abuse. In most cases, emotional abuse accompanies the various forms of physical abuse. Verbal abuse is a form of emotional abuse and demeaning treatment, respectively.

Alienating abuse entails cutting off the child from the people, pets or object he/she had gotten emotionally attached to, the abuser prohibiting the child from developing emotional bonds that he/she should have with certain significant people in his/her lifer. A special case is that of parental alienation, whereby the abuser denigrates another person in front of the minor. Particular cases of alienation abuse include the custodial parent's failure to respect the visitation program set by the court or the international abduction of minor children.

Child neglect means the omission by one person responsible for the child's upbringing, care and education to take any measures with respect to such responsibility, which can endanger the child's life, his/her physical, mental, spiritual, moral or social development, his/her physical integrity, and physical or psychological heath. Neglect is a non-physical form of violence. Neglecting the child's physical and psycho-emotional needs is the most frequent form of child abuse and violence.

The forms of neglect include the following: nutritional neglect – the child is not nourished according to his/her needs (inadequate or unsuitably served food)

and nutritional deprivation; clothing-related neglect – the child does not have clothes or is wearing unsuitable or dirty clothes; hygiene-related neglect – lack of bodily hygiene, repulsive body odors, parasites; medical neglect – when parents fail to care for their children's health, providing them with the prescribed medical treatments and following through with routine medical checks; educational neglect – failure to enroll the child in kindergarten/school, the parents' lack of interest in the intellectual stimulation of the child, inconsistency in the rewards and punishments system, failure to monitor school progress; emotional neglect – the most frequent and insidious form of neglect (the adult's lack of attention for the child, lack of physical contacts, signs of affection and words of appreciation); child desertion / abandonment is the most severe form of child neglect and abuse (Schilling *et al.,* 2016; Southall, Samuels, & Golden *et al*., 2003).

The particularities of the cultural, confessional and socio-professional level, ethnic origin, generate in the contemporary medical activity situations in which the neglect gets an antagonistic character, for example the child who is in the family environment and enjoys proper affection and nutrition, but suffering from an oncological condition, is denied the right to chemotherapy treatment due to the lack of parental consent of his or her spouse for confessional or other reasons. In order to guarantee the right to life, access to health, from the perspective of state intervention, according to art. 5 of the Law no. 272/2004 were issued opinions referring to the incidence of the parents' decay from the exercise of the parental rights, institution regulated by art. 41 of the law cited as evidence of the child's importance and supremacy over any constraints of philosophical, confessional or social constraints (Barbur, 2010).

Statistical data regarding child abuse

Every year, roughly 133-275 million children witness frequent episodes of violence between their parents. According to some studies, approximately 20 to 65% of children in developing countries have reported being physically and verbally abused. In Central and Eastern Europe, 35% of school-age children reported being beaten (Christian, 2015).

The World Health Organization estimates that approximately 150 million girls and 73 million boys are subject to sexual abuse year after year. An epidemiologic study conducted in 21 countries with an average to higher living standard indicated that around 7 to 36% of women and 3 to 29% of men, respectively, have reported being sexually abused during childhood (World Health Organization, 2014).

According to the United Nations, over the last decade 2 million children were killed in armed conflict situations, more than 1 million became orphaned, over 6 million were severely injured, and over 10 million suffered severe psychological trauma (Schauer & Elbert, 2010). Around 300,000 young people under the age of 18 are actively involved in military forces, and approximately 800 children are

killed or severely injured by landmines every month. Around 25 million people are deemed displaced, and 40-50% of them are under the age of 18. According to the data provided by UNICEF, in January 2016, an estimated 535 million children live in countries affected by conflict or disaster (UNICEF, 2016).

War affects almost every aspect of child development. Children affected by armed conflicts can be injured or killed or become refugees, orphaned or separated from their parents and families. They can be victims of abuse and sexual exploitation, affecting their psychological health mainly because of their exposure to violence, and will become deprived of their right to education. Certain statistics indicate that they are at a higher risk of becoming child-soldiers. Children living in conflict areas are deprived of basic needs, such as shelter, food and medical care. "War violates every right of a child – the right to life, the right to be with family and nurtured and respected" (Ressler, Tortorici, & Marcelino 1993 ; Machel, 1996).

In Romania, the social census carried out by UNICEF on 120,000 homes indicates that at least one in ten children is the victim of a form of violence. Domestic violence is perceived as a normal part of life. Around 60% of the population is tolerant of violent behaviors within the family. Over 11,000 cases of abuse, neglect and exploitation were recorded in 2011. However, estimates suggest that for each reported case there are 100 other cases that are ignored. (UNICEF, 2014).

A national study conducted by the "Save the Children" Romania organization in 2013 regarding child abuse and neglect shows that 63% of the interviewed children confirmed that they were beaten up at home by their parents and 20% of the parents believe that physical punishment is a means of education. Most parents and a part of the children do not perceive certain physical punishments – such as slapping – as a form of physical abuse (Gradinaru & Stanculeanu, 2013).

Social, economic, family and personality related factors increasing the risk of abuse

There is a series of social and economic factors that increase the risk of child abuse, including: overcrowded or inadequate housing, poverty, unemployment, cultural beliefs regarding male authority, increased tolerance of violence in the family, owning weapons, institutional violence, and violence in the audio-visual media.

Mass media is viewed as a risk factor in the manifestation of violence. In recent years, there has been an increase in the number of TV programs including violence and that are designed for children and teenagers. Specialty studies have highlighted an association between violence in the mass media and aggression in children, and exposure to violent television contents determine children to mimic and become more antisocial or "violent" (Bellis *et al.,* 2013). The list of negative effects of

mass media on children also includes the following: disinhibition, desensitization towards the victim, affecting the operational status of the cognitive system, learning aggression techniques; also, the erotic message incites the children's imagination and essentially contributes to their precocious sexual maturation. It is necessary to implement particular ethical principles that may lead to a new civilization, where information technology contributes to the development of human personality rather than to its downfall.

The family related factors contributing to higher rates of child abuse are as follows: low levels of education, traumatizing childhood experiences, alcohol consumption (Freisthler, Johnson-Motoyama, & Kepple 2014; Laslett *et al.,* 2012; Iliescu-Bulgaru *et al.,* 2015), drug consumption, young ages of first-time mothers, mental health issues, disabilities or chronic diseases, family structure instability, large number of children in the family, violence in the family of origin, isolation from family and friends, unrealistic expectations regarding children, aggressive reaction to stress, very frequent relocations from one place to another, and lack of role models.

The personality factors that increase the risk of abuse include: behavioral disorders, certain disabilities, the child's feeling of rejection because his/her being born out of wedlock, adopted or placed with a foster parent or family.

Medical and psychological evaluation of the abused child

Abuse has multiple consequences. Immediate effects include physical pain, fear, humiliation, injuries of various levels of severity and loss of self-respect. Physical abuse leads to physical sequelae that can range from traumatic brain injury, fractures, disabilities, and mutilation all the way to death. Long-term consequences may include increased risks of substance abuse, suicidal behavior, depression, anxiety, post-traumatic syndrome, chronic fatigue syndrome, obsessive-compulsive disorder, bulimia, phobias, criminal behavior, aggression, cardiovascular disease (hypertension, angina pectoris, and atherosclerosis), diabetes mellitus, obesity, irritable bowel, and migraines (Young & Widom, 2014).

Abused children present to the hospital for various reasons and accompanied by various people. They may present to the hospital because of an "accident" or another reason, subsequently ascertaining the abuse. The next of kin may offer fake, made-up explanations for the child's lesions or offer no explanation at all. It is recommended to find out as many details as possible about the "accident", how and where it occurred, any potential witnesses, as well as accurate data about personal pathological conditions and family history. Pediatricians should pay attention to lesions that raise suspicions of abuse but that could be overlooked by unwary physicians, including any injury/traumatism in an infant: bruising

or fractures, lesions in unusual places, such as along the torso or at the ear or neck level, lesions with a particular pattern, multiple lesions in various stages of healing, or significant lesions that cannot be explained. Infants with cranial-cerebral injuries resulting from physical abuse may be brought to the hospital in extremis or with nonspecific symptoms, alteration of the mental state, coma, irritability, agitation, vomiting, seizures, abnormal movements, eating disorders, or cardiac arrest (Magana & Kaufhold, 2015).

A complete physical examination is mandatory in case of suspected abuse, analyzing aspects ranging from the general status and growth parameters to osteoarticular and cutaneous-mucous integrity. Scrapes, bruises, hematomas and burn marks can be identified at the skin level; these can be either all by themselves or accompanied by more severe traumatic lesions, namely fractures. Contusions and bruising in infants are highly suspicious for abuse: bruises located at a distance from bony eminences (the inner side of the arms and submental area), bruising at the ears, eyes and neck level, on the upper part of the arms, abdomen, back, genital organs or buttocks, multiple bruises of similar shapes and sizes or with a specific pattern (palm or belt shaped). Authors report that ophthalmic manifestations may be caused even by well-meant but harmful traditional practices or by neglect and sometimes outright abuse (Chana & Klauss, 2002). Palpation of the entire skeletal system is necessary in order to rule out the existence of any current fractures or determine any old fractures that are pending healing. Fractures that are extremely indicative of abuse include classic metaphyseal lesions (that occur by forced pulling or twisting), rib fractures, scapular and sternal fractures. Fractures of moderate specificity include multiple fractures (particularly if they are bilateral), fractures of different ages, vertebral fractures, finger fractures, and complex cranial fractures. Common fractures with low specificity include clavicle fractures, long-bone fractures, and linear skull fractures (Christian, 2015; Herrmann *et al.,* 2014).

Shaken baby syndrome is a clinical syndrome caused by repeated, violent shaking of babies, followed by an impact at the cranial level as a result of throwing or slamming them against a fixed surface. The following clinical aspects are identified: retinal hemorrhage, cranial injury (subdural hemorrhages), secondary cerebral edema, rib fractures or classic metaphyseal lesions. Normal lab testing is useful from a paraclinical perspective in order to identify a high level of liver transaminases that could be indicative of abdominal trauma, coagulation tests, toxicology screening tests (recommended in case of unexplainable symptoms, including alteration of the level of consciousness, coma, agitation, nervousness, or after taking the patient from a high-risk environment), imaging investigations. Full skeletal X-ray examination is indicated in any child under the age of 2 and with suspected physical abuse. Clinically occult, asymptomatic fractures have a 24% incidence rate in physically abused children under the age of 2. The skeletal X-ray examination should include at least 2 views of each extremity of the long bones, anteroposterior and lateral view of the skull, anteroposterior and lateral view of the vertebral column, as well as the thorax, abdomen, pelvis, arms and legs

(Offiah *et al.,* 2009; Kleinman *et al.,* 2011). Psychological examination should be carried out in a trusting environment. Most of the times, the abused child learns that asking for someone else's help will only make matters worse for them if the abusive parent finds out. The child learns to cope on his/her own, to keep out of the abuser's way, to defend himself/herself, to avoid triggering conflicts or to move out as much as possible of the abuser's way. Although subject to abuse, many of these children want to be reintegrated in the family, as this is the only lifestyle they know. The evaluation aims to assess the patient as much as possible without the parent being present, and to ensure that the patient report data be supplemented with data from family members or the community, as well as from teachers – if the child is enrolled in school. Creating a positive relationship based on trust with the psychologist and the doctor is a means of improving the chances for suitable therapy and adequate social support (Al Odhayani, Watson, & Watson, 2013).

For some children, the hospital is the only possibility to escape from a hostile environment. The hospital is one of the institutions requiring psychological and social assistance services the most, as well as qualified personnel that can handle matters such as patient counselling, prevention of abandonment, carrying out social evaluations, as well as representing the medically assisted persons before authorities. The medical care provided for abused children must be delivered by a multidisciplinary team including a physician with experience in treating pediatric emergency cases, a surgeon with experience in managing pediatric traumas, and a physician with experience in the therapeutic approach to child abuse cases. The team can request assistance from specialists in fields such as pediatric radiology, neurology, neurosurgery, pediatric orthopedics, ophthalmology, and psychiatry. Solving the risk situations that children are a part of entails close collaboration between the hospital physicians, the child's legal guardians, as well as local authorities (General Directorates for Social Assistance and Child Protection, police, prosecutors, city halls, various non-governmental organizations, and other health care institutions) (Bannon & Carter, 2003; Benger & Pearce, 2002).

Parental education

The socio-economic situation in Romania led to an increase in the number of families (and consequently children) in various risk categories: risk of abandonment, risk of being handed over to various institutions for indefinite periods of time, risk of physical, psycho-emotional or sexual abuse, risk of delinquency or becoming victims of violence and abuse (Ryan *et al.,* 2013). Ethnic and cultural factors can be categorized as risk factors and can increase the risk of emotional and physical abuse by enforcing certain customs – for instance, early marriage in Roma teenage girls and multiple births before the age of majority (Diaconescu *et al.,* 2015; Widom, Czaja, & Dutton, 2014; Godbout *et al.,* 2014; Ciubara *et al*., 2015).

Parental support provided by the parents throughout childhood and adolescence improves the chances of a harmonious psychological, social, and emotional development. Parents need to be aware that physical punishment, regardless of its intensity and reason for employ it, weakens the attachments between parents and children. Previous studies highlights the need to build a national system of parental education in Romania (Cojocaru, Cojocaru, & Ciuchi, 2011). When parents physically or emotionally hurt them, children learn that they cannot trust their parents for their own protection (Hornor, 2014) Physical aggression determines resentment and hostility in the child towards the parents, fear, avoiding contact with the parents, as well as a tendency to dissimulate or lie so as not to be in a position that engenders punishments or aggression. This means of solving various situations using physical force becomes a model that the child internalizes and that he/she will resort to when encountering a similar situation. The abused child, in turn, grows up to become an abuser because these become his/her problem, relationship and conflict solving models.

Children subject to physical punishments are more likely to develop aggressive behaviors, indecent language, anxiety and depression, drugs and alcohol consumption, serious mental health disorders or psychosomatic disorders (Shin, Miller, & Teicher, 2013; Donohue et al., 2014] Emotionally abused children are more susceptible to having a low self-esteem, being emotionally unstable, facing difficulties in becoming independent, being more socially withdrawn, introverted or extremely obedient, avoiding annoying others, and having suicidal thoughts.

Conclusions

Although there is easier access to information and there are various forms of support aimed at guiding parents to acquire skills for having an optimal relationship with their children (parenting), the rate of child abuse by family members is still very high. Preventing and fighting abuse against minors requires increasing awareness in the general population about the negative effects of abuse on the child's psychosocial development. School-based intervention policies are also necessary in terms of developing educational materials designed for both parents and the education, healthcare and social protection professionals, and that aim to improve the adults' knowledge of positive child discipline methods and techniques. It is also necessary to implement parenting programs in kindergartens, schools and high schools, programs that are adapted for various child ages and stages (preschool age, school age, and adolescence). Concurrently, it is necessary to encourage continuing education programs for general practitioners and pediatricians for the purpose of enabling early identification and adequate reporting of child abuse and neglect cases and for monitoring struggling families. Developing a communication network and work methodologies among education, healthcare and child protection professionals remains a major objective.

References

Al Odhayani, A., Watson, W.J., & Watson, L. (2013). Behavioural consequences of child abuse. *Canadian Family Physician*, *59*(8), 831-836.

Bannon, M., & Carter, Y. (2003). Paediatricians and child protection: the need for effective education and training. *Archives of Disease in Childhood*, *88*(7), 560-562.

Barbur, F.D. (2010). *Autoritatea parinteasca*, Bucuresti: Hamangiu.

Bellis M.A., Hughes, K., Jones, A., Perkins, C., & McHale, P. (2013). Childhood happiness and violence: a retrospective study of their impacts on adult well-being. *BMJ Open*, *3*(9), e003427.

Benger, J.R., & Pearce, A.V. (2002). Simple intervention to improve detection of child abuse in emergency departments. *BMJ*, *324*(7340), 780-782.

Chana H.S., & Klauss P.V. (2002). Ocular Manifestations of Child Abuse. *Community Eye Health*, *15*(41), 11-12.

Christian, C.W. (2015). The Evaluation of Suspected Child Physical Abuse. *Pediatrics*, *135*(5), e1337-e1354.

Christoffersen, M. N., Armour, C., Lasgaard, M., Andersen, T. E., & Elklit, A. (2013). The Prevalence of Four Types of Childhood Maltreatment in Denmark. *Clinical Practice and Epidemiology in Mental Health, 9*, 149-156.

Ciubara, A., Burlea, S. L., Sacuiu, I., Radu, D. A., Untu, I., & Chiriţa, R. (2015). Alcohol Addiction–A Psychosocial Perspective. *Procedia-Social and Behavioral Sciences*, *187*, 536-540.

Cojocaru, D., Cojocaru, S., & Ciuchi, O.M. (2011). Conditions for Developing the National Program for Parent Education in Romania. *Revista de Cercetare si Interventie Sociala*, *34*, 144-158.

Diaconescu, S., Ciuhodaru, T., Cazacu, C., Sztankovszky, L. Z., Kantor, C., & Iorga, M. (2015). Teenage Mothers, an Increasing Social Phenomenon in Romania. Causes, Consequences and Solutions. *Revista de Cercetare si Interventie Sociala*, *51*, 162-175.

Donohue, B., Azrin, N.H., Bradshaw, K., Van Hasselt, V.B., Cross, C.L., Urgelles, J., Romero, V., Hill, H.H., & Allen, D.N., (2014). A controlled evaluation of family behavior therapy in concurrent child neglect and drug abuse. *Journal of Consulting and Clinical Psychology*, *82*(4), 706-720.

Freisthler, B., Johnson-Motoyama, M., & Kepple, N.J. (2014). Inadequate child supervision: The role of alcohol outlet density, parent drinking behaviors, and social support. *Children and Youth Services Review*, *43*, 75-84.

Godbout, N., Briere, J., Sabourin, S., & Lussier, Y. (2014). Child sexual abuse and subsequent relational and personal functioning: The role of parental support. *Child Abuse & Neglect*, *38*(2), 317-325.

Gradinaru, C., & Stanculeanu, D. (2013). *Abuzul si neglijarea copiilor, studiu sociologic la nivel naţional*. Bucuresti: Salvati Copiii. http://www.salvaticopiii.ro/upload/p0002000100000002_Studiu%20-%20abuzul%20si%20neglijarea%20copiilor.pdf

Herrmann, B., Banaschak, S., Csorba, R., Navratil, F., & Dettmeyer, R. (2014). Physical Examination in Child Sexual Abuse: Approaches and Current Evidence. *Deutsches Arzteblatt International*, *111*(41), 692–703.

Hornor, G. (2014). Child neglect: Assessment and intervention. *Journal of Pediatric Health Care*, *28*(2), 186-192.

Iliescu-Bulgaru, D., Costea, G., Scripcaru, A., & Ciubara, AM. (2015). Homicide and alcohol consumption. A medico-legal and psychiatric interdisciplinary approach. Multivariate analysis. *Rom J Leg Med* , *23*, 137-142.

Kleinman, P.K., Perez-Rossello J.M., Newton, A.W., Feldman, H.A., & Kleinman, P. L. (2011). Prevalence of the Classic Metaphyseal Lesion in Infants at Low Versus High Risk for Abuse. *American Journal of Roentgenology*, *197*(4), 1005-1008.

Laslett, A. M., Room, R., Dietze, P., & Ferris, J. (2012). Alcohol's involvement in recurrent child abuse and neglect cases. *Addiction*, *107*(10), 1786-1793.

Machel, G. (1996). *Impact of armed conflict on children*. UN General Assembly http://www.un.org/documents/ga/docs/51/plenary/a51-306.htm

Magana, J., & Kaufhold, M. (2015). *Child Abuse Clinical Presentation*. https://emedicine.medscape.com/article/800657-clinical

Martin, E.K., & Silverstone, P.H. (2013). How Much Child Sexual Abuse is "Below the Surface," and Can We Help Adults Identify it Early? *Frontiers in Psychiatry*, *4*, 58.

Offiah A., van Rijn R.R., Perez-Rossello J.M., & Kleinman P.K. (2009). Skeletal imaging of child abuse (non-accidental injury). Pediatr Radiol, *39*, 461-470.

Ressler, E.M., Tortorici J.M., & Marcelino A. (1993). *Children in War: A guide to the provision of services*, UNICEF. https://www.unicef.org/sowc96/referenc.htm

Ryan, J.P., Williams, A.B., & Courtney, M.E. (2013). Adolescent neglect, juvenile delinquency and the risk of recidivism. *Journal of Youth and Adolescence*, *42*(3), 454-465.

Schauer, E., & Elbert, T. (2010). The Psychological Impact of Child Soldiering. In: E. Martz (ed.), *Trauma Rehabilitation After War and Conflict*, Springer, pp. 311-360.

Schilling, C., Weidner, K., Brähler, E., Glaesmer, H., Häuser, W., & Pohlmann, K. (2016). Patterns of Childhood Abuse and Neglect in a Representative German Population Sample. *PLoS ONE*, *11*(7), e0159510.

Shin, S. H., Miller, D. P., & Teicher, M. H. (2013). Exposure to childhood neglect and physical abuse and developmental trajectories of heavy episodic drinking from early adolescence into young adulthood. *Drug and Alcohol Dependence*, *127*(1), 31-38.

Southall, D., Samuels, M., & Golden, M. (2003). Classification of child abuse by motive and degree rather than type of injury. *Archives of Disease in Childhood*, *88*(2), 101-104.

Sprober, N., Schneider, T., Rassenhofer, M., Seitz, A., Liebhardt, H., Konig, L., & Fegert, J. M. (2014). Child sexual abuse in religiously affiliated and secular institutions: a retrospective descriptive analysis of data provided by victims in a government-sponsored reappraisal program in Germany. *BMC Public Health*, *14*, 282.

UNICEF (2003). *Declaration of the rights of the child*. https://www.unicef.org/malaysia/1959-Declaration-of-the-Rights-of-the-Child.pdf

UNICEF (2014). *Cunostințe, atitudini și practici parentale ale familiilor si persoanelor care ingrijesc copii cu varsta intre 0-6 ani*. http://www.unicef.ro/media/cunostinte-atitudini-si-practici-parentale-ale-familiilor-si-persoanelor-care-ingrijesc-copii-cu-varsta-intre-0-6-ani-studiu-unicef-romania-2014/

UNICEF (2016). *Nearly a quarter of the world's children live in conflict or disaster-stricken countries*, UNICEF. https://www.unicef.org/media/media_93863.html

Widom, C.S., Czaja, S., & Dutton, M.A. (2014). Child abuse and neglect and intimate partner violence victimization and perpetration: A prospective investigation. *Child Abuse & Neglect*, *38*(4), 650-663.

World Health Organization. (2014). *The Global status report on violence prevention*. http://www.who.int/violence_injury_prevention/violence/status_report/2014/report/report/en/

Young, J.C., & Widom, C.S. (2014). Long-term effects of child abuse and neglect on emotion processing in adulthood. *Child Abuse & Neglect*, *38*(8), 1369-1381.